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

Jose Valdez,
Petitioner,

vs. No: 05 WC 51126

Kap Roofing,
Respondent.

15IWCC0864

DECISION AND OPINION ON REVIEW

Petitioner, through his present counsel Nicholis J. Stein, appeals Arbitrator Falcioni's March 26, 2015 order denying Petitioner's Petition to Reinstate Case. The Commission, after considering the record, hereby affirms the Arbitrator's order. In support, the Commission makes findings of facts and conclusions of law as follows:

1. On November 18, 2005, Petitioner, Jose Valdez, though his original counsel David Martay, filed his Application for Adjustment of Claim.

2 On October 21, 2009, Attorney James M. Geraghty substituted in for Mr. Martay. The Form IC29, Stipulation to Substitute Attorneys, filed with the Commission listed Mr. Geraghty's address as 111 W. Washington Street, Suite1861, Chicago, Illinois 60602.

3. On May 9, 2014, a hearing on this matter was held before the then-presiding Arbitrator Fratianni. Presenting on the claimant's behalf was Mr. Stein. Mr. Stein at this point had not filed a Stipulation to Substitute Attorneys, or otherwise entered his written appearance in this matter. Mr. Stein requested a continuance, which was granted over Respondent's objection; the matter was reset for the arbitrator's August 6, 2014 status call.

4. At the arbitrator's August 6, 2014 status call, this matter received a trial date of August 8, 2014.

5. On August 8, 2014, neither the claimant nor any counsel on his behalf appeared for trial. Arbitrator Fratianni then dismissed the case for want of prosecution.

6. On August 27, 2014, notices of dismissal were sent to the parties' attorneys of record, including to Mr. Geraghty at the 111 W. Washington Street address.

7. On February 11, 2015, Mr. Stein entered his written appearance, and Mr. Geraghty withdrew as counsel, through the filing of the Stipulation to Substitute Attorneys.

8. On February 26, 2015, Mr. Stein filed a Form IC23, Petition To Reinstate Case, indicating the intent to present the petition on March 20, 2015.[1] This petition ultimately was presented before Arbitrator Falcioni on March 26, 2015. Arbitrator Falcioni denied reinstatement. A record was made of this proceeding.

9. On May 21, 2015, Petitioner filed a Form IC11, Petition For Review Of Arbitration Decision, requesting review of the March 26, 2015 ruling. Petitioner further requested that the Commission enter an order vacating the dismissal and remanding the case for arbitration.

At the March 26, 2015 proceeding, Arbitrator Falcioni cited lack of jurisdiction to grant the relief sought by Petitioner, as the reinstatement petition was untimely. It had been filed more than six months after dismissal for want of prosecution, far past the 60-day period of moving for reinstatement referenced in the Commission's rules of practice, which provide in relevant part:

Section 7020.90 Petitions to Reinstate

a) Where a cause has been dismissed from the arbitration call for want of prosecution, the parties shall have 60 days from receipt of the dismissal order to file a petition for reinstatement of the cause onto the arbitration call. Notices of dismissal shall be sent to the parties.

b) Petitions to Reinstate must be in writing. The petition shall set forth the reason the cause was dismissed and the grounds relied upon for reinstatement.

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[1] Attached to the Petition To Reinstate Case is a document titled "Petition To Vacate Dismissal," signed by Mr. Stein, that purports to bear a filing date of November 14, 2014. On page 4 of "Petitioner's Brief In Support Of His Motion To Vacate Dismissal For Want of Prosecution" filed subsequent to the Petition For Review, Mr. Stein states that "On November 14, 2014 ... after realizing that the case had been dismissed, the motion to vacate the dismissal was filed." Insofar as this November 14, 2014 document purports to be a Section 7020.90 reinstatement petition, it fails. Among its defects is that it does not comport with subsection (b) of Section 7020.90, regarding setting forth a presentment date. Counsel must exercise due diligence in setting the petition for hearing. *See* Van Poucke v. Dominick's Finer Foods, Inc., No. 03 WC 46936, 2009 WL 1719452, 09 I.W.C.C. 0254 (May 19, 2009). There also appears to be no service of this document upon the other side at the time of its "filing." Moreover, at that time, Mr. Stein *still* had not entered proper appearance, and thus would not have been recognized by the Commission anyway. Section 7020.30(b) provides that "[n]o attorney or law firm will be recognized in any case before the Commission unless he or they have duly entered their written Appearance." The Commission's case docket reflects no filing of this or any other document on November 14, 2014. As noted in the body of this Decision, it was not until February 11, 2015 that Mr. Stein entered his appearance by filing a Stipulation to Substitute Attorneys; he then filed the Petition To Reinstate Case about two weeks later.

> The petition must also set forth the date on which Petitioner will appear before the Arbitrator to present his petition. A copy of the petition must be served on the other side at the time of filing with the Commission in accordance with the requirements of Section 7020.70.

50 Ill. Admin. Code 7020.90.

According to Mr. Stein, in late 2013, the Petitioner sought to replace Mr. Geraghty with Mr. Stein, and he (Mr. Stein) sought to get the Stipulation to Substitute Attorneys on file, but through his own error failed to do so. On review, Mr. Stein argues that, technically speaking, since he did not receive the notice of dismissal, the reinstatement petition actually was timely. To-wit, as he argues, the rules of practice speak in terms of "receipt of the dismissal order" as the point at which the 60-day period starts running. Mr. Stein's position appears to be that, so long as a notice of dismissal is never received, the time period for moving for reinstatement is open-ended. As for Mr. Geraghty, according to his affidavit, he never received the notice either since, at the time of the dismissal, he was no longer at the address to which the notice was sent, and he had not notified the Commission of his new address.

So, according to this disingenuous argument of Petitioner's counsel, the arbitrator did have jurisdiction and should have considered the grounds relied upon by Petitioner for reinstatement. Those grounds apparently include that Mr. Stein lacked knowledge of both the dismissal and the fact that a trial in this matter had been set for August 8, 2014 – the trial that Mr. Stein did not attend, which failure to appear prompted the dismissal of this nearly nine-year-old case. As noted earlier, Mr. Stein admits that his ignorance of these matters was due to his own mistake. On page 3 of his "Petitioner's Brief In Support Of His Motion To Vacate Dismissal For Want Of Prosecution," he writes that he "did not receive notice of the dismissal due to his error in not filing the substitution of attorneys prior to the case being dismissed." As to his obliviousness to the August 8, 2014 trial date, Mr. Stein offers no explanation. The Commission notes that this trial date was set during the August 6, 2014 status call, and it is clear that he was aware that the matter had been set for a status call on that day, regardless of whether he attended the status call.

At any rate, with respect to the Commission's jurisdiction to consider the instant Petition For Review, the Commission notes that the 30-day period within which to file a Petition For Review prescribed by 820 ILCS 305 §19(b) is applicable where a claimant seeks review of a "decision;" however, a dismissal for want of prosecution is not a "decision." *See* Cranfield v. Industrial Commission, 78 Ill.2d 251 (1980). In the event that a petition for review is filed, the Commission may interpret it as a petition for reinstatement. Id. The granting or denying of a petition for reinstatement rests in the sound discretion of the Commission, and the standard is the same whether the dismissal takes place at arbitration or on review. Bromberg v. Industrial Commission, 97 Ill.2d 395 (1983).

With respect to whether the Petitioner has shown justification for reinstatement, the Commission finds that he has not. Arbitrator Fratianni's dismissal of the case on August 8, 2014 was entirely appropriate, given the age of the case at the time. Denial of reinstatement is routinely used to ensure proper adherence to timely filing, and for cases on file for three or more

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years, the failure of a claimaint or his attorneys to be present at each status call in which the case appears may result in the case being dismissed for want of prosecution. *See* 50 Ill. Admin. Code 7020.60. Likewise, Arbitrator Falcioni's denial of reinstatement was appropriate. It is the responsibility of the parties to keep on file with the Commission the names and addresses of any agent upon whom notices shall be served, and this duty includes keeping the Commission informed of any mailing address changes. *See* Ocampo v. KMW Gutterman, Inc., No. 06 WC 11467, 2010 WL 4600007, 10 I.W.C.C. 1057 (Oct. 22, 2010) (claimant's former attorney withdrew; the case was then dismissed for want of prosecution but the claimant did not receive notice of the dismissal because he was no longer living at the address he had previously provided to the Commission; a petition to reinstate filed more than 60 days after entry of order of dismissal was stricken). Ultimately, a party must exercise due diligence in pursuing his or her claim before the Commission. Contreras v. Industrial Commission, 240 Ill. Dec. 14 (1999). This diligence has not been done in this case.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's order, dated March 26, 2015, is hereby affirmed.

No bond is required for removal of this cause to 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: NOV 2 4 2015

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-10/28/15
jdl/ac
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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 Down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TANA TRICE,

Petitioner,

15IWCC0880

vs.

NO: 06 WC 1646

PARK HAVEN CARE CENTER,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by both the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, temporary total disability, and the nature and extend of Petitioner's permanent partial disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below.

Findings of Fact and Conclusions of Law

1. Petitioner testified she was 60 years old and had a GED. She went to college at St. Louis University and received a degree in criminal justice and psychology. She was currently unemployed and last worked in January of 2006 where she counseled mentally ill patients.

2. Prior to the incident of August of 2005, she had worked for Respondent for about a month. She indicated on her application for employment with Respondent that she had previous back surgery. She began treating with Dr. Heffner for her back in 2003 and he performed surgery on September 3, 2003. She followed up with Dr. Heffner after the surgery and "did pretty good." She went back to work in five weeks and was shocked and amazed at how well she was doing. He released her from treatment in March 2004.

3. Petitioner testified she returned to Dr. Heffner in September of 2004 because she had aching pain in her back. She did not remember whether she had right leg pain at that time. Dr. Heffner treated her with medication and physical therapy. That was the last time she saw Dr. Heffner prior to the "event" in August of 2005. Between those dates she occasionally took Flexeril, a muscle relaxer, but only at night. She was not taking Vicodin, but she was taking medication for chronic bronchitis that helped her sleep at night.

4. Petitioner also testified that when she began working for Respondent she "wasn't having any problems really," with her back. On August 22, 2005, she was walking through the dining area and "slipped and fell on a baked apple." She tried to reach back and grab a table she was passing. She fell flat on her right side and hit her shoulder on the table. She felt immediate pain including burning pain down her right leg. She had "very, very little" right leg pain prior to her 2003 back surgery. She went to an emergency room.

5. Petitioner followed up with her general practitioner, Dr. Lattimore. He prescribed medication and she had physical therapy. Dr. Lattimore released her to work on September 19, 2005. She was only working 20 hours a week and was still in physical therapy. She was laid off in January of 2006, and has not worked since. Eventually, Dr. Lattimore referred her back to Dr. Heffner. He also prescribed medication and a TENS unit. Dr. Heffner referred her to Dr. Feinberg, who administered nerve root injections. They would help for about less than a week. She continued to have back and right leg pain. Petitioner continued to treat with Dr. Lattimore and taking medication after she was no longer treating with Dr. Feinberg and Dr. Heffner.

6. On January 4, 2008, she reported to Dr. Lattimore that she fell on her left knee about a month previously. She fell because her right leg gave out. That happened previously, but luckily she was able to hold onto something to avoid being injured. Her leg currently gives out as well. She is very careful especially on stairs. She returned to Dr. Feinberg in June of 2008 and March of 2009 hoping that injections would alleviate her back and leg pain. He ordered a myelogram, which was performed in July of 2009.

7. Thereafter, Dr. Feinberg referred her to Dr. Kennedy who performed surgery on February 1, 2010. The pain down her right leg and hip resolved for about four months, but then it returned. She continued to follow up with Dr. Kennedy for about a year. He released her from treatment "shortly after" November of 2010. After that Dr. Lattimore continued her pain and relaxant medication.

8. Dr. Lattimore referred Petitioner to Dr. Randall for pain management, whom she saw in 2014. She continues to take medication but she tried to limit the Hydrocodone because she was "so scared to get addicted." She had no more injections because of all the tissue damage from the previous injections and surgeries.

9. Petitioner had visits with Respondent's section 12 medical examiner, Dr. Mirkin. She was actually in his office with him for three or four minutes. She would tell him what was going on and he laughed at her and indicated there was nothing wrong with her.

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10. Petitioner also saw a vocational rehabilitation counselor, Karen Kane, at Respondent's request. She was told to call Ms. Kane every morning at 8. She had to look up places at the library because she did not have a computer. Ms. Kane wanted reports sent to her every day. Petitioner informed her that she could not do that because there were days she could barely walk. She won't go outside if it's icy out, and won't put others in jeopardy by driving while on medication. She also does not go outside when she is on medication because she is afraid of falling. Ms. Kane found her employable and non-compliant.

11. Petitioner further testified that a lot of times she is in so much pain that she can't go anywhere. She cannot do a lot of chores like vacuuming and mopping. Her 16 year old grandson comes over and performs those tasks. She had to change her furniture because she cannot get up from low chairs.

12. Petitioner goes in and out of her home through the garage because she has difficulty with stairs and it really hurts her back and right leg. She uses a heating pad up to four times a day. She still takes medication every day. She wears a back brace at times to get some support and it relieves the pain sometimes. She can walk up to 10 minutes "maybe if [she's] lucky." She has pain a majority of the time.

13. On cross examination, Petitioner testified that she informed Respondent that she would not be able to do any heavy lifting or restrain patients when she began working there. She had a previous workers' compensation claim from an injury in March of 1983, when a lift on a van dropped and a lady in a wheelchair fell on her. She thought she "recovered 100%," but it appears she received a settlement of 40% loss of the person as a whole in 83WC41843 for an alleged herniated lumbar disc. She had another lifting incident in 1999 when she lifted her dog; for which she did not file a workers' compensation claim.

14. Petitioner denied she had problems with her back as a child. She did not look for work after she was laid off from Respondent except "in the newspapers." She still looks in the newspapers for jobs, but has not contacted any prospective employer. Petitioner agreed the results of the injections were unsatisfactory, but she continued them because she had to try something, she couldn't just give up. She did not remember when a doctor recommended she begin wearing a back brace.

15. Petitioner also testified that she actually timed the period of time she was with Dr. Mirkin. He asked her to move her arms and legs and to bend, which she did when she could. He did not touch her with his hands but did with an instrument.

16. On redirect examination, Petitioner testified she enjoyed her job with Respondent. She loved the work and working in general, she has "worked two jobs at a time most times." However, who would hire her full time when she has to "lay down on a heating pad for awhile, or, you know, taking medication if" she had to drive?

17. On re-cross examination, Petitioner testified that the factors that limit her from being hired full time also affect her ability to be hired part time.

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18. The medical records indicate that on August 25, 2005, Petitioner presented to Dr. Lattimore for severe back pain since August 22nd when she slipped on baked apples and fell at work. Her right leg went out and she twisted to catch herself and landed on her left knee and buttocks. She had immediate pain in the low back radiating down the right leg. She was sent to an emergency room. "She did have a drug test and came back positive for opiates; she is on Histussin with hydrocodone and took a dose the night before." Dr. Lattimore advised Petitioner "that there was no hint of a dangerous problem and that rapid recovery expected." Two to four days of bedrest was OK for severe leg pain. He advised Petitioner on lifting mechanics and recommended aerobic activities. He took her off work until further notice.

19. On January 6, 2006, Petitioner presented to Dr. Heffner on referral from Dr. Lattimore. Dr. Heffner noted that Petitioner had a new MRI after complaining of continued low back pain which was "the same that's he has had ever since the fall that she had in August of last year." She was doing very well prior to that. He indicated that the MRI showed expected scar tissue, but no sign of a new disc herniation or nerve compression; "nothing that would warrant any type of surgical intervention." There were some degenerative disc changes of L4-5 and L5-S1. The pain she was experiencing was probably related to the aggravation of that condition in her fall. He diagnosed a strain and recommended to treat the symptoms and prescribed Neurontin, a TENS unit, and a muscle relaxer.

20. Dr. Heffner ordered a myelogram CT to see if there was some pathology he did not see in the MRI because Petitioner's condition had not improved. On July 10, 2006, Dr. Heffner noted the myelogram showed no major structural concerns that would warrant surgery. He continued medications and referred her to pain management for "other suggestions on a long term basis."

21. On July 29, 2006, Petitioner presented to Dr. Feinberg on referral from Dr. Heffner. Between that date and February 7, 2007 it appears that Dr. Feinberg administered 11 separate injections. By March 28, 2007 Dr. Feinberg indicated Petitioner reported 9/10 pain, which gets up to 10/10, and little improvement overall. He recommended a spinal cord stimulator.

22. Dr. Heffner's treatment notes suggest that Petitioner was getting minimal if any benefit from the injections administered by Dr. Feinberg. However, Dr. Feinberg testified by deposition that Petitioner was responding to injection therapy. In Dr. Heffner's treatment record of June 18, 2007, he noted that Dr. Feinberg discussed with Petitioner the possibility of a spinal cord stimulator. "Given her studies have shown primarily degenerative changes," he thought that option made sense. She remained unable to work and given the length of time she had trouble, it may be unrealistic for her to consider returning to work.

23. Dr. Heffner testified by deposition on May 2, 2008. He initially saw Petitioner in 2003 when she reported longstanding back problems dating back to childhood. He eventually performed L4-5 laminectomy and discectomy on September 3, 2003.

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24. Dr. Heffner released Petitioner from treatment on March 30, 2004. She returned to him on September 3, 2004 for pain in her right leg. An MRI showed no recurrent disc herniation. He prescribed some medication and physical therapy.

25. The next time he saw Petitioner was on November 10, 2005. She reported slipping on a baked apple on the floor on August 22, 2005. She reported back pain sometimes radiating into the right leg. She already had some physical therapy which improved her condition somewhat. The findings of degenerative disc disease in the post-accident MRI were similar to those he saw in the previous MRI study but also showed expected scar tissue from the surgery. There was no indication of recurrent disc herniation or nerve compromise. He did not feel surgery was a good option at that point. He prescribed medication and a TENS unit.

26. Petitioner's condition did not improve so Dr. Heffner recommended a myelogram and post myelogram CT. It had basically the same findings as the MRI. There was nothing to suggest the need for surgery. He thought a fusion "had a low likelihood of success" and he eventually referred her to Dr. Feinberg for pain management treatment. He thought her need for pain management treatment was "life long." He thought the spinal cord stimulator recommended by Dr. Feinberg was a reasonable plan for treating Petitioner's pain because surgery was not indicated. Dr. Heffner deferred to Dr. Feinberg on whether Petitioner's work accident caused the need for the spinal cord stimulator. However, opined that the accident was a "symptomatic aggravation."

27. Dr. Heffner released Petitioner from treatment in September of 2007 because as a surgeon, there was no additional treatment he could offer her. He had previously released her to work. Her degenerative changes were essentially the same as when he released her to work, so he thought she could return to work if she were asymptomatic. However, because she had chronic pain for two years her condition was probably permanent.

28. On cross examination, Dr. Heffner agreed that the August 22, 2005 accident did not cause a structural injury or change of Petitioner's condition. She was able to work in that condition prior to the accident. Petitioner had chronic back problems prior to her August 22, 2005 accident. She reported she had back problems in childhood and when he first saw her she was 5'5" and 288 lbs. Basically, Petitioner had the same underlying degenerative changes after surgery. However, another injury can aggravate that condition and cause it to become symptomatic.

29. Dr. Heffner did not believe it was reasonable for her to work because of her symptoms and not because of any structural changes. There is no way to measure Petitioner's subjective symptoms. He suspected that the "degenerative change is the underlying culprit in her low back pain" as well as her radicular symptoms. Petitioner had essentially no pain when he saw her in March of 2004 after surgery. Petitioner reported a flare up of pain in September of 2004, which he treated with physical therapy and Medrol dose pack. She did not return for a scheduled follow up in November of 2004, so "apparently she was doing well."

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30. Dr. Heffner agreed that there can certainly be a temporary as opposed to a permanent aggravation of an underlying condition. He described her aggravation as a symptomatic aggravation of her condition because it did not change the structure of her spine. If her symptoms never improve then she suffered a permanent chronic aggravation of symptoms. Degenerative changes can cause symptoms without a mechanism of injury. The only way he could relate Petitioner's symptoms to the accident was her history. Because her impairment is based on symptoms and not structural changes, he would defer to Dr. Feinberg regarding any restrictions.

31. Dr. Mirkin testified by deposition on March 8, 2009. He examined Petitioner on "at least three occasions," on January 27, 2006, November 6, 2006, and September 14, 2007, reviewed records, and issued reports. He concluded that Petitioner suffered a lumbar contusion in her August 22, 2005 accident and reasonable and necessary treatment for that injury was some physical therapy and non-narcotic pain medication. Treatment should have lasted two to six weeks.

32. Dr. Mirkin was not sure that Petitioner needed to be taken off work completely from her job as social worker because of her work injury; it is not a physically demanding job. However, a couple of weeks would be reasonable. He would have recommended temporary restrictions including avoiding heavy lifting, stooping, and squatting which would last two to six weeks. However, a person with Petitioner's body habitus and underlying back condition should avoid extremely heavy lifting in any event.

33. Dr. Mirkin thought Petitioner was at maximum medical improvement at the time of his initial examination on January 27. 2006. "Certainly she has some other back conditions that could be contributing to her condition." She complained of back and leg pain before as well as after the accident. Her current complaints were related to her underlying back condition and not the work injury. Dr. Mirkin diagnosed Petitioner as having degenerative spine disease and addiction to tobacco and medications. He recommended that she stop smoking, lose weight, and get off the narcotics.

34. The Commission notes that on July 31, 2006, Dr. Cantrell performed a medical record review. Dr. Cantrell noted Petitioner reported slipping and falling on August 22, 2005 after which she had severe pain in the low back radiating into the right leg. He also noted that on August 7, 2005, prior to the accident, Dr. Lattimore referenced neck pain and lumbar radiculitis with positive straight leg raises. That note does not appear to be in Petitioner's exhibit of his treatment records. Dr. Cantrell believed the initial MRI and a course of physical therapy was reasonable, but continued treatment of her chronic lumbar condition was unrelated to her work accident. He believed Petitioner was at maximum medical improvement at the time of Dr. Mirkin's initial examination.

35. On cross examination in his 2008 deposition, Dr. Mirkin agreed that when he first saw Petitioner she related a history of a compensable work injury sustained on August 22, 2005. He also agreed that she reported falling and developing pain in her low back radiating into her right buttock and that Dr. Lattimore diagnosed lumbar radiculopathy.

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36. An MRI in January of 2006 showed mild osteoarthritis with a disc bulge and neuroforaminal narrowing at L5-S1 and postop changes at L4-5. Those conditions "certainly" could have been aggravated in an injury which Petitioner described to him.

37. Dr. Mirkin also testified that the pathology shown in the post accident MRI represent wear and tear which takes years to develop and would not develop within six months of an injury. He agreed with Dr. Heffner's assessment that Petitioner had a lumbar strain which may have aggravated her underlying condition, but he was not aware of lumbar strain that last for three or four years.

38. Dr. Mirkin did not disagree that the injections Petitioner received is a treatment option for a patient with degenerative and post-operative changes. However, he believed that the number of injections she received was clearly excessive; "if your first three or four shots don't work, there's really not a whole lot of hope that the next five, or six, or seven, or eight would help." He would also disagree with the recommendation for a spinal cord stimulator. For a spinal cord stimulator to be effective, you have to have signs of the nerves being inflamed or compressed, and you have to have atrophy to predict a good result, you'd have to have neurologic deficit. "But simply just taking more and more pain medicines and saying it's not helping" was not sufficient. He has seen a lot of these that Feinberg and his associates have put in, and he really has not seen a lot of good results. "All of his patients tend to be completely disabled."

39. On redirect examination, Dr. Mirkin testified that it is impossible to tell whether the disc narrowing at L5-S1 was related to the August 22, 2005 accident, but the MRI clearly indicates that it is not compressing the nerve, which was the same finding in the myelogram. The pathology noted in the post accident MRI film showed degenerative changes at L5-S1, which take many years to materialize. He believed that in the accident Petitioner "likely aggravated her condition. She had a bruise on her back or a strain of her back." The only treatment he thought was reasonable and necessary for her work accident was two to six weeks of physical therapy and anti-inflammatories. Petitioner was being treated for her postoperative and degenerative changes "and some of her pains symptoms are not substantiated by her objective findings."

40. On re-cross examination, Dr. Mirkin agreed that Petitioner's accident could have temporarily aggravated her condition. He also thought it was fair to say it could have aggravated her condition to the extent that she needed some additional medical treatment; there is just a difference of opinion on the extent of that treatment.

41. Dr. Feinberg testified by deposition on September 12, 2008. He opined that his injection treatments were "reasonable and necessary in an attempt to relieve her from the effects of her injury of August 22, 2005." She reported improvement after the injections. He eventually recommended a spinal cord stimulator because Dr. Heffner did not think surgery was indicated. He did not agree with the opinions of Dr. Mirkin about Petitioner's condition and the efficacy of treatment.

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42. Dr. Feinberg knew that Petitioner had some symptoms prior to the August 22, 2005 accident, but it was much worse thereafter and she became dysfunctional. He did agree with Dr. Mirkin that Petitioner would benefit from some weight loss. He agreed that there is an association between smoking and acceleration of degenerative disc disease (the medical history indicated variably that Petitioner smoked between ½, ¾, or 1 pack of cigarettes a day for 35 years).

43. Dr. Feinberg also agreed that degenerative changes can become symptomatic without mechanism of injury. He also believed in temporary aggravation of preexisting conditions. The definition of "temporary" is difficult. Depending on the degree of pain, one may start treating an aggravation after 10 days to three weeks if there was no spontaneous response. He thought her aggravation was permanent and explained on redirect examination that his conclusion was based on the timing of the increase of symptoms and the sudden spike of pain.

44. Dr. Feinberg also testified by deposition on January 14, 2011. Petitioner returned to him on March 30, 2009 again complaining of low back and right leg pain. Between that date and June 15, 2009, it appears that Dr. Feinberg administered five transforaminal epidural injections for lumbar radiculopathy.

45. A CT myelogram was performed on July 20, 2009. Dr. Feinberg noted that the CT showed a small disc protrusion at L4-5 with mild narrowing of the right lateral recess, mild spinal stenosis at the canal at L4-5, "and normal at L5-S1 with bilateral facet joint hypertrophy." The myelogram showed degenerative disc disease most prominent at L5-S1 but also noted from L3-L5, more prominently at L4-5. No spinal instability was noted. Other tests which were "part of the same evaluation" showed advanced degenerative disc disease at L4-5 and L5-S 1 and bilateral facet osteoarthritis at L3-4, L4-5, and L5-S1.

46. Dr. Feinberg opined that the injury aggravated her problem so that she eventually needed surgical consultation, his treatment and monetary charges were reasonable and necessary, she was unable to work, her condition was permanent, and she needed surgery. Dr. Feinberg thought Dr. Mirkin's characterization of her condition simply as degenerative disc disease was incorrect because she also had a disc herniation and narrowing of the canal. He also disagreed with Dr. Mirkin that Petitioner's injury did not permanently aggravate her preexisting condition and she could return to work as a social worker.

47. Dr. Mirkin again testified by deposition on October 27, 2010. He examined Petitioner twice after his previous testimony, reviewed additional medical records, and identified two additional reports he authored on August 19, 2009 and September 27, 2010. He noted that she had a fusion, and that had to be monitored for a period to ensure it is completely healed. He did not see any signs of it failing, but he also did not see a lot of bone and she was at high risk for problems because "she won't quit smoking." Sometimes you have to monitor the development of a fusion for a year and a half or so.

48. Regarding the additional injections, Dr. Mirkin indicated patients with radiculopathy and a structural abnormality can benefit from one to three injections every six months to a year. "Beyond that is just completely excessive." Any need for injections would be based on her overall condition of degenerative disc disease with radiculopathy, which predated her August 22, 2005 accident. He thought the surgery was reasonable because Petitioner had degenerative disc disease and if she could not live with it fusion was a reasonable option.

49. Dr. Mirkin recommended a permanent 35-pound lifting restriction to avoid any flare-up of her back problems. Those restrictions would be based on the fact that she had surgery because of degenerative disc disease, and not because of the August 22, 2005 injury.

50. On cross examination, Dr. Mirkin agreed that he based his opinion of causation on the fact that Petitioner complained of symptoms prior to the accident. Dr. Mirkin acknowledged that Dr. Heffner indicated that Petitioner had done well after the 2003 surgery until the accident and he recommended continued treatment with Dr. Feinberg including the spinal cord stimulator. However, he also noted that Dr. Heffner never opined that additional surgery was indicated.

51. On redirect examination, Dr. Mirkin testified that the condition for which Petitioner was being treated is degenerative disc disease. There are both temporary and permanent aggravations of preexisting conditions. He characterized Petitioner's work injury as a contusion and "maybe a temporary aggravation of her condition" based on her history. Degenerative disc disease is a permanent and progressive condition with or without aggravation of any type.

52. Dr. Kennedy testified by deposition on February 9, 2011. He initially saw Petitioner on November 12, 2009 on referral from Dr. Feinberg. She reported she was injured in August of 2005 when she slipped and impacted her lower back. She developed back pain that worsened despite injections and physical therapy. The pain radiated into her right leg into the foot. Besides the back problems she also suffered from depression. She reported a 2003 laminectomy, from which she recovered. After reviewing a 2009 myelogram, Dr. Kennedy diagnosed spinal stenosis at L4-5 with foraminal encroachment on the right causing her leg pain.

53. Dr. Kennedy noted that Petitioner had already failed extensive conservative treatment, so he recommended decompression and fusion surgery at L4-5. He opined that the need for surgery resulted from the accident. On February 1, 2010, he performed L4-5 decompression and fusion surgery with instrumentation. A month after surgery Petitioner had improved with little or no leg pain and was walking easier.

54. Petitioner continued to have some back pain and x-rays showed some bone growth, but not as much as Dr. Kennedy would have liked. A CT taken on November 2, 2010 showed that the bone had not fused, but there was not much loosening of the hardware. He prescribed vitamin D and urged Petitioner to stop smoking. Dr. Kennedy recommended another surgery because he did not think she was optimally fused.

55. Dr. Kennedy opined that his treatment was reasonable and necessary in an attempt to improve Petitioner's condition and the charges were reasonable compared to others in the vicinity. There was not a time during his treatment of Petitioner that he thought she was able to work. He considered her condition to be permanent. He thought Petitioner should not lift more than about 10 pounds, with minimal bending, twisting, and stooping, with the need to change positions frequently and to sit, stand, and lie down as necessary. She will need some ongoing pain medication in the future.

56. On cross examination, Dr. Kennedy testified he did not review any records from before 8/22/05, including any imaging studies. He also did not review any subsequent records from Dr. Feinberg, Dr. Heffner, or Dr. Mirkin. He based his causation opinion only on the history Petitioner gave him. Petitioner never informed him of any back problems immediately before the accident.

57. Dr. Kennedy also testified there would not need to be a structural change because you are dealing with a clinical problem. Petitioner's spinal stenosis could have predated the accident; it is something that typically takes a long time to develop. It does not typically occur traumatically, but it can be worsened or made symptomatic by trauma. He agreed that smoking correlates to acceleration of spinal stenosis and Petitioner reported smoking a pack a day for 35 years. However, interestingly, he did not believe obesity was a correlative factor. Smoking was probably a factor for the nonunion, but it is not uncommon; they obtain 80% to 90% union in fusion patients.

In finding Petitioner proved causation of a current condition of ill-being, the Arbitrator found Petitioner credible in her testimony about her continuing symptoms. He also found her complaints supported by the opinions of Drs. Heffner, Kennedy, and Feinberg whose testimony he found were more persuasive than that of Dr. Mirkin.

The Commission finds that Petitioner suffered a strain in her lumbar spine on August 22, 2005, which resulted in a permanent but not substantial aggravation of her underlying degenerative disc disease. The record is clear that Petitioner had a serious underlying and longstanding lumbar degenerative condition as evidenced in her award of 40% loss of the person as a whole in a workers' compensation claim in 1983 and laminectomy/discectomy in 2003. The Commission notes that there are no objective findings to corroborate Petitioner's assertion that the August 2005 accident fundamentally changed her lumbar spine condition. In fact, Dr. Heffner specifically found that there was no structural change in her condition based on the imaging from before and after the accident. His opinion is corroborated by the findings of Dr. Mirkin who stated that the changes noted in the post-accident MRI were the result of longstanding degeneration and not of a traumatic nature. Finally, even Dr. Kennedy only recommended surgery as of November 12, 2009 when a new diagnostic study showed stenosis at L4-5 more than four years after the accident. Even then, Dr. Kennedy suggested that Petitioner's condition of ill being may have not been "structural" but more "clinical" in nature. The Commission finds Petitioner has not sustained her burden of proving that the development of stenosis at that time and the latest surgery was not simply the natural progression of Petitioner's degenerative disc disease which had nothing to do with any aggravation caused by the accident.

The Commission finds persuasive the opinion of Dr. Mirkin that Petitioner was at maximum medical improvement from her work injury when he saw her initially on January 27, 2006. In that regard, his opinion was supported by the opinion of Dr. Cantrell who agreed that Petitioner reached maximum medical improvement as of that date. Therefore, the Commission adopts the opinion of Drs. Mirkin and Cantrell and finds that Petitioner reached maximum medical improvement from her work-related injury as of January 27, 2012. Accordingly, the Commission terminates temporary total disability benefits as of that date. In addition, the Commission finds that any medical treatment incurred after that date was not related to her work-related injury and vacates the award of any medical expenses incurred thereafter.

The Arbitrator awarded Petitioner 20% loss of the person as a whole because her condition reduced her earning potential at least to the age of 65; she was 60 at the time of the hearing. He noted that it would be difficult for her to find employment due to her medical history and need for medication. The Commission notes that there are very little objective findings to substantiate Petitioner's substantial subjective complaints. In addition, the Commission finds that the majority of Petitioner's current condition of ill being is the result of her underlying degenerative condition and not her work-related injury. In looking at the record as a whole, the Commission finds that Petitioner's work-related injury resulted in the loss of 7.5% of the use of the person as a whole.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $320.00 per week for a period of 22&4/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $288.00 per week for a period of 37.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of the use of 7.5% of the person as a whole

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay reasonable and necessary medical expenses incurred through January 27, 2006 under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION, that the award of medical expenses incurred after January 27, 2006 is 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 injury.

15IWCC0880

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $20,000.00. The party commencing the 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: NOV 2 4 2015

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
O-10/20/15
46

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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Laurie Chapman,

Petitioner,

vs.

No. 09 WC 29095

15IWCC0885

Marion High School,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of wage calculations, benefit rates, prospective medical care, temporary disability, maintenance benefits, penalties and attorney fees, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation, medical benefits or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327 (1980).

The Arbitrator found the average weekly wage to be $1,576.55.[1] In its response brief on review, Respondent submits the average weekly wage is actually $1,616.24, and indicates it is amenable to modifying the Arbitrator's decision accordingly. The Commission modifies the Arbitrator's decision to reflect an average weekly wage of $1,616.24.

[1] In the request for hearing form Petitioner claimed an average weekly wage of $1,578.85.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 25, 2015, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $1,077.49 per week for a period of 21 6/7 weeks, from August 6, 2010, through January 2, 2011, and from April 19 through April 21, 2011, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation, medical benefits or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall provide vocational rehabilitation and pay maintenance benefits to Petitioner in accordance with the Arbitrator's Findings of Fact on those issues.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the medical bills in the sum of $58,528.14 pursuant to §§8(a) and 8.2 of the Act. Respondent shall be given a credit for the medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit, as provided in §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay for prospective conservative medical care recommended by Dr. Gornet, 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.

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: NOV 2 5 2015
o-11/05/2015
SM/sk
44

Stephen J. Mathis

Mario Basurto

David L. Gore

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

CHAPMAN, LAURIE
Employee/Petitioner

Case# **09WC029095**

15IWCC0885

MARION HIGH SCHOOL
Employer/Respondent

On 2/25/2015, 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:

0355 WINTERS BREWSTER CROSBY ET AL
THOMAS CROSBY
PO BOX 700 111 W MAIN ST
MARION, IL 62959

2904 HENNESSY & ROACH PC
MICHAEL HOLT
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

15IWCC0885

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Laurie Chapman
Employee/Petitioner

v.

Marion High School
Employer/Respondent

Case # **09** WC **29095**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **November 13, 2014** and **Collinsville** on **December 16, 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 **Vocational Rehabilitation**

FINDINGS

On the date of accident, **10/8/2008**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**61,485.65**; the average weekly wage was $**1,576.55**.

On the date of accident, Petitioner was **46** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of $**14,955.40** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**14,955.40**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $1,051.03/week for 21 6/7 weeks, commencing August 6, 2010 to January 2, 2011, and April 19-21, 2011, as provided in Section 8(b) of the Act.

Respondent is ordered to provide vocational rehabilitation and pay maintenance to Petitioner in accordance with the attached finding of fact.

Respondent shall pay reasonable and necessary medical services of $58,528.14, as provided in Section 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 claim by any provider of the services for which Respondent is receiving credit, as provided in Section 8(j) of the Act.

Prospective surgical medical benefits are denied, conservative benefits are awarded.

Penalties are denied.

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

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

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

Ethel Lee 2/17/15

FEB 25 2015

Chapman v. Marion High School
09 WC 29095

15IWCC0885

Findings of Fact as to All Disputed Issues

The following is a summary of the trial testimony of Petitioner and the exhibits offered by the parties. Petitioner was the only trial witness. Reference is made to the supporting exhibit or trial testimony as noted. Although Petitioner testified to her medical treatment, the Arbitrator references the medical exhibits as best demonstrating the treatment Petitioner received unless otherwise noted.

Petitioner testified that she has worked as a physical education teacher for Respondent since 1993. She became department chair in 2003.

Petitioner suffered an initial low back injury on December 14, 2005, and she filed Case No. 08 WC 182. She had a fusion surgery by Dr. Kee Park on December 1, 2006 consisting of a two-level fusion at L4-5 and L5-S1. (Rx 5) The Commission on February 17, 2010 awarded 40% MAW to Petitioner with respect to this earlier work injury. (Rx 2) The prior award and its supporting bases are not in dispute as that Commission decision was introduced into evidence at trial.

Case No. 08 WC 182 was tried on July 7, 2009. (Rx 2) The work accident at issue in this case occurred on October 8, 2008. However, Petitioner did not file her current claim (08 WC 29095) until July 14, 2009, after the first case went to trial. (Rx 3) Respondent has filed a Section 19(h) petition on July 27, 2014 with the Commission in Case No. 08 WC 182 to reopen that prior award on the ground that Petitioner's failed fusion at L5-S1; diagnosed following the October 8, 2008 work accident at issue herein, was a continuation of her original December 14, 2005 work injury. (Rx 1) The Arbitrator notes that he has no jurisdiction over the Section 19(h) Petition.

Following the first fusion surgery, Dr. Park released Petitioner to work as a PE teacher in May 2007. (Rx 2; Rx 6) Petitioner testified that she worked the balance of the 2006-2007 school year, and the 2007-2008 school year (until the work accident at issue), as a PE teacher and departmental head. She testified that she was able to complete her work duties with some modifications to account for her prior fusion and limitations from same.

Per the prior Commission decision, due to her first injury, Petitioner had to give up coaching girls team sports. She self-limited her personal activities, including grocery shopping; loading/unloading her groceries; her husband had to vacuum; and she limited the amount of time she spent doing yard work. She fatigued easily and had difficulty with certain movements. (Rx 2)

After being released by Dr. Park following the first surgery, Petitioner formally treated only a few times with her chiropractor for episodic increases in back pain. (Rx 7)

On October 8, 2008, Petitioner testified that she tripped over a student in gym class while attempting to avoid a volleyball coming her direction. She landed on her buttocks area. She was not able to break her fall with her outstretched hands. She experienced immediate and severe pain in her low back. She treated at Herrin Hospital emergency room on October 9, 2009. X-rays of the wrist were negative. X-rays of the low back were negative for fracture; there was no evidence of hardware failure. (Rx 8)

The post-accident treatment included an attempted return to Dr. Kee Park, but he had since left the area. Dr. Fonn took over for Dr. Park, and Petitioner saw Dr. Fonn on January 22, 2009. (RX 9) She had ongoing back pain, stiffness but no radiation into her legs. Physical therapy and chiropractic manipulation provided only minimal help. An MRI was recommended. In follow up, Dr. Fonn reviewed an MRI and x-ray and thought Petitioner might be having a problem at L3-4. A myelogram was recommended. At the last visit with Dr. Fonn on March 26, 2009, Petitioner reported ongoing back pain and numbness and tingling into her right leg. Additional physical therapy was recommended because Petitioner reported benefits from prior therapy. (Rx 9) Petitioner testified at trial she did not feel comfortable with Dr. Fonn as a treating physician because all he wanted to do was perform surgery.

The exhibits in this case reflect that Petitioner's post-accident medical care included chiropractic treatment and therapy modalities with Dr. Bradley, a chirpractor. (Px 4) Petitioner saw Dr. Bradley initially between November 7 – 11, 2008, and she began another course of treatment between April 1, 2009-October 1, 2009. (Px 4) Petitioner participated in physical therapy upon Dr. Fonn's prescription between February 6, 2009-March 17, 2009, for a total of 13 visits. (Px 6.) On Dr. Parks' prescription, Petitioner participated in more physical therapy between February 10, 2010 - March 15, 2010. (Px 6.)

Petitioner was referred to Dr. Gornet for orthopedic care. Dr. Gornet testified via evidence deposition on June 9, 2014. (Px 14.) His records were also introduced. (Px 7.) Dr. Gornet is a board certified orthopedic surgeon. Dr. Gornet first examined Petitioner on May 4, 2009 relative to the October 8, 2008 work accident. Petitioner described tripping and falling backwards over a student while working as a gym teacher.

Dr. Gornet testified that Petitioner's symptoms were either due to adjacent segment failure at L3-4 or due to a failed fusion at L5-S1. He believed the accident of October 8, 2008 aggravated a pre-existing condition either by causing a non-union at L5-S1 or rendering more symptomatic a pre-existing non-union at the L5-S1 level. Dr. Gornet initially ordered a discogram to rule out contribution of the L3-4 disc space, but this study was negative. Petitioner was allowed to continue working as a PE teacher, and she followed up periodically with Dr. Gornet who monitored her condition. Petitioner's symptoms progressed and surgery was ultimately performed on July 7, 2010. The surgery date was coordinated around Petitioner's teaching schedule. Dr. Gornet re-fused the L5-S1 disc space during this surgery. Post-operatively, on Dr. Gornet's prescription, Petitioner participated in physical therapy between October 26, 2010-April 4, 2011. (Px 6)

Regarding off work dates, Dr. Gornet testified that he removed Petitioner from work between the surgery date and January 3, 2011. Dr. Gornet declared MMI at the July 14, 2011 office visit. (Px 14) Although he has continued to treat Petitioner through his deposition date in June 2014 due to ongoing back symptoms, worsening over time, Dr. Gornet testified that he never retracted his MMI declaration or altered Petitioner's work status. In deposition, he agreed an FCE would help define what level of work Petitioner could perform. At the office visit on October 20, 2014, which was after Dr. Gornet's deposition, Dr. Gornet reviewed the FCE and imposed permanent work restrictions of 10 pounds lifting; alternate between sitting and standing as needed; and no repetitive bending or lifting. The Arbitrator notes that this is the first time Dr. Gornet imposed any restrictions on Petitioner since he had permitted a full duty return to work in January 2011.

Per Dr. Gornet's testimony and records, Petitioner has developed a symptomatic L3-4 disc space which Dr. Gornet attributes to adjacent segment failure. Her current condition is related to both of her prior work accidents in 2005 and 2008. Dr. Gornet believes that a future surgery is inevitable, and the surgery date will be determined by when Petitioner's symptoms reach a point where the future surgery will improve her condition. Until then, conservative care will be attempted to postpone that surgery. Dr. Gornet did not know how invasive the future surgery will need to be. Part of the problem was that the first surgery removed so much bone and this will impact what surgery Dr. Gornet is surgically able to perform. As of his deposition date, Dr. Gornet testified that all of his medical bills had been paid.

On Dr. Gornet's prescription, Dr. Kaylea Boutwell performed lumbar epidural injections on November 19 and December 5, 2012; May 7 and 19, 2014. (Px 9). Respondent introduced Prium utilization review reports which non-certified the May 7 and 19, 2014 injections. (Rx 18)

Petitioner testified at trial that, after returning to work in fall 2011, her back pain worsened to the point she was crying a lot due to the pain. She continued to work through the pain with accommodations but it got to the point where she could not tolerate the level of pain she was having. She returned to Dr. Parks, and he removed Petitioner from work beginning in early December 2011. Per Dr. Parks' deposition, he testified he took Petitioner off work as of December 16, 2011. (Px 15)

As of trial, Petitioner is still an employee with Respondent, but she is on temporary disability status. She has worked with Dr. Parks' office on an annual basis to have disability certifications such as Petitioner's Exhibit 10 completed for submission to Teacher's SRS. Petitioner's Exhibit 19 is a ledger of the disability payments paid to Petitioner. It reflects disability benefits beginning in February 2012 and continuing through the present time. Petitioner is paid $2,218.07 per month. (Px 10)

Petitioner testified that she and Dr. Gornet have discussed future surgery at L3-4. They are trying to postpone the surgery as long as possible. The surgery might help

stabilize her back but there is no guarantee it will help her pain improve. She manages her pain by limiting her activities, using a heating pad, and taking narcotics as needed. She also wears a corset back brace. She avoids taking prescriptions as much as possible.

Per Petitioner, the pain impacts her ability to sleep. She changes from the recliner to the couch to the floor and to the bed. She does not sleep through the night. She does not golf or play tennis or bike ride anymore. She has to change positioning throughout the day, including lying down at times. She would not be able to teach a class because she cannot be on her feet that long or lay down. Working a regular work day, day after day, would not be possible. She has to limit her driving to about 20 minutes because any longer period increases her pain.

She has looked for work in the education field. She is looking for a teaching job that would allow her to be flexible in terms of hours worked per day or in a given week. She was not able to find such a job in southern Illinois.

Petitioner prepared a written summary of her job search efforts, and it was marked as an exhibit to the Laila Slaise deposition. She prepared this document herself, and she first provided it to her attorney on the date she met with Ms. Slaise. It was not provided to Respondent prior to the meeting with Ms. Slaise. She has not looked for any work outside the field of education.

Petitioner testified her job search commenced in 2011 and has continued throughout 2014. During this time interval, Respondent did not offer any non-PE classroom teaching jobs. However, she is aware that Respondent has hired teachers and other administrative individuals during the 2011-2014 time interval. However, Petitioner testified she would need accommodations from Respondent for any position she could potentially perform. Respondent was not willing to create a position for her.

Petitioner testified that she has looked for teaching positions by using various web based search sites for various school districts within her driving range, like Marion, Herrin and Carbondale. She has also checked on line for jobs with Southern Illinois University and John A Logan College. She testified that she checked these sites daily for open positions.

Petitioner testified that she used her contacts in the education field to find potential jobs. One of her contacts at SIU placed her in contact with the Dean at Southwestern College in Wichita, Kansas. She was hired for a web based instructional teaching position with Southwestern College. She obtained training for this position between November 11-December 22, 2013. She then taught a 6-week online physical education program between February 17-March 30, 2014 for which she was paid $750. She was then hired to teach beginning March 31, 2014 a 12-week course but she resigned on April 11, 2014 because she learned that her temporary disability benefits would be discontinued if she did not immediately resign. Petitioner testified that she had been erroneously told by SRS that she could teach on line as long as it was not in Illinois, but

that turned out to be incorrect. Per Petitioner, she is not allowed to be involved in teaching at any level or she forfeits her benefits.

Petitioner agreed at trial that she advised Respondent in late November 2013 of her intent to retire effective the 2016-2017 school year. (Rx 29) At that time, she will be 55 and eligible for retirement benefits. In August 2014, she met with Respondent's superintendent and was told that her permanent restrictions could not be accommodated.

Petitioner testified that she participated in training in January 2013 in teacher performance evaluations, and again in June 2013. She has kept current with her qualification requirements to be a mentor of teachers. She was mentoring a teacher at time of trial but that was not a paid position.

Petitioner testified she agreed with the conclusions of Dr. Upton's report. He said she is not employable in the open labor market within her restrictions, and she agrees with that conclusion because she has looked for work in her field in Southern Illinois and found nothing. However, if Respondent would pay her while she looked for jobs within her restrictions, she would be willing to participate in vocational counseling. Petitioner's attorney on the record indicated that, if Respondent would pay all back benefits, and pay Petitioner maintenance while Ms. Slaise provided vocational rehabilitation, Petitioner would then agree to participate in vocational rehabilitation.

Petitioner testified that she had not heard whether Respondent offered vocational counseling through Bob Hammond prior to Ms. Slaise. Petitioner also was not aware whether Respondent had offered for her to participate in an FCE in October 2013 as part of the 3rd IME she had with Dr. Bernardi. Respondent introduced a letter dated September 1, 2014 from its attorney to Petitioner's attorney offering Bob Hammond to act as a vocational counselor. (Rx 25) Respondent introduced letters from its attorney to Petitioner's attorney offering an FCE in October 2013 following the third Dr. Bernardi IME report. (Rx 21)

Dr. Parks testified via evidence deposition on August 11, 2014. (Px 15) His office notes were also introduced. (Px 3) Dr. Parks is a board certified family physician, and he has been the long time family physician of Petitioner, including back when Petitioner injured her back in 2005 and received a fusion surgery to her lumbar spine in 2006. His office also treated Petitioner following the work accident of October 8, 2008 when she tripped backwards over a student. He helped manage her care for this later work accident, including ordering some initial physical therapy. Her original surgeon – Dr. Park left the area, so Petitioner was referred to Dr. Gornet, who diagnosed a failed fusion. Dr. Parks cleared her for surgery in June 2010. He continued to treat Petitioner after the surgery and continues treating her through the date of his deposition.

Petitioner returned to work following surgery, but in December 2011, she reported increasing levels of back pain and physical dysfunction to Dr. Parks. Her medications were not controlling the pain or they were causing adverse side effects. At the office

visit on December 16, 2011, Dr. Parks recommended she apply for disability through the teacher's retirement system. Petitioner was at maximum medical improvement. He understood that she needed to remain on temporary disability until her worker's compensation case concluded, but he did not consider this a red flag or evidence of secondary gain.

At the office visit in January 2012, Dr. Parks' partner, Dr. Smith, examined Petitioner and completed teacher's retirement disability paperwork which certified Petitioner as being unable to work. Petitioner at trial testified that Dr. Parks' office has assisted her on a yearly basis to submit disability paperwork so her disability benefits could continue. The Arbitrator notes that one of those disability forms was admitted at trial as Petitioner's Exhibit 10. Dr. Parks testified that Petitioner's condition is permanent. Also, the October 8, 2008 accident caused Petitioner to suffer a permanent aggravation of her prior condition.

On May 2, 2013, Dr. Parks outlined specific restrictions for Petitioner, namely: no lifting over 10 pounds; no standing over 15 minutes or a total of two hours in an 8-hour day; no running; no rotation of her trunk; no climbing; no bending; no stooping; no pushing; no pulling; no crouching; no crawling; no kneeling; no sitting for more than one hour at a time or more than four hours in an 8-hour day; she should change positions every 15 minutes; and she should have frequent breaks to lay down or walk. Dr. Parks identified his examination findings on this date as being limited flexion of the low back. There were no other objective findings and the restrictions were based on what she told him and his interactions with her. (Px 15)

Dr. Parks has authored letters on various dates indicating that Petitioner is unable to work in any capacity. At his deposition, he further testified that Petitioner was not able to work as a physical education teacher, and she would not be able to work in any capacity except for just a few hours a day plus she needed to frequently change positions. She would need to lay down up to 30 minutes to rest her back. Her medication of Hydrocodone would further limit her employability because it would affect her mentally. His opinions that Petitioner was unable to work were based more on her subjective complaints as opposed to objective findings on examination. His earlier letters suggesting complete disability were not based on an FCE. (Px 15)

He ultimately ordered an FCE at Petitioner's request. He reviewed the FCE report dated July 22, 2014, and he agreed the results were a good indication of her physical abilities as of that date. He could not say if her demonstrated abilities in the FCE were the same back in December 2011. However, her overall condition had not changed very much since December 2011. Dr. Smith agreed that he outlined work restrictions in May 2013, and some of the restrictions he imposed then were more restrictive than what the FCE later determined. (Px 15)

The FCE dated July 22, 2014 was introduced by both parties at trial. (See Rx 16) Petitioner did not meet the physical demand requirements of a PE teacher for the specific physical demands of static standing, sitting, stooping, and crouching in that she

demonstrated infrequent tolerances (less than 1/3 day) versus required tolerance of occasional (up to 1/3 day) for a PE teacher. The FCE therapist did not believe Petitioner could return to work as a PE teacher. However, she was capable of competitive employment in the light physical demand level. She would be able to work as a teacher. She would benefit from a position that would permit her to change positions from sitting to standing. (Rx 16)

Respondent introduced the evidence deposition of Dr. Bernardi taken on June 29, 2012. (Rx 13) Dr. Bernardi authored 4 IME reports dated June 30, 2010; November 9, 2011; October 8, 2013 (Rx 14); and July 29, 2014 (Rx 15). He is a board certified neurosurgeon. The deposition covered the first two reports whereas the latter two reports were admitted without any corresponding deposition.

As of his first exam on June 30, 2010, Dr. Bernardi diagnosed a pseudoarthrosis at L5-S1. He believed that surgery was a reasonable consideration as Petitioner had exhausted conservative care. His prognosis following surgery was that she only had a 50/50 chance of having improvement in her symptoms.

At the second IME on November 9, 2011, Petitioner had received the revision surgery from Dr. Gornet. She was working full duty as a PE teacher, but she was having ongoing back pain, stiffness in the lower back, pain into the buttocks area, numbness into the right foot, among other complaints. Dr. Bernardi thought as he predicted that the revision surgery did not succeed in relieving her pre-surgery complaints. While the L5-S1 disc space was solidly fused, she had mild L3-4 juxtafusional disease but this did not require any treatment. She could continue to work as a PE teacher but she should moderate her activities including avoiding contact sports and high impact exercises. She was at MMI for the revision surgery. She did not need further treatment except a home exercise program and to use over the counter medications as needed. (Rx 13)

In his deposition, Dr. Bernardi testified that, based on the operative report of Dr. Gornet, which identified incomplete bone growth at L5-S1, Petitioner never completely fused at L5-S1 following the original fusion surgery. The CT scan dated May 4, 2009 was also consistent with a pre-existing non-union at L5-S1 that pre-dated the October 8, 2008 accident. This radiograph was not consistent with a fracture of a previous solid fusion, which would appear differently than a non-union. He had never previously seen a prior, solid fusion fracture except on one extraordinary occasion. He thought it was extraordinarily unlikely this occurred with Petitioner. Falling backwards onto the back would not be a sufficiently forceful mechanism to cause a solid fusion to fracture. However, Dr. Bernardi agreed that the accident of October 8, 2011 aggravated the pre-existing psuedoarthrosis. (Rx 13)

As of the third IME on October 8, 2013 (Rx 14), Petitioner was off work by Dr. Park as of December 2011. She was on temporary disability. She was having ongoing back pain, which Dr. Gornet thought was due to the L3-4 disc space and juxtapositional disease. Per history, surgery to address the condition was possible but Dr. Gornet was

not enthusiastic about it nor was Petitioner. Dr. Bernardi in his report could not clearly articulate the source of the ongoing back pain, such as having the L3-4 disc space being its source, but that was possible. In any event, he did not recommend further surgery.

He disagreed with Dr. Parks' restrictions from May 2013. (Rx 14) These were excessive and, if true, would make it difficult for Petitioner to care for herself or her family. Petitioner's examination was essentially devoid of objective abnormalities. Her radiographic studies had not materially changed since when she was permitted full duty work by Dr. Gornet. Inactivity was not in Petitioner's best interests. To better address her functional abilities, an FCE was recommended. (Rx 14)

In his fourth IME report dated July 29, 2014 (Rx 15), Petitioner reported ongoing back pain and other symptoms which were worsening. Her self-reported disability scores were very high. Her examination results were essentially normal on an objective basis Yet, Dr. Bernardi believed Petitioner's complaints were credible and permanent restrictions were warranted. He reviewed the functional capacity evaluation dated July 22, 2014 and noted that Petitioner gave good effort. He believed that Petitioner could work in the light demand level, with a lifting restriction of 25-35 pounds; a carry restriction of 40 pounds; a push/pull restriction of 20 pounds; she should stoop and crouch infrequently. She needed to alternate sitting, standing and walking every 15-30 minutes. Dr. Bernardi was not able to accurately ascribe or assign these permanent work restrictions to only the 2005 work accident, or to only the 2008 work accident. (Rx 14)

Dr. Bernardi could not say whether the L3-4 disc space was the cause of Petitioner's ongoing pain. It could be or could not be, but in any event he did not recommend further surgery. No further medical treatment was necessary. The prior epidural injections she had were not medically necessary since Petitioner did not have true nerve root involvement at the L3-4 level. Instead, she had mild findings at L3-4 based on the more recent radiographic studies. The L3-4 disc space had only progressed a fairly minor degree based on serial radiographic comparisons. She should moderate her activities and take medications sparingly. She should participate in a home exercise program and keep her weight down. (Rx 14)

Petitioner participated in chiropractic care with Dr. Miller beginning on October 10, 2012–January 29, 2013. Another round of care with Dr. Miller occurred between March 10–April 8, 2014. (Px 8)

Petitioner introduced the evidence deposition, CV and vocational report of Dr. Thomas Upton (Px 16, 22.) Mr. Upton has a Bachelor's, Master's and Ph.D degrees in rehabilitation counseling. He is certified rehabilitation counselor (CRC). He met with Petitioner on November 5, 2014 for about 1 ½ hours. He reviewed Petitioner's medical records and interviewed Petitioner concerning her past work experience and education credentials. He reviewed Petitioner's written job search results. He did not conduct a labor market survey or a transferrable skills analysis.

Dr. Upton believed that Petitioner conducted a valid job search. Petitioner used her existing contacts within the field of education to attempt to locate work opportunities in her field, and she was able to find a part-time teaching position. She had to quit it prematurely because it conflicted with her receipt of teacher's disability benefits. The separation was not performance related. He agreed a valid job search is one where the individual looks for work on a weekly basis. They should apply for 20 jobs per week. Dr. Upton did not know if Petitioner applied for 20 jobs a week, but that many jobs would not be available to Petitioner. He did not attempt to verify the contacts reflected in the written job search. She did not look for work outside the educational field. He did not know if she formally submitted any job applications for actual teaching positions beyond the part-time position she obtained.

Dr. Upton did not believe Petitioner could work either part-time or full time. This was supported by the testimony of Dr. Parks in terms of the limitations he imposed on Petitioner, which included needing to frequently change positions and needing to lie down for 30 minutes before resuming her job duties. Also, Petitioner has a Master's Degree, and this will cut against her because school districts are looking to hire individuals at a lower pay scale. He disagreed with Ms. Slaise that Petitioner could work in the human resource field or as a teacher's selection specialist.

Dr. Upton acknowledged that the FCE said Petitioner could work as a teacher. With reference to Dr. Gornet's restrictions, he doubted whether Petitioner could be gainfully employed because the job market in southern Illinois is very competitive and not a lot of jobs are available. Petitioner would be employable at SIU Carbondale with the restrictions that Dr. Gornet imposed, but he did not know of any jobs available that would permit employment with those restrictions. He agreed that Drs. Gornet and Bernardi did not impose any restrictions on Petitioner with regard to driving a car or because of prescription medications. Neither of those doctors imposed any restrictions limiting Petitioner to less than a 40-hour work week.

Dr. Upton believed that Petitioner's inability to sustain any gainful employment is permanent in nature. He did not believe vocational assistance, such as assistance finding a job, would be of any benefit to Petitioner. He reasoned that there is just not a high likelihood of her being able to find any work on a full-time basis.

Respondent introduced the evidence deposition, CV and vocational report of Liala Slaise. (Rx 32) She is employed at Triune Health Group as a vocational rehabilitation consultant. She is a certified rehabilitation counselor (CRC). She has a Master's in rehabilitation counseling. Dr. Upton was one of her professors. She is familiar with the southern Illinois labor market given she attended SIU and has placed individuals in that geographic area for 10+ years. She reviewed Petitioner's medical records and the depositions of Drs. Parks, Gornet and Bernardi.

She reached out to Petitioner's attorney office first on October 6, 2014, but she did not meet with Petitioner until November 5, 2014. The purpose of the meeting was to

conducting an initial vocational assessment. She took an employment history which reflected that Petitioner has worked as a PE teacher dating back to 1993. Her education includes a Master's Degree in education, and she has four education related certificates. Petitioner was intelligent, articulate and presented well. Petitioner voiced that she wanted to work but Petitioner did not know what work she could do within her restrictions. Ms. Slaise performed a transferable skills analysis. Ms. Slaise did not perform a labor market survey.

In Ms. Slaise' opinion, Petitioner was employable in the open labor market. If Dr. Gornet's restrictions were referenced, Petitioner could work sedentary duty. If Dr. Bernardi's restrictions were referenced, Petitioner could work light duty. Using standard vocational reference tools, Ms. Slaise identified a sedentary position for an academic counselor and admissions evaluation as potential jobs that Petitioner could work, and those positions paid on average in southern Illinois $59,190.00 and $26,840.00, respectively. She identified in the light duty range potential positions of a high school and elementary teacher, and those paid in the $48,000.00-$49,000.00 range. Additional positions could be available with further educational training. Nothing in the restrictions of Drs. Gornet or Bernardi limited Petitioner to less than full time work.

Ms. Slaise did not discuss with Petitioner her job search effort, and she was not provided a copy of the job search summary prepared by Petitioner except as part of her deposition. Petitioner did not think she could consistently work full time. She might possible be able to work part-time or from home. Petitioner's Exhibit 2 to her deposition was a job search summary that she reviewed. She could not say whether it reflected a valid job search without additional information and detail concerning how much time per day Petitioner looked for work; how many times she contacted people; and how she presented to employers. She encourages her candidates to devout at least four hours per day, including search time. They should make 3-4 contacts per day. It is a daily effort to look for work. Petitioner did not follow through enough with employers in Ms. Slaise's opinion. She also looked for jobs that were not available or beyond her restrictions. Her resume was too long.

Dr. Parks' restrictions from May 2013 were not clear to Ms. Slaise. The restrictions from May 2013 were not based on the FCE, whereas Drs. Bernardi and Gornet reviewed the FCE. However, if Petitioner indeed needed to lie down from time to time for 30 minutes, outside standard breaks in a work day, that would impact her employability on a sustained or full time basis.

Findings of Fact Applicable to Issue F - Causal Connection

The Arbitrator finds that the work accident of October 8, 2008 constituted an aggravation of a pre-existing condition under *Sisbro* and similar case law. While the medical evidence supports Respondent's contention that Petitioner had incomplete fusion at L5-S1 before October 8, 2008, Drs. Gornet and Bernardi also believed the work accident of October 2008 aggravated a pre-existing condition. This evidence is sufficient to establish medical causation in the instant case. The Arbitrator does not

have jurisdiction over Respondent's Section 19(h) Petition or the medical causation arguments Respondent raises therein. The Arbitrator cannot deny causation based on the Section 19(h) petition.

Findings of Fact Applicable to Issue G - AWW

Per Petitioner's Exhibit 17, Petitioner had a base salary of $49,834.00 effective September 1, 2007. She had a base salary of $51,982.00 effective September 1, 2008. Under her school contract, she earned her wages over a 39-week school year. Per established case law, 39 weeks becomes the denominator in the average weekly wage calculation even though Petitioner accepted her pay over a 52-week period. Petitioner's exhibit 17 reflects additional stipends that Petitioner earned due to other services she performed during the school year. It is not disputed for example that Petitioner was a department chair and had other certifications.

Petitioner's Exhibit 17 reflects earnings of $59,409.23 between pay periods ending October 10, 2007 to September 25, 2008. This pay period is short by one pay check of a full earnings year. Petitioner would have earned another $2,076.48 for the pay period ending before the October 10, 2007 pay period. The pay period after September 25, 2008 would include the accident date of October 8, 2008, so it must be excluded from the calculations per Section 10 of the Act. Thus, Petitioner total earnings for purposes of the numerator would be $61,485.65 ($59,409.23 + $2,076.48).

The Arbitrator finds Petitioner's AWW to be $1,576.55.

Findings of Fact Applicable to Issue J - Medical Bills

Petitioner's Exhibit 1 is a medical bill spreadsheet and accompanying medical bill documentation. At trial, Respondent did not stipulate to the figures on the medical bill summary but the medical bills were allowed into evidence. There are inaccuracies in the medical bill summary as noted below.

Petitioner's medical bill summary claims the following providers; amounts billed; claimed outstanding balances; and co-payments by Petitioner:

Provider	total charges	payments	balances	co-pay
Herrin Hospital	$2,899.54	$2,899.54	$0.00	
Logan Primary Care	$1,069.00	$1,699.00	$0.00	$75.20
Dr. Bradley	$1,823.00	$1,823.00	$0.00	
Dr. Fonn	$2,369.00	$2,369.00	$0.00	
HR Physical Therapy	$13,730.00	$13,100.00	$630.00	
Dr. Gornet/ St. Louis Surgery Center	$164,492.74	$157,149.20	$7,342.94	
Dr. Miller	$1,106.77	$1,011.77	$95.60	$414.80

Dr. Boutwell	$5,523.01	$2,803.00	$2,722.01

In his deposition on June 9, 2014, Dr. Gornet testified that the medical bill for MFG Spine, LLC. was paid in full. (Px. 14, page 41). Exhibit 2 to the Dr. Gornet deposition was dated June 9, 2014, which was more current then the bill for Dr. Gornet contained in Petitioner's trial Exhibit 1 (i.e., March 19, 2014). The Arbitrator finds that, contrary to the medical bill summary, as to MFG Spine, LLC., there is no current balance per Dr. Gornet's testimony. However, Petitioner was seen by Dr. Gornet on October 20, 2014 (after his deposition), and an additional $123.00 in charges were incurred. Those charges are hereby awarded.

Petitioner's Exhibit 1 also included billing documentation for The Orthopedic Center of St. Louis where Petitioner had her L5-S1 fusion on July 7, 2010. The charges incurred were $28,051.00. These charges were all paid with adjustments taken and a $0.00 balance is shown.

With respect to Dr. Boutwell, Petitioner's Exhibit 9 contains Dr. Boutwell's records and bills. Exhibit 9 includes $7.020.00 in charges incurred at St. Louis Spine & Orthopedic Center embracing the injections that occurred on May 7 & 14, 2014. No actual bills or billing statements of Dr. Boutwell for her professional fees are contained in Petitioner's Exhibit 1. Although Respondent has introduced contrary evidence as to the medical necessity of the Boutwell injections, the Arbitrator finds Dr. Boutwell's injections were medically necessary and reasonable efforts at conservative care.

With respect to Dr. Miller, Petitioner's Exhibit 8 contains Dr. Miller's records and bills. It reflects total charges of $1,443.60 of which Petitioner paid $933.60. Worker's compensation paid $510.00.

Based on the foregoing, the Arbitrator makes the following medical award per the fee schedule as applicable, and hereby finds the following charges reasonable, medically necessary, and related to the work accident at issue. Respondent shall receive credit for any medical bills previously paid. Respondent shall reimburse Petitioner $2,017.60, the sums she directly paid. To the extent any bills were paid by Petitioner's group health insurance available through Respondent, Respondent shall receive a credit and hold Petitioner harmless pursuant to Section 8(j). The specific medical bills per provider hereby awarded are as follows:

Provider	total charges	payments	balances	co-pay
Herrin Hospital	$2,899.54	$2,899.54	$0.00	
Logan Primary Care	$1,069.00	$1,699.00	$0.00	$75.20
Dr. Bradley	$1,823.00	$1,823.00	$0.00	
Dr. Fonn	$2,369.00	$2,369.00	$0.00	
HR Physical Therapy	$13,730.00	$13,100.00	$630.00	
Dr. Gornet	$123.00	$0.00	$123.00	
St. Louis Surgery Center	$28,051.00	$28,051.00	$0	

Dr. Miller	$1,443.60	$1,443.60	$0	$933.60
Dr. Boutwell	$0.00	$0.00	$0.00	
St. Louis Spine & Ortho. Center/	$7,020.00	$0.00	$7,020.00	
Totals:	$58,528.14	$51,375.14	$7,773.00	$1,008.80

Findings of Fact Applicable to Issue L - TTD/Maintenance

Petitioner testified that the request for hearing form lists dates she claimed as being off work due to her back condition. In year 2009, she claimed the following dates: January 20-22; February 11; March 2; March 26; April 3; May 4; June 2; September 4; September 29; and November 5. In year 2010, she claimed the following dates: February 18; March 24; and May 13. Additionally, Petitioner was off work between August 6, 2010 to January 2, 2011 for her lumbar fusion surgery with Dr. Gornet, and Respondent has also stipulated to this time period per the request for hearing form. Additional dates of TTD claimed by Petitioner in 2011 were as follows: January 14; January 27; March 10; March 25; April 19-21; November 9-10; and November 29-30.

Petitioner's Exhibit 20 is a document Petitioner authenticated as being a record of dates a substitute teacher filled her position during her absences. The Arbitrator finds that the dates on Exhibit 20 support Petitioner missing work on the dates claimed. The Arbitrator further notes that Petitioner agreed on cross examination that she was paid salary and received full benefits for each of the dates she missed work but, in exchange, she had to use personal sick leave days. She ran out of sick leave sometime in May 2012. For the period of time Dr. Gornet had her off work for surgery, the TTD benefits were paid to the school and she received full salary and benefits.

At trial, Petitioner described a pain episode on April 19, 2011 when she went to the emergency room. This was after Dr. Gornet had released her to work following surgery. The principal had to help her with a wheel chair, and her son took her to the emergency room. She missed a few days of work. The Arbitrator notes that, per Petitioner's Exhibit 2, a corroborating emergency room record exists and a supporting off work slip from April 19-21, 2011 is contained in that ER chart.

On the issue of TTD, the Arbitrator concludes that, other than Dr. Gornet formally taking her off work between August 6, 2010 to January 2, 2011, and the April 19-21, 2011 dates, Petitioner has not met her burden of proof to support her claim for TTD benefits on the other dates. Per established case law, Petitioner needed to submit a supporting medical opinion or off work slip beyond her testimony on all dates of TTD claimed. Further, Dr. Gornet testified that Petitioner was at MMI as of July 14, 2011. Petitioner in fact continued to work full time as a PE teacher after Dr. Gornet released her in January 2011. Dr. Bernardi also found Petitioner to be at MMI as of his second IME on November 9, 2011.

Therefore, Petitioner is not entitled to TTD for any period other than August 6, 2010–January 2, 2011, and April 19-21, 2011, a period of 21 6/7 weeks.

Per the request for hearing form, Petitioner claims entitlement to maintenance benefits from December 16, 2011 to present. Petitioner did not request TTD after December 16, 2011 even though Dr. Parks removed her from work on that date and has kept Petitioner off any and all work since mid-December 2011. Petitioner is bound by her stipulation and specific request to receive maintenance benefits on and after December 16, 2011.

Petitioner has demanded maintenance benefits after December 16, 2011. Maintenance benefits are denied for the following reasons. First, Petitioner's written job search summary was admittedly prepared a short time before when she met Ms. Slaise on November 5, 2014. The job search summary purports to document Petitioner's job search activities dating back to late 2011 when Dr. Parks removed her from work. This written summary is not a contemporaneous job search log. Rather, it was prepared retrospectively in anticipation of the trial issue concerning the propriety of vocational rehabilitation and/or Petitioner's claim that she is unable to work in the open labor market. Written evidence of this job search was not provided to Respondent until November 5, 2014 when Petitioner met with Ms. Slaise. Petitioner withheld evidence of her job search from Respondent until just days before trial.

Second, Petitioner's permanent work restrictions were not objectively established until the FCE in July 2014. Respondent offered Petitioner an FCE in October 2013 (Rx 21 & 22), but Petitioner did not submit to the FCE until much later. Prior to the FCE, Dr. Gornet permitted Petitioner to continue working full duty as a PE teacher even though Petitioner frequently returned to Dr. Gornet for ongoing office visits. Dr. Gornet never retracted his MMI opinion or full duty work release. At the IME on October 8, 2013, Dr. Bernardi questioned the severity of the restrictions that Dr. Parks imposed in May 2013. Dr. Parks' deposition testimony offers minimal objective support on examination for the restrictions he imposed in May 2013. His restrictions on that date are much more restrictive then what was later shown in the FCE on an objective basis. The FCE is the best evidence of Petitioner's true functional abilities. The Arbitrator believes that Petitioner's job search between late 2011 and the FCE date was predicated on overly restrictive restrictions that lacked objective support.

Third, Petitioner's job search was limited to the field of education. Petitioner did not look for work within her restrictions outside the field of education. While Petitioner's earning capacity is stronger in the field of education, her decision to limit her search to education does not establish that she is not employable in *some* capacity in the open labor market outside the field of education. While ultimately Petitioner may not find work within her chosen field of education, she cannot claim a valid job search to support her claim to maintenance absent a good faith job search in the *entire* open labor market, not just the open *education* labor market.

Fourth, Petitioner's job search was not anywhere near a regular and consistent job search. Although Dr. Upton testified that Petitioner made a valid job search, his opinions are not conclusive on the issue. Dr. Upton testified his clients should look for work weekly, perhaps seeking 20 jobs per week. Ms. Slaise also questioned the vigor of Petitioner's job search. Petitioner's written job search exhibit does not reflect a regular and consistent job search to support an award of maintenance.

Finally, even as of trial, Petitioner's attorney went on record as qualifying Petitioner's intention to cooperate with vocational rehabilitation. Until all back maintenance benefits were paid, Petitioner would not agree to submit to vocational rehabilitation through Ms. Slaise.

For the foregoing reasons, Petitioner's request for back maintenance benefits are denied.

Findings of Fact Applicable to Issue - Nature and Extent

Petitioner has requested an award of permanency. The Arbitrator finds that further vocational rehabilitation is warranted, see Issue O below. The Arbitrator makes no opinion on whether Petitioner is employable in the open labor market. However, it is clear that Petitioner is well educated. She presents well. She has a long record of employment with Respondent. She testified to a willingness to submit to vocational rehabilitation within her restrictions if maintenance benefits were paid moving forward. Ms. Slaise has indicated her opinion that Petitioner is employable in the open labor market. The Arbitrator finds Ms. Slaise's opinion on Petitioner's employability more persuasive than those of Dr. Upton. As such, Petitioner's request for an award of permanency is premature and denied.

Findings of Fact Applicable to Issue M - Penalties

Respondent introduced a Section 19(h) Petitioner filed in the earlier worker's compensation case wherein Petitioner received an award of 40% MAW. The Arbitrator expresses no opinion on that 19(h) Petition as he has no jurisdiction. Respondent has medical evidence to support that the L5-S1 psuedoarthrosis pre-existed the fall accident of October 8, 2008. Respondent's position in the instant case is based on medical opinion testimony and a statutory provision which permits modifications of prior awards.

Until her FCE on July 22, 2014, permanent work restrictions were not determined on an objective basis. Respondent clearly offered Petitioner the opportunity to participate in an FCE in a letter directed to Petitioner's attorney October 22, 2013. (Rx 21) Another offer of the FCE was made via letter to Petitioner's attorney on February 11, 2014. (RT 22) Had the FCE been performed sooner, medical restrictions on an objective basis could have been determined. Dr. Gornet testified in his deposition in June 2014 that an FCE was reasonable.

Dr. Park has removed Petitioner from all work since mid-December 2011. He also imposed significant restrictions in May 2013. However, his decisions in this regard were not based on an FCE or objective criteria but, rather, his interactions with Petitioner and her subjective pain complaints. The Arbitrator believes the opinions on Petitioner's ability to work are better established by way of the opinions of Drs. Gornet and Bernardi than Dr. Park. Until Dr. Gornet imposed permanent restrictions in October 2014, he never retracted his MMI or full duty work opinion previously rendered even though he continued to treat Petitioner.

At the second IME of Dr. Bernardi on November 9, 2011, Dr. Bernardi agreed with Dr. Gornet that Petitioner was not in need of any work restrictions. She just needed to moderate her activities as appropriate; avoid contact sports; and avoid high impact exercises. (Rx 13, Exhibit 3) Yet, roughly one month later, Dr. Park began removing Petitioner from all work, and his office certified Petitioner completely disabled for purposes of TRS disability benefits in early February 2012. Respondent could reasonably rely on the opinions of Dr. Bernardi over the contrary work ability opinion of Dr. Park. As board certified back surgeons, the opinions of Drs. Gornet and Bernardi are more persuasive than Dr. Parks' contrary opinions.

Respondent offered Petitioner an FCE in October 2013 but Petitioner refused to submit to same until July 2014. As noted, permanent restrictions on an objective basis could have been determined sooner had Petitioner submitted to the FCE. The Arbitrator has already found that the FCE objectively determined Petitioner's restrictions, and Drs. Bernardi and Gornet have based their opinions on permanent restrictions based on the FCE.

Lastly, Petitioner withheld evidence of a job search until just before trial. Respondent did not act unreasonably in not paying maintenance benefits until evidence of a job search was provided. Further, Petitioner has continued to contest the propriety of vocational rehabilitation through the opinions of Dr. Upton, and further qualified future participation by Petitioner with vocational rehabilitation until Respondent paid all back benefits.

Penalties are denied for the foregoing reasons.

Findings of Fact Applicable to Issue O - Other

As noted, Petitioner may be employable in the open labor market. The Arbitrator orders Respondent to provide Petitioner with vocational rehabilitation through Ms. Slaise and to pay maintenance during any such time as Petitioner cooperates with Ms. Slaise. The efforts of Ms. Slaise shall be predicated on the permanent restrictions of Dr. Gornet imposed on October 20, 2014, which were objectively based on the FCE.

K Is Petitioner Enitiled to Any Prospective Medical Care?

The Arbitrator finds that the Petitioner may need further surgery to stabilize the injuries related to the October 8, 2008 accident and the December 2005 accident, case number 08WC182. P EX 14, Dr. Gornet's Deposition, pp 33, line 7. The Arbitrator is of the opinion these two cases should have been consolidated because the injuries are so inter- connected and the second accident occurred before the hearing of the first accident.

Dr. Gornet visualized Petitioner's anatomy during the fusion revision performed in July 2010 and has reviewed post-surgical MRIs which clearly show a juxtafusional failure at the level above the fusion. Dr. Gornet testified that by March 16, 2014, it was his medical opinion that Petitioner's adjacent failure at L3-4 would continue to deteriorate and future surgery was likely. However, at that time in his judgment corrective surgery should be delayed and he testified his treatment "will remain conservative for as long as I can manage her and she can tolerate her symptoms". P EX 14 , Dr. Gornet's Deposition, pp 31, line 31.

Accordingly, the Arbitrator finds the Petitioner's need for surgery is not sufficiently imminent to warrant an award for prospective surgical care, but does award conservative care as prescribed by Dr. Gornet.

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

James Gomez,

Petitioner,

vs. NO. 09WC033405

City of Chicago Department of Streets and Sanitation, 15IWCC0882

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 30, 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.

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: NOV 2 5 2015
SJM/sj
o-10/22/15
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GOMEZ, JAMES
Employee/Petitioner

Case# **09WC033405**

12WC024488

CITY OF CHICAGO DEPT OF STREETS & SANITATION
Employer/Respondent

15IWCC0882

On 3/30/2015, 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 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0154 KROL BONGIORNO & GIVEN LTD
DAN COLLINS
100 W MONROE ST SUITE 1410
CHICAGO, IL 60603

0766 HENNESSY & ROACH PC
JOSEPH ZWICK
140 S DEARBORN ST 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

15IWCC0882

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

James Gomez
Employee/Petitioner

v.

Case # 09 WC 33405

Consolidated cases: 12 WC 24488

City of Chicago, Department of Streets and Sanitation
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 Brian Cronin, arbitrator of the Workers' Compensation Commission in the city of Chicago, on 10/3/2014. After reviewing all of the evidence presented, the arbitrator hereby makes findings ozn 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? 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 the respondent?
N. ☐ Is the respondent due any credit?
O. Other _____

FINDINGS

15IWCC0882

- On 7/20/2009, the respondent City of Chicago, Dept. of Streets and San., 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.
- Petitioner's current condition of ill-being *is* causally related to the accident.
- In the year preceding the injury, Petitioner earned $**61,034.48**; the average weekly wage was $**1,173.74**.
- On the date of accident, Petitioner was **37** years of age, ***single*** with **0** dependent children.
- Petitioner ***has*** received all reasonable and necessary medical services.
- Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.
- Respondent shall be given a credit of $**97,923.03** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**97,923.03**.
- Respondent is entitled to a credit of $**0** under Section 8(j) of the Act.

ORDER

- The respondent shall pay the petitioner temporary total disability benefits of $ 782.49 /week for 123-4/7 weeks, from 7/21/09 through 12/2/11, which is the period of temporary total disability which compensation is payable.
- The respondent shall pay the petitioner permanent partial disability benefits of $664.72/week for 175.60 weeks because Petitioner sustained permanent partial disability to the combined extent of 35.12% loss of use of the man as a whole.
- The Respondent shall pay the outstanding medical bills or Northwest Neurosurgical (Px.6), Dr. Konowitz (Px.10) and ATI Physical Therapy (Px.11). Pursuant to the stipulation of the parties, Respondent shall pay those bills directly to the medical providers pursuant to Section 8(a) and subject to Section 8.2 of the Act.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest of 0.10 % 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

3/27/15
Date

MAR 30 2015

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

15IWCC0882

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMES GOMEZ,	)	
	)	
	)	
vs.	)	No. 09 WC 33405
	)	
	)	
CITY OF CHICAGO, DEPARTMENT OF STREETS & SANITATION	)	
	)	

Findings of Fact

Petitioner was employed by Respondent as a laborer in the Department of Streets and Sanitation. It is undisputed that Petitioner sustained an accidental injury to his low back and his left shoulder while working for Respondent on July 20, 2009. Petitioner was examined at Respondent's company clinic, MercyWorks, that same day and was diagnosed as suffering from a left shoulder strain and a low back strain. He was placed on light-duty restrictions that Respondent could not accommodate. Respondent began payment of TTD benefits.

On July 27, 2009, Petitioner returned to MercyWorks. It was recommended that he obtain an MRI of the left shoulder. He was also referred to Dr. Wesley Yapor, a neurosurgeon, for further evaluation of his low back. Dr. Yapor had performed surgery on Petitioner's back previously.

On August 11, 2009, Petitioner was examined by Dr. Yapor for his left shoulder and low back. Dr. Yapor noted that the MRI of the left shoulder revealed significant pathology. He recommended Petitioner be evaluated by Dr. Brian McCall for further evaluation of the shoulder. In regard to the low back, Dr. Yapor recommended an MRI. On August 19, 2009, Petitioner underwent a lumbar MRI which revealed degenerative changes but no new disc herniation.

On August 19, 2009, Petitioner was examined by Dr. Brian McCall regarding his left shoulder. He had complaints of clicking and popping in the left shoulder along with pain radiating down the arm. Dr. McCall diagnosed Petitioner as suffering from impingement syndrome along with a possible tear of the labrum. He administered a subacromial injection and recommended ongoing physical therapy treatment.

On September 16, 2009, Petitioner followed up with Dr. McCall. He reported no relief from the prior injection and/or therapy. Surgery was recommended.

On October 12, 2009, Petitioner underwent surgery performed by Dr. McCall consisting of a subacromial decompression with distal clavicle excision. Dr. McCall also debrided the tear of

the superior labrum.

On November 9, 2009, at the request of the Respondent and pursuant to Section 12 of the Act, Petitioner presented to Dr. Nikhil Verma. Dr. Verma opined that the Petitioner's condition of ill-being regarding the left shoulder was causally related to the work accident of July 20, 2009. Dr. Verma also found that the surgery which was performed was both reasonable and necessary.

Petitioner also remained under the care of Dr. Yapor in regards to his low back pain. He underwent a course of physical therapy treatment which failed to relieve that pain.

On December 22, 2009, Dr. Yapor referred Petitioner to Dr. Howard Konowitz for diagnostic testing and injections to determine whether Petitioner's complaints of back pain were related to retained hardware from a prior surgery.

On December 23, 2009, Petitioner followed up with Dr. McCall regarding his left shoulder. Dr. McCall found that Petitioner had recovered nicely following surgery. In regards to the shoulder, he placed Petitioner at maximum medical improvement and felt that he was cleared to return to regular work.

On December 31, 2009, Petitioner came under the care of Dr. Konowitz for his complaints of ongoing back pain. Dr. Konowitz agreed with Dr. Yapor's recommendation for further diagnostic testing, including diagnostic injection. Dr. Konowitz prescribed medications including Mobic and a Lidoderm patch.

On January 25, 2010, at the request of the Respondent and pursuant to Section 12 of the Act, Petitioner presented to Dr. Kern Singh for an examination. At the conclusion of his examination, Dr. Singh opined that Petitioner's current symptoms were the result of the work-related injury sustained on July 20, 2009. Dr. Singh recommended a CT myelogram of the lumbar spine. Dr. Singh further opined that Petitioner could require more treatment depending upon the results of that study.

On February 4, 2010, Petitioner underwent the CT myelogram.

On February 19, 2010, Dr. Singh had an opportunity to review the results of that study. Dr. Singh recommended a revision laminectomy at the L4-5 level with a foraminotomy. Dr. Singh further reiterated, once again, that he believed that the Petitioner's current symptoms were related to the injury of July 20, 2009. In a separate note dated March 15, 2010, Dr. Singh indicated that removal of the hardware from the prior surgery would also be reasonable as part of the upcoming recommended surgical procedure.

On March 10, 2010, Petitioner followed up with Dr. Yapor. Dr. Yapor concurred with the recommendations of Dr. Singh regarding additional surgery.

On March 25, 2010, Petitioner underwent surgery performed by Dr. Yapor that consisted of a left L4-5 foraminotomy and hardware removal.

On May 4, 2010, Petitioner underwent a functional capacity evaluation ("FCE"). Based on the results, the evaluator opined that the Petitioner was only capable of working at a light-duty basis.

On May 25, 2010, Dr. Yapor referred the Petitioner to Dr. Konowitz for further pain management treatment including possible injections.

On June 24, 2010, Dr. Singh conducted another Section 12 examination. Dr. Singh felt Petitioner had not yet reached maximum medical improvement. He recommended Petitioner undergo a course of physical therapy treatment to then be followed by a work conditioning program.

On July 7, 2010, Petitioner was examined by Dr. Yapor, who prescribed physical therapy treatment, Celebrex and a Lidoderm patch. On August 4, 2010, Dr. Yapor recommended Petitioner begin a work conditioning program followed by a functional capacity evaluation.

On September 29, 2010, Petitioner followed up with Dr. Yapor. He had ongoing complaints of low back pain for which Dr. Yapor once again referred him to Dr. Konowitz for pain management treatment.

On November 1, 2010, Dr. Singh conducted another Section 12 examination. Dr. Singh recommended an FCE. He did not believe the Petitioner required any further pain management treatment.

On November 3, 2010, Dr. Konowitz diagnosed Petitioner as suffering from post-laminectomy syndrome and myofascial pain syndrome. He recommended further diagnostic testing including an ultrasound and EMG.

On November 17, 2010, Petitioner returned to Dr. Yapor. Respondent denied further treatment by Dr. Konowitz based on Dr. Singh's Section 12 examination. Consequently, Dr. Yapor opined that the Petitioner had reached maximum medical improvement (if further treatment was not going to be authorized) and prescribed an FCE.

On November 22, 2010, Petitioner underwent an FCE at ATI. At the conclusion of the test, the evaluator felt that the Petitioner had put forth full effort. The evaluator found the results to be valid. Such FCE results indicated that the Petitioner was only capable of returning to work at a light physical demand level. The evaluator noted that Petitioner's job as a sanitary engineer is rated at the very heavy physical demand level by Department of Labor Dictionary of Occupational Titles.

On December 7, 2010, Petitioner followed up with Dr. Yapor. Dr. Yapor released the Petitioner to return to light-duty work within the limits of the FCE. He felt that, from a surgical standpoint, the Petitioner had reached maximum medical improvement. He once again referred Petitioner to Dr. Konowitz for further pain management care.

On January 5, 2011, Petitioner was examined by Dr. Konowitz complaining of ongoing low back pain radiating down the left leg. Dr. Konowitz once again recommended an EMG along with a

left sacroiliac injection. 15IWCC0882

On January 5, 2011, diagnostic ultrasounds were taken of Petitioner that revealed extremely significant left sacroiliac joint capsulitis, very significant left piriformis myositis and insertional fibrositis and significant left lateral hip joint spurring.

On October 3, 2011, a second FCE was scheduled at Respondent's request. This FCE was performed at NovaCare. The evaluator that performed this evaluation, at Respondent's request, opined that Petitioner was putting forth an invalid effort. The evaluator felt Petitioner was capable of working at least at the medium demand level, but that the results of the test were invalid.

Petitioner testified that he was released return to work on December 2, 2011. Petitioner testified that on or about that date, he went back to work on the garbage truck and performed all the duties that such position required.

Conclusions of Law

In support of his decision relating to issue (F) "Is the Petitioner's current condition of ill-being causally related to the injury?", the Arbitrator finds the following:

Petitioner testified that in July 2009, while pulling a garbage cart, he tripped and felt something pop in his back and felt pain in his left shoulder. Accident is not in dispute.

On cross-examination, Petitioner testified that he did not recall telling Dr. Yapor in January 2007 that he had fallen and had hurt his left shoulder. Petitioner acknowledged that in 2006, he underwent fusion surgery to his low back after which he was released to return to full-duty work.

The Respondent's Section 12 physician, Dr. Verma, opined that Petitioner's shoulder condition was causally related to the work accident.

The Respondent's other Section 12 physician, Dr. Singh, opined that Petitioner's lumbar spine injury and treatment were causally related to the work accident.

The Arbitrator finds that Petitioner's current condition of ill-being of his left shoulder and low back are causally related to the undisputed accident of July 20, 2009.

In support of his decision relating 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 the following:

The Arbitrator has had an opportunity to review the medical records and finds the Petitioner has undergone reasonable and necessary medical treatment. This is supported by the finding that Petitioner's medical care ultimately allowed him to obtain a full duty work release. Also, the opinions of Dr. Verma and Dr. Singh support a finding that the treatment was reasonable and necessary. As such, the Arbitrator awards the following medical bills, pursuant to Section 8(a) and subject to Section 8.2 of the Act:

1. Northwest Neurosurgical, $600.00 (Px.6)
2. Dr. Konowitz, $2,239.00 (Px.10)
3. ATI Physical Therapy, $958.53 (Px.11)

In support of his decision relating to issue (L) " What is the nature and extent of the injury?", the Arbitrator finds as follows:

As a result of the work-related injury of July 20, 2009, Petitioner sustained injury to his left shoulder and low back.

Regarding the left shoulder, on October 12, 2009, Dr. McCall performed surgery on Petitioner that consisted of a subacromial decompression, distal clavicle excision, and debridement of a superior labrum tear.

Respondent's own Section 12 physician, Dr. Verma, felt that the Petitioner's condition of ill-being was causally connected to the work injury and that the surgery performed was both reasonable and necessary.

On December 23, 2009, following a course of physical therapy, Dr. McCall released Petitioner to return to full-duty work. Dr. McCall's chart notes of that date include the following:

> Mr. Gomez follows up ten weeks out from left shoulder arthroscopy. He is stable, doing extremely well. He states that he really has no pain in the shoulder. He has full ROM and his strength has come back . . . he is well appearing in no apparent distress. Examination of the left shoulder reveals active elevation to 180 degrees, abduction to 180 degrees. He can externally rotate symmetric to the contralateral side. Internal rotation is symmetric to his contralateral side. Strength to drop arm is 5 out of 5. External rotation is 5 out of 5. External rotation strength is 5 out of 5. He has negative Neer and Hawkins impingement signs, no pain over the clavicle. (Px.5)

There is no evidence that after December 23, 2009, Petitioner treated with Dr. McCall or any

other medical provider for his left shoulder.

Yet, at the October 3, 2014 arbitration hearing, Petitioner testified that he continues to suffer from burning pain in his left shoulder that disrupts his sleep. Overhead activities cause a popping sensation in his shoulder along with shooting pain. Cold, damp weather affects his shoulder as well.

In his September 17, 2014 chart notes, Dr. Konowitz notes a past medical history of sleep apnea.

As it pertains to the left shoulder, the Arbitrator finds that Petitioner has sustained permanent partial disability to the extent of 10.12% loss of use of the man as a whole.

In regard to his low back, Petitioner underwent surgery on March 25, 2010 that consisted of a left L4-5 foraminotomy and hardware removal. Following the surgery, Petitioner received treatment from Dr. Konowitz, a pain management physician, for complaints of paracentral low back pain with radiating pain to the buttocks and left leg.

Respondent's own Section 12 physician, Dr. Singh, found that the Petitioner's condition of ill-being was related to the work injury of July 20, 2009 and that the surgery that was performed was both reasonable and necessary. Petitioner eventually returned to work on a full-duty basis as of December 3, 2011 with all TTD benefits being paid through that date.

At the October 3, 2014 arbitration hearing, Petitioner testified that he continues to suffer from low back pain that radiates down his left side into his buttock and left leg. It disrupts his sleep. Cold, damp weather affects his back pain. He remains under the care of Dr. Konowitz who prescribes Norco, Lyrica and a muscle relaxer to help control his pain.

In regard to the low back, the Arbitrator finds that Petitioner has sustained permanent partial disability to the extent of 25% loss of use of the man 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 Choose reason	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☒ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Miguel Arroyo,

Petitioner,

15IWCC0879

vs.

NO: 09 WC 34077

Elite Staffing,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, temporary total disability and permanent disability and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below. On August 17, 2009 Petitioner filed an Application for Adjustment of Claim alleging an injury to his back on June 23, 2009. Evidence was presented at arbitration on October 14, 2014, and the Decision of the Arbitrator was filed on January 22, 2015. We adopt the Arbitrator's findings of fact as contained in the Decision attached hereto and made a part hereof but modify the Arbitrator's conclusions of law and ordered benefits.

Petitioner, a 55-year-old laborer, sustained an undisputed accidental injury to his back on June 23, 2009 attempting to lift a box. The Arbitrator found that Petitioner's current condition of ill-being is causally related to the accident, and that Petitioner is permanently and totally disabled from all employment. The Arbitrator awarded Petitioner temporary total disability benefits for the period June 29, 2009 through February 9, 2011 and weekly permanent total disability benefits commencing February 10, 2011 and continuing for life. The Arbitrator further awarded all medical expenses set forth in Petitioner's Exhibit #1 pursuant to the medical fee schedule, totaling $134,132.19.

After reviewing all of the evidence, the Commission finds that Petitioner reached maximum medical improvement from his June 23, 2009 injury by October 21, 2010. On that date, Petitioner was examined at his own request by Dr. Salehi. We note that Petitioner had been treating with Dr. Malek for

15IWCC0879

over one year and reported very little symptom improvement despite a series of caudal epidural steroid injections and extensive physical therapy and chiropractic treatments. Dr. Malek opined that surgery would be an appropriate treatment if Petitioner was acquiescent, however Petitioner did not wish to undergo a lumbar fusion. Dr. Salehi's §12 report stated his opinion that he would not recommend a lumbar fusion for Petitioner for several reasons. The report, as summarized by the Arbitrator, reads as follows:

> "[Dr. Salehi] performed a neurologic exam and reviewed: Dr. Bernstein's IME's from 8/31/09 and 3/1/10; Dr. Malek's records from 1/4/10, 1/26/10, 1/28/10, the 9/1/09 lumbar MRI as well as other various records including physical therapy and chiropractic notes. The doctor noted that Petitioner's low back pain complaints were consistent with the mechanism of injury. It was Dr. Salehi's opinion that the Petitioner's condition had become chronic as a result of a permanent exacerbation of pre-existing lumbosacral spondylosis. Dr. Salehi did not recommend surgery opining that a fusion was likely to worsen Petitioner's back condition given the fact that petitioner has multilevel disease as opposed to disease at one or two disc levels." (Arb. Dec., p. 4)

Dr. Salehi's report further recommended that in order to manage Petitioner's chronic pain, he should perform home exercises, refrain from smoking, and take over-the-counter analgesics rather than narcotics and prescription muscle relaxants. Dr. Salehi opined that while Petitioner's work-up and treatment was medically appropriate, he would not recommend any further treatment. Dr. Salehi listed the medical records he reviewed in preparation for his examination, including the records of Concentra Medical Services ("Concentra") and Grandview Health Care ("Grandview") from the initial weeks and months following the accident. We find it significant in weighing the medical opinions in this case that Dr. Malek reviewed no prior medical records other than the lumbar MRI taken on September 1, 2009 several days prior to his initial examination of Petitioner. We find that Dr. Malek's opinion lacks a thorough and complete basis of fact with respect to Petitioner's complaints and response to treatment in the weeks and months following the accident and we find it relevant to briefly review the initial records here.

On June 29, 2009, the first date of treatment post-accident, Petitioner presented to Concentra and was examined by Dr. Bunting. Petitioner described the lifting accident on June 23, 2009 wherein he claimed he twisted his back. Petitioner testified that he continued working the remainder of his shift on June 23, 2009 but that he did no strenuous activity. Petitioner did not claim any temporary total disability benefits between June 23, 2009 and June 29, 2009. Petitioner denied any prior history of back pain or injuries and complained of sharp low back pain, without radiation, that he rated at level "2/10." Petitioner denied any radicular symptoms such as numbness or tingling in his lower extremities and his straight leg raise test was negative for back pain. At the conclusion of the examination, Dr. Bunting diagnosed a lumbar strain and released Petitioner to return to work with restrictions.

On July 1, 2009 Petitioner returned to Concentra and reported some improvement in his symptoms and once again denied any radiation of pain from his low back or radicular symptoms. On that same day, Petitioner was evaluated by a physical therapist at Concentra. On July 8, 2009, Petitioner returned to Dr. Bunting a final time. Petitioner reported further improvement after a few sessions of physical therapy. He rated his pain level at "2/10" in the low back without radiation. On July 13, 2009

the physical therapist noted that Petitioner completed five sessions and showed signs of expected progress; the physical therapist recommended that Petitioner continue to return for further sessions.

However, the following day Petitioner began treating at Grandview and did not return to Concentra. Following his examination by Dr. De Las Casas at Grandview, Petitioner began a course of very frequent physical therapy sessions and chiropractic manipulations. On July 30, 2009, Petitioner reported to Dr. Cummings at Grandview that he experienced 40% improvement since starting care at Grandview and felt less pain in his low back overall. He continued to participate in frequent sessions of physical therapy and chiropractic manipulations and on August 26, 2009 he reported to chiropractor Kristen Kuk that his low back pain was slightly better but he reported a new symptom of coldness and itching in his right foot. Petitioner was subsequently referred for a §12 examination by Dr. Bernstein at the request of Respondent. Dr. Bernstein opined on August 31, 2009 that no further treatment was necessary for Petitioner's lumbar strain.

On September 10, 2009, Petitioner presented to Dr. Malek for a surgical consultation. As stated above, Dr. Malek confirmed at his deposition that he reviewed Petitioner's lumbar MRI but did not have any other prior records for review. Petitioner complained to Dr. Malek of low back radiating into his buttocks and tingling in his lower extremities. Dr. Malek noted that Petitioner had prior physical therapy but according to Petitioner's report "he did not tolerate the regimen he was on." Dr. Malek diagnosed Petitioner with lumbar radiculopathy and back pain with annular tears at L5-S1 and L3-L4. Dr. Malek recommended caudal epidural steroid injections. Petitioner continued physical therapy and chiropractic treatments at Grandview and Dr. Malek performed a series of three caudal epidural steroid injections from January through March of 2010. Petitioner testified at hearing that the injections provided little to no relief of his back pain. On March 1, 2010, Petitioner was reexamined by Dr. Bernstein. Dr. Bernstein reviewed the September 2009 MRI and found no distinct herniation directly causing any nerve root compression. Dr. Bernstein did not change his opinion following the new examination and updated record review; he believed that Petitioner was at maximum medical improvement and could work full duty.

Although Petitioner did not wish to undergo surgery, Dr. Malek continued to order additional surgical workup for Petitioner, including electrodiagnostic studies and a lumbar discogram, in order to "isolate the pain generator." We note that Dr. Salehi reviewed the discogram results and concluded that the positive findings did not change his opinion that it was not medically appropriate to surgically address Petitioner's condition. He believed that Petitioner could return to work under restrictions due to his chronic back pain.

After considering all of the evidence and for the reasons set forth below, we find that Petitioner's treatment following his October 21, 2010 examination by Dr. Salehi was not reasonable, necessary or causally related to the lumbar strain he sustained on July 23, 2009 and that Respondent is not liable for the charges incurred by Petitioner or for temporary total disability benefits after that date. Additionally, we find that Respondent is not liable for "travel" expenses totaling $3,450.00 charged by Grandview Health Care between January 28, 2009 and May 18, 2010 and between December 8, 2009 and December 22, 2009 as there is no evidence establishing the validity or necessity of these charges. Furthermore, in accordance with our findings we vacate the Arbitrator's award of permanent and total disability benefits and we find that as a result of the accidental injury of June 23, 2009 Petitioner sustained a loss of 30% of the person as a whole pursuant to §8(d)2.

15IWCC0879

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $237.67 per week for a period of 68 4/7 weeks, commencing June 29, 2009 through October 21, 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 $461.78 per week for a period of 150 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 30% loss of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the following charges for reasonable and necessary medical expenses incurred through October 21, 2010 pursuant to §8(a) and §8.2 of the Act, with the exception of "travel" charges totaling $3,450.00 by Grandview Health Care between January 28, 2009 and May 18, 2010 and between December 8, 2009 and December 22, 2009: $15,655.00 to Dr. Malek, $1,087.70 to Prescription Partners, $6,545.00 to Windy City Anesthesia, $50,145.35 to Instant Care, $675.00 to Instant Care Medical Group, $7,941.98 to MedHealth Partners, $180.00 to Preferred Open MRI, $22,873.71 to Grandview Health Partners, $1,700.00 to MRI Lincoln Imaging Center, $1,500.00 to Advantage MRI, $2,352.63 to MNF Supplies, Inc., and $3,989.48 to EQMD, Inc., all subject to the medical fee schedule.

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: NOV 2 4 2015
RWW/plv
o-10/28/15
46

Ruth W. White

Joshua D. Luskin

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0879

ARROYO, MIGUEL
Employee/Petitioner

Case# **09WC034077**

ELITE STAFFING
Employer/Respondent

On 1/22/2015, 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:

1067 ANKIN LAW OFFICE LLC
JOSHUA E RUDOLFI
162 W GRAND AVE SUITE 1810
CHICAGO, IL 60654

4866 KNELL O'CONNOR & DANIELEWICZ
THOMAS BOYD
901 W JACKSON BLVD SUITE 301
CHICAGO, IL 60607

15IWCC0879

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

Miguel Arroyo
Employee/Petitioner

v.

Elite Staffing
Employer/Respondent

Case # **09** WC **34077**

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 **October 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. [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 [x] 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 **6/23/2009**, 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 $**13,838.24**; the average weekly wage was $**266.12**.

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 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

Medical benefits

- Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $18,965.00 to Dr. Michel Malek, $1,087.70 to Prescription Partners, $6,545.00 to Windy City Anesthesia, $50,145.35 to Instant Care, $675.00 to Instant Care Medical Group, $7,941.98 to Medhealth Partners, $183.60 to Preferred Open MRI, $26,190.16 to Grandview Health Partners, $1,700.00 to MRI Lincoln Imaging, $1,500.00 to Advantage MRI, $2,352.63 to MNF Supplies, Inc., $3,989.48 to EQMD, Inc., $8,624.87 to Fullerton Surgery Center, $2,399.01 to NR Anesthesia, $1,300.00 to Best Practice Physical Therapy, and $532.41 to Injured Workers' Pharmacy, as provided in Sections 8(a) and 8.2 of the Act.

- Respondent shall pay reasonable and necessary medical services of $134,132.19, as provided in Sections 8(a) and 8.2 of the Act.

- Respondent shall be given a credit of $0.00 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.

Temporary Total Disability

- Respondent shall pay Petitioner temporary total disability benefits of $237.67/week for 84 5/7 weeks, commencing 6/29/2009 through 2/9/2011, as provided in Section 8(b) of the Act.

- Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 6/29/2009 through 2/9/2011, and shall pay the remainder of the award, if any, in weekly payments.

- Respondent shall be given a credit of $0.00 for temporary total disability benefits that have been paid.

Permanent Total Disability

- Respondent shall pay Petitioner permanent and total disability benefits of $**461.78**/week for life, commencing **2/10/2011**, as provided in Section 8(f) of the Act.

- Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment Fund***, as provided in Section 8(g) of the Act.

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

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

Signature of Arbitrator

1/22/15
Date

JAN 22 2015

STATE OF ILLINOIS)
) ss.
COUNTY OF COOK)

15IWCC0879

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MIGUEL ARROYO, Petitioner,	)	
vs.	)	Case No.: 09 WC 34077
ELITE STAFFING, Respondent.	)	

ADDENDUM TO ARBITRATION DECISION

Background

On October 14, 2014, this matter proceeded to hearing before Arbitrator Jessica A. Hegarty in the City of Chicago, County of Cook. The issues in dispute between the parties are causal connection, reasonableness and necessity of medical services, medical bills, temporary total disability (TTD) and the nature and extent of Petitioner's injury. (Arb. 1).

The parties stipulated that the body parts/injuries at issue are only for Petitioner's low back/lumbar spine. (Arb. 1).

Findings of Fact

The Petitioner, a 60-year-old Hispanic male, worked for the Respondent as a laborer for approximately 12 years. His job duties included sweeping, packing, and stacking pallets on top of each other.

On June 23, 2009, the Petitioner was involved in an undisputed accident while attempting to lift a box. Petitioner testified that the box weighed approximately 180 pounds. As the Petitioner lifted the box, he felt a "crack" in his middle and lower back. The Petitioner notified Respondent, and continued working with the assistance of three other workers for the remainder of his shift.

On June 29, 2009, the Petitioner sought medical care at Concentra Medical Center where his complaints of pain in his mid to lower back were noted. (Pet. Ex. #2.) Petitioner denied radicular symptoms. The Petitioner was diagnosed with a lumber strain, placed on light duty, and recommended physical therapy. (*Id.*)

On July 8, 2009, the Petitioner followed up at Concentra where his lumbar pain complaints were noted. Petitioner also reported that he was completely off of work because Respondent could not accommodate his light duty restrictions. (*Id.*)

From July 1, 2009, through July 13, 2009, the Petitioner participated in physical therapy at Concentra. (*Id.*)

On July 14, 2009, the Petitioner sought treatment with Dr. Lee de las Casas at Grandview Health Partners ("Grandview"). (Pet. Ex. #3.) Grandview medical records reflect Petitioner's complaints of pain in his thoracic and lumbar spine. (*Id.*) Physical therapy was recommended and the Petitioner was taken off of work. (*Id.*) The Petitioner was also referred for x-rays of his skull to ensure clearance for an MRI. The Petitioner began physical therapy at Grandview on the same date. (*Id.*)

On July 23, 2009, a skull x-ray performed at Preferred Open MRI cleared the Petitioner for an MRI. (*Id.*)

On July 30, 2009, the Petitioner followed up at Grandview where his continued complaints of pain in his lower back were noted. (*Id.*) Physical therapy and no-work restrictions were continued. (*Id.*)

On August 26, 2009, the Petitioner consulted with Dr. Krysten Kuk at Grandview. The doctor recommended an MRI of Petitioner's lower back. No-work restrictions were continued, and Petitioner was referred to neurosurgeon, Dr. Michel Malek. (*Id.*)

On August 31, 3009, the Petitioner was examined by Dr. Avi Bernstein at Respondent's request pursuant to Section 12 of the Act. Dr. Bernstein noted a mechanism of injury consistent with the Petitioner's trial testimony. (Rsp. Ex. #2.) Petitioner complained of pain to his lower back. (*Id.*) Dr. Bernstein opined that the Petitioner sustained a lumbar sprain and recommended physical therapy. (*Id.*)

On September 1, 2009, the Petitioner underwent a lumbar MRI that revealed:

> *At the T12-L1, and L1-2 levels, there are 3 to 4 mm subligamentous posterior disc herniations elevating the posterior longitudinal ligaments and indenting the thecal sac, without significant spinal stenosis or significant neuroforaminal narrowing.*
>
> *At the L3-4 level, there is a 2-3 mm posterior disc herniation with a small annular tear indenting the thecal sac, without spinal stenosis or significant neuroforaminal narrowing.*
>
> *At the L5-S1 level, there is a 3 to 4 mm broad based posterior disc herniation indenting the thecal sac, without significant spinal stenosis or significant neuroforaminal narrowing.* (Pet. Ex. #3 & 4.)

On September 10, 2009, the Petitioner saw Dr. Michel Malek who noted Petitioner's complaints of low back pain radiating into his buttocks with tingling in his legs. (Pet. Ex. #5.)

Dr. Malek diagnosed Petitioner with back pain accompanied by radiculopathy. The doctor recommended a series of epidural steroid injections (ESI's) along with a thoracic spine MRI. (*Id.*) The Petitioner 's off-work status was continued. (*Id.*)

On September 11, 2009, an MRI of the Petitioner's thoracic spine was unremarkable. (Pet. Ex. #4.)

The Petitioner continued physical therapy and work conditioning during this time at Grandview. (Pet. Ex. #3.)

On January 12, 2010, Dr. Malek noted that the Petitioner's exam remained unchanged. The doctor continued to recommended a series of ESI's. (Pet. Ex. #5.)

The Petitioner had ESI's performed on January 14, 2010 and January 28, 2010. (Pet. Ex. #4 and #5.) The Petitioner testified that these injections helped his pain for a brief period of time.

On March 1, 2010, the Petitioner participated in a second Section 12 exam with Dr. Avi Bernstein at the request of the Respondent. (Rsp. Ex. #3.) The Petitioner reported that he had two ESIs with only five to six days of pain relief. (*Id.*) Dr. Bernstein opined that the Petitioner was neurologically intact, was at maximum medical improvement, and could return to work full duty. (*Id.*)

On March 18, 2010, the Petitioner followed up with Dr. Malek who noted a partial response to the two ESIs. (Pet. Ex. #5.) An additional ESI was recommended along with a course of work conditioning and an eventual FCE. (*Id.*) The Petitioner was released with light duty restrictions. (*Id.*) The Petitioner testified that he continued to be off-work as light duty work was not made available to him.

The Petitioner had his third ESI performed on March 24, 2010. (Pet. Ex. #4 and #5.)

On April 8, 2010, Dr. Malek consulted with Petitioner at which time work conditioning was recommended. Petitioner's light duty work restrictions were continued. (Pet. Ex. #5)

The Petitioner underwent a course of work conditioning at Grandview following this appointment. (Pet. Ex. #3)

On April 22, 2010, the Petitioner again saw Dr. Malek. (Pet. Ex. #5) Dr. Malek noted continued low back pain and a positive straight leg test. (*Id.*) Dr. Malek recommended a discogram for the Petitioner's lumbar spine. (*Id.*)

On May 20, 2010, a discogram was performed, revealing the Petitioner's pain generator at L4-L5 with contribution from the L5-S1 level. (Pet. Ex. #4) A post-discogram CT scan was performed the same day showing evidence of abnormal nucleogram at L3-L4, L4-L5, as well as evidence of a grade IV tear at L3-L4 and L4-L5. (*Id.*)

15IWCC0879

On June 3, 2010, Dr. Malek noted Petitioner's continued complaints of low back pain. The doctor discussed the possibility of surgery with the Petitioner. (Pet. Ex. #5.) Prior to recommending surgery, Dr. Malek recommended an updated MRI and an EMG/NCV of the right lower extremity. (*Id.*) Petitioner was continued on light duty. (*Id.*)

On June 3, 2010, An MRI of the Petitioner's lumbar spine on June 3, revealed:

> *At the L3-L4, L4-L5 and L5-S1 levels 3-4 mm, 2-3 mm, and 3-4 mm disc protrusions/herniations respectively indented the thecal sac without significant spinal stenosis, nor significant neuroforaminal narrowing.* (Pet. Ex. #4.)

The Petitioner was continued on light duty restrictions at his July 22, 2010 appointment with Dr. Malek. (Pet. Ex. #5) An EMG performed on July 22, 2010 was essentially normal. (*Id.*)

On September 2, 2010, the Petitioner followed up with Dr. Malek who noted Petitioner to be stable but still complaining of paraspinal pain. (*Id.*) Dr. Malek recommended an SI joint injection in an effort to alleviate Petitioner's pain. The doctor also ordered an FCE. (*Id.*)

On October 21, 2010, Dr. Malek noted that the FCE and SI joint injections had not been approved. (*Id.*)

On October 21, 2010, the Petitioner consulted with Dr. Sean Salehi of the Neurological Surgery & Spine Center at Petitioner's request, pursuant to Section 12 of the Act. (Pet. Ex. #7.) Dr. Salehi noted Petitioner's complaints of low back pain at a 6/10 and a burning sensation in the bottom of his feet. The Petitioner indicated that sitting and standing make his symptoms worse while bed rest improves his pain complaints. The doctor performed a neurologic exam and reviewed: Dr. Bernstein's IME's from 8/31/09 and 3/1/10; Dr. Malek's records from 1/4/10, 1/26/10, 1/28/10, the 9/1/09 lumbar MRI as well as other various records including physical therapy and chiropractic notes. The doctor noted that Petitioner's low back pain complaints were consistent with the mechanism of injury. (*Id.*) It was Dr. Salehi's opinion that the Petitioner's condition had become chronic as a result of a permanent exacerbation of pre-existing lumbosacral spondylosis. (*Id.*) Dr. Salehi did not recommend surgery opining that a fusion was likely to worsen Petitioner's back condition given the fact that Petitioner has multi level disease as opposed to disease at one or two disc levels. Dr. Salehi recommended an FCE to determine permanent restrictions and released the Petitioner with a lifting restriction of 20 pounds, no repetitive bending or twisting, and alternating standing and sitting every 30 to 45 minutes. (*Id.*)

On November 22, 2010, the Petitioner had an FCE performed at Best Practice Physical Therapy that was deemed to be valid. The FCE determined that the Petitioner is capable of working in the light strength category with a maximum lifting restriction of 20 pounds and a maximum carrying restriction of 10 pounds. (Pet. Ex. #5.)

On January 12, 2011, The Petitioner followed up with Dr. Malek at which time SI injections were again recommended. (*Id.*) The doctor noted that Petitioner's physical exam remained unchanged. The Petitioner was released again with light duty restrictions. (*Id.*)

The Petitioner had SI joint injections performed by Dr. Malek on January 21, 2011, and February 4, 2011. (*Id.*)

On February 9, 2011, Petitioner reported to Dr. Malek that the epidural injections had helped his back while the SI injections had not provided any significant relief. Dr. Malek told Petitioner he had two options: surgery or declare MMI. (*Id.*)

The Petitioner testified that he does not wish to have the surgery. He testified that he is fearful the surgery may produce a negative outcome such that he might not be able to walk again.

The Petitioner was released from Dr. Malek's care with permanent restrictions consistent with his FCE.

The Petitioner testified that he is sixty (60) years old. He completed school through the 6th grade in his native Mexico. He has been in the United States for thirty-five (35) years and has worked in general labor positions the entire time. The Petitioner was approved for Social Security Disability (SSD) benefits in March, 2011 and he continues to receive those benefits as of the date of trial.

Petitioner testified that his back continues to cause him pain, and that he is unable to walk more than 5-6 blocks, or for more than 15 minutes at a time. Petitioner also testified that he has not looked for work or applied to any positions since the date of accident.

The Petitioner has had nurses come to his home from Medicare that have shown him stretches to perform in order to help him cope with his continued back pain. The Petitioner continues to follow up with his primary care doctor, Dr. Monteverde, who prescribes him medication for his back pain. The Petitioner testified that prior to this work injury he never had any problems with his back, nor had he ever sought medical care for a back injury. The Petitioner has not received any TTD benefits from the Respondent and still has outstanding medical bills as of the date of trial.

The Arbitrator had an opportunity to observe the Petitioner during his testimony and thought him to be an open, straightforward and honest person.

The Petitioner called Ms. Kari Stafseth to testify. Ms. Stafseth is a certified vocational counselor who works with Vocamotive. She has a Master of Science in Rehabilitation degree from the University of Illinois at Urbana-Champaign and has been a certified Rehabilitation Counselor since 2009. Ms. Stafseth testified that she met with the Petitioner personally for the purpose of a vocational consultation and that she reviewed the Petitioner's medical records in conjunction with the one-on-one interview with the Petitioner. Ms. Stafseth opined that the Petitioner is permanently and totally disabled. (Pet. Ex. #8.) She based her opinion on the Petitioner's age, education, language, prior work history, transferrable skills and physical capabilities. (*Id.*) According to Ms. Stafseth, a 60 year old Spanish speaking male with a permanent 20 pound lifting restriction, falls into the "unskilled sedentary" work group. Ms. Stafseth further testified that approximately 1% of the jobs in the entire country fall into such category. (*Id.*)

Ms. Stafseth reviewed a Labor Market Survey introduced by the Respondent at trial. (Rsp. Ex. #6.) After reviewing the survey, Ms. Stafseth opined the Labor Market Survey to be invalid because of the failure to consider the Petitioner's physical limitations and permanent restrictions.

Dr. Michel Malek testified by way of evidence deposition. (Pet. Ex. #9.) Dr. Malek testified that the Petitioner had an asymptomatic, pre-existing degenerative condition in his lumbar spine that was aggravated and accelerated beyond its normal progression by the Petitioner's work accident. (*Id.* at 33.) Dr. Malek further opined that the mechanism of injury, the contemporaneous nature of the complaints, onset of symptoms, physical examinations, diagnostic testing and response to treatment were all consistent with Petitioner's work injury. (*Id.* at 33-34.) Dr. Malek disagreed with Dr. Bernstein's diagnosis of Petitioner's back as a muscle sprain. (*Id.* at 35.) Dr. Malek disagreed with Dr. Bernstein's diagnosis of a muscle sprain because he failed to consider Petitioner's radicular pain complaints. Dr. Malek testified that radicular complaints are inconsistent with a muscular sprain. (*Id.* at 36.) Dr. Malek further opined that the Petitioner's 5 to 6 day positive response to ESI's is further evidence of radiculopathy and a disc injury. (*Id.* at 37-38.) In Dr. Malek's opinion all of the Petitioner's medical care has been reasonable, necessary and causally related to his undisputed work accident. (*Id.* at 34.)

Dr. Sean Salehi testified by way of evidence deposition. (Pet. Ex. #10.) Dr. Salehi testified that he reviewed the post discogram CT dated May 20, 2010 showing annular tears at L2-3, L3-4, and L4-5 and Petitioner's June 3, 2010, lumbar MRI film. The doctor testified that the MRI showed multilevel disc degeneration and dehydration. Dr. Salehi diagnosed Petitioner with lumbosacral spondylosis and lumbar strain. In Dr. Salehi's opinion Petitioner's work injury caused a permanent exacerbation of Petitioner's pre-existing lumbar spondylosis. (*Id.* at 15.) He based this opinion on the fact that the Petitioner had no previous history of back problems, had a mechanism of injury consistent with his complaints, and did not improve within 6 months. (*Id.* at 15-16.) Dr. Salehi opined that the Petitioner was capable of work pursuant to his valid FCE. (*Id.* at 17-18.) He further opined that the Petitioner's medical care has been reasonable, necessary and causally related to his work accident. (*Id.* at 17.)

Dr. Avi Bernstein testified by way of evidence deposition. (Rsp. Ex. #8.) Dr. Bernstein testified that it is possible that the Petitioner aggravated his underlying pre-existing condition, but he did not believe that that would account for all of the Petitioner's complaints. (*Id.* at 19.) Dr. Bernstein testified that Petitioner's permanent restrictions are unwarranted as he does not have a distinct injury. (*Id.* at 20.) With respect to SI joint pain, Dr. Bernstein testified pain in the SI joint, 99.99% of the time, is related to low back pain. (*Id.* at 18.) Dr. Bernstein was unaware of any previous injury to the Petitioner's low back. (*Id.* at 23) He opined that a patient who has temporary relief from an ESI would benefit from additional injections, not to exceed three in a six month period. (*Id.* at 26.) He further opined that when a patient has radiating pain in the buttocks or thighs, it is commonly due to a discogenic cause. (*Id.* at 27-28.)

CONCLUSIONS OF LAW

F. Whether the Petitioner's Current Condition of Ill-Being is Causally Related to the Work Accident.

The Arbitrator finds that the Petitioner's current condition of ill-being is causally related to the Petitioner's undisputed June 23, 2009, work injury.

Dr. Michel Malek testified that the Petitioner had a pre-existing degenerative lumbar spine condition that was silent and asymptomatic prior to his work accident. (Pet. Ex. #9 at 33.) Dr. Malek further testified that the Petitioner's work accident caused the Petitioner's pre-existing condition to become "symptomatic by aggravation, precipitation and/or acceleration beyond the natural progression of the disease." (*Id.*)

Dr. Sean Salehi opined as to a causal connection between the Petitioner's current condition and the work injury. (Pet. Ex. #10 at 15.) Dr. Salehi testified that the Petitioner sustained a permanent aggravation of his pre-existing spondylosis. (*Id.*)

Dr. Avi Bernstein opined in his Section 12 reports that the Petitioner sustained a lumbar sprain and could have returned to work as of 2009. (Resp. Ex. #2, #3, and #4.) Dr. Bernstein based this opinion partly upon the MRI reports that he reviewed, however, he did not review the actual films in arriving at his opinion. (Resp. Ex. #8 at 26-27.) Dr. Bernstein arrived at this opinion despite documentation that the Petitioner complained of radiating pain which he testified is typically of a discogenic cause. (*Id.* at 27-28.)

Dr. Malek also testified that a lumbar sprain does not cause radiation. (Pet. Ex. #9 at 38.)

Based on the credible, medical evidence contained in the record, the Arbitrator finds that the Petitioner has sustained his burden with respect to causal connection.

J. Whether the Medical Services were Reasonable and Necessary and Whether Respondent has Paid all Appropriate Charges.

Having previously found causation, the Arbitrator finds that the Petitioner's medical care was causally related to his undisputed work accident. Dr. Malek and Dr. Salehi both testified that the medical treatment provided to the Petitioner was reasonable and necessary. The Petitioner's treatment consisted of diagnostic testing, doctor's visits, pain medication, ESIs, SI injections, physical therapy, work conditioning and a FCE.

With regard to the ESIs, the Arbitrator notes Dr. Bernstein's testimony in which he agreed that up to three ESIs within a 6 month period is reasonable. (Resp. Ex. #8 at 26.) Dr. Bernstein further testified that ESIs can be diagnostic with respect to identifying the location of the pain generator. (*Id.* at 24) The Respondent relies on the UR report of March 26, 2010, in disputing these injections. (Rsp. Ex. #7.) The Arbitrator agrees with Dr. Malek, Dr. Salehi and Dr. Bernstein in finding that these injections were reasonable and necessary.

With regard to the SI injections, Dr. Bernstein testified that 99.9% of the time pain in the SI joint is due to low back pain. (*Id.* at 18.) Dr. Malek testified that the SI injections were performed in a diagnostic capacity. (Pet. Ex. #9 at 54.) Based upon the medical opinions in this case the Arbitrator finds that the SI joint injections were reasonable and necessary and were performed due to the low back pain.

The Respondent introduced UR reports to dispute physical therapy. (Resp. Ex. #7 *generally.*) The Arbitrator finds that due to the Petitioner's significant, consistent pain complaints, a conservative course of physical therapy was reasonable and necessary. The Arbitrator chooses to accept the opinions of Dr. Malek and Dr. Salehi in so finding.

Concerning the discogram performed by Dr. Malek, the Arbitrator finds that it was reasonable and necessary. Dr. Malek testified that a discogram helped to determine exactly where the pain generator was in the Petitioner's spine. (Pet. Ex. #9 at 22-23.) The discogram confirmed the Petitioner's complaints were related to the L4-L5 and L5-S1 levels, which is consistent with other objective medical evidence. (*Id.*) No medical testimony refuting this test was entered into evidence.

Concerning the FCE that was performed, the Arbitrator finds that the FCE was reasonable and necessary in helping to determine the Petitioner's functional abilities. In a case where permanent restrictions are assessed, an FCE is an accepted standard in quantifying those restrictions.

Based on the above findings, the Arbitrator finds that the Petitioner's medical care was reasonable and necessary in aiding the Petitioner in achieving maximum medical improvement.

The Arbitrator further finds that the Respondent has not paid all appropriate charges and awards the Petitioner's medical bills contained in Petitioner's Exhibit #1.

K. Whether the Petitioner is Entitled to TTD, Maintenance, or PTD Benefits.

The Petitioner is entitled to TTD benefits from June 29, 2009, to February 9, 2011, a period of 84 5/7 weeks, payable at the minimum rate of $220.00 per week. The Arbitrator further finds that the Petitioner is entitled to PTD benefits from February 10, 2011 through the date of trial.

With regard to TTD, the Petitioner's initial medical records from Concentra indicate that he was placed on light duty restrictions on June 29, 2009, and that the Respondent was unable to accommodate those restrictions. (Pet. Ex. #2.) Despite having an undisputed work accident, the Respondent did not start TTD benefits at that time. The Respondent has provided no basis for the non-payment of benefits at that time. The Petitioner's medical records from that date forward indicate that the Petitioner was either provided off work notes, or provided light duty restrictions that the Respondent did not accommodate. The Petitioner credibly testified that the Respondent was unable to accommodate light duty, and the Petitioner's medical records support this fact. The Concentra medical note from July 9, 2009 indicates that "[p]atient has not been working because light duty is not available." (Pet. Ex. #2) Accordingly, the Arbitrator finds that

the Petitioner is entitled to TTD benefits from June 29, 2009 through February 9, 2011, the date he was released by Dr. Malek at maximum medical improvement with permanent work restrictions. (Pet. Ex. #5.)

Concerning the Petitioner's right to PTD benefits, please see the analysis in "Nature and Extent." *Infra.*

L. What is the Nature & Extent of the Injury?

The Arbitrator finds that as a result of the Petitioner's undisputed June 23, 2009 work injury the Petitioner is permanently and totally disabled.

The Arbitrator places significant weight on the valid FCE performed on November 22, 2010, in determining the level of permanency caused by the Petitioner's injury. (Id.) The FCE determined that Petitioner is capable of assuming a position in the light strength category with a maximum lifting capacity of 20 lbs., and a maximum carrying capacity of 10 lbs. The FCE determined that in order for Petitioner to successfully return to work in the light strength category the following job restrictions must be met:

- No standing for more than 15 minutes continuously.
- No walking for more than 0.3 mile continuously.
- No pushing more than 80 lbs.
- No crouching.
- No stooping.
- No crawling on hands and feet. (Id.)

The Arbitrator notes that the Petitioner is 60 years of age, does not speak English, has a 6th grade education (from schooling in Mexico) and has worked solely as a laborer during his 35 years in the United States. The Petitioner has been receiving SSD benefits since March 2011.

The Petitioner's vocational expert, Ms. Kari Stafseth testified that the Petitioner is permanently and totally disabled. (Pet. Ex. #8.) She based her opinion on the Petitioner's age, education, language, prior work history, transferrable skills and physical capabilities. (*Id.*) According to Ms. Stafseth, a 60 year old Spanish speaking male with a permanent 20 pound lifting restriction, falls into the "unskilled sedentary" work group. Ms. Stafseth further testified that approximately 1% of the jobs in the entire country fall into such category. (*Id.*)

Ms. Stafseth reviewed a Labor Market Survey introduced by the Respondent at trial. (Rsp. Ex. #6.) After reviewing the Labor Market Survey, Ms. Stafseth opined the Labor Market Survey to be invalid because of the failure to consider the Petitioner's physical limitations and permanent restrictions.

The Arbitrator notes that Respondents labor market survey suggests that Petitioner is capable of obtaining work as:

- a housekeeper
- laundry feeder/ironer
- janitor
- pizza assembler
- dishwasher/steward.

After reviewing the labor market survey, the Arbitrator agrees with Ms. Stafseth that based upon the job leads contained, it does not appear that the Petitioner would in fact qualify for any of the positions in light of his permanent restrictions. As such, the Arbitrator affords little weight to the Respondent's vocational opinion and labor market survey.

Based upon the totality of the Petitioner's current physical condition (age, education, work history, skills, etc.) the Arbitrator finds that the Petitioner has proven by the preponderance of credible evidence that he is permanently and totally disabled. The Arbitrator therefore awards Permanent Total Disability benefits in the amount of $461.78 (50% of State Average Weekly Wage as of the date of accident) per week from February 10, 2011, and ongoing for the rest of Petitioner's life.

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

Jolanta Wroblewska,
Petitioner,
vs.
Lacosta,
Respondent,

NO: 10 WC 09316

15IWCC0872

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 21, 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 $8,700.00. 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: NOV 2 4 2015

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
o:11/19/15
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WROBLEWSKA, JOLANTA
Employee/Petitioner

Case# **10WC009316**

15IWCC0872

LACOSTA
Employer/Respondent

On 10/21/2014, 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:

2731 SALVATO & O'TOOLE
DAVID FROYLAN
53 W JACKSON BLVD SUITE 1750
CHICAGO, IL 60604

1596 MEACHUM STARCK BOYLE & TRAFMAN
JAMES JANNISCH
225 W WASHINGTON ST SUITE 1400
CHICAGO, IL 60606

15IWCC0872

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

JOLANTA WROBLEWSKA
Employee/Petitioner

v.

LACOSTA
Employer/Respondent

Case # **10** WC **9316**

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 **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

On **10/28/09**, 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 through March 13, 2010 is causally related to the accident. SEE DECISION

In the year preceding the injury, Petitioner earned $**21,330.40**; the average weekly wage was $**410.20**.

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 through 3/13/10.

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

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 the reasonable, necessary and causally related medical expenses as detailed in the attached Arbitration Decision pursuant to Sections 8(a) and 8.2 of the Act. Respondent shall receive credit for amounts paid.

Respondent shall pay Petitioner permanent partial disability benefits of $246.12/week for 35 weeks in that the injuries sustained caused 7% 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.

Carolyn Doherty
Signature of Arbitrator

10/20/14
Date

OCT 21 2014

FINDINGS OF FACT

Jolanta Wroblewska (hereinafter Petitioner) was employed as a janitor for Lacosta (hereinafter Respondent) on October 28, 2009. On that date, she was cleaning a classroom at Northwestern University when she was struck in the right side of the head by a whiteboard which was leaned up against the wall. She did not immediately seek medical treatment despite experiencing head and neck pain. Petitioner first sought medical treatment the next day on October 29, 2009 at Union Health Service. She provided a history of a headache and dizziness "since yesterday". Petitioner was prescribed a CT of the brain and a cervical spine x-ray. Both studies were read as normal with the CT scan specifically indicating "No CT evidence of acute intracranial process". (PX 1) Due to ongoing complaints she was referred for an MRI. This study was performed on January 7, 2010. The primary reading of this study indicated, "No evidence of acute ischemia, infarction, mass or intracranial hemorrhage." Petitioner continued to seek treatment with Union Health Service after the MRI. On January 11, 2010 she was diagnosed with sinusitis and prescribed amoxicillin. (PX 1)

Petitioner continued to seek medical treatment for complaints of headaches, dizziness and imbalance with her primary care physician, Dr. Weislaw Wojnarski, as well as neurologist Dr. Neil Allen, neurologist Dr. Daniel Greenberg, Dr. Krzysztof Siemionow, Loyola Hospital, Dr. Ronald Schreiber, Dr. Lavacarre, Dr. Edward Herba, Dr. Kranzler, Illinois Masonic Medical Center, Our Lady of Resurrection Hospital, Peak Therapeutics, Accelerated Rehabilitation Centers, and MRI Lincoln Imaging Center. There are no objective findings in the medical records from these providers which relate the petitioner's ongoing complaints to the October 28, 2009 accident.

On March 13, 2010 Petitioner was examined by Dr. Sean Salehi pursuant to Section 12 of the Illinois Workers' Compensation Act. Petitioner testified that she appeared for the exam and was truthful with the doctor regarding her medical history and subjective complaints. Petitioner acknowledged that a Polish interpreter was present and participated in the exam process. Dr. Salehi diagnosed the petitioner with a cervical strain and post-concussion syndrome as a result of the occurrence. The doctor noted that by the time of the exam the petitioner's cervical symptoms had resolved. He further noted that "her residual symptoms can be on the basis of a mild post traumatic closed head injury; however, she has a normal neurological examination and a normal MRI of the brain. It appears that her issues relate to insomnia and anxiety and can be adequately treated with amitripytline at night ... She would also benefit from six sessions of physical therapy concentrating on balance training. She will be at MMI at the conclusion of the six sessions of PT and can work unrestricted. For now she can work at a light duty capacity... as there is no focal neurologic deficit." RX 1.

Petitioner did not immediately attend the recommended physical therapy. Rather, she underwent a repeat CT scan of the brain on March 15, 2010 which was read as normal - "There are no acute concerning abnormalities". (PX 3) Petitioner sought treatment in April 2010 with Dr. Neil Allen, a neurologist. Dr. Neil Allen prescribed Amitriptyline and Lexapro. He also referred Petitioner to Balance Centers of America (AKA Peak Therapeutics). (PX 4). Petitioner then attended physical therapy at Balance Centers of America from April 27, 2010 through June 25, 2010. Petitioner received vestibular rehabilitation. (PX 5). On June 25, 2010, it was noted that

"she is getting better but is having insurance problems and needs to talk to doctor and lawyer about cont PT." PX 5. Petitioner did not return to physical therapy.

On November 17, 2010, Petitioner sought the services of Dr. Krzysztof Siemionow at Weiss Memorial Hospital. Petitioner complained of neck and head pain. Petitioner gave a history of her October 28, 2009 work injury. Dr. Krzysztof Siemionow recommended Petitioner continue with physical therapy and undergo an MRI of her cervical spine. (PX 6).

On November 23, 2010 Petitioner underwent a Functional Capacity Evaluation at Accelerated Rehabilitation Centers. Petitioner testified at trial that she put forth the maximum effort she could for the evaluation. The Functional Capacity Evaluation Report indicates that "The overall results of this evaluation represent an invalid and unreliable performance secondary to the submaximal performance demonstrated by Ms. Wroblewska during her performance of a variety of functional tasks." In addition, the report reflects "The client demonstrates inconsistent reliability." Accordingly, a physical demand level could not be determined due to the invalid effort. (PX 6)

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner's current condition of ill-being through the date of her exam with Dr. Salehi on March 13, 2010 is causally related to the accident of October 28, 2009. Petitioner alleged condition of ill-being subsequent to March 13, 2010 is not causally related to the accident.

The Arbitrator notes that the parties stipulated to the issue of accident on October 28, 2009. ARB EX 1. Based on the petitioner's testimony and the initial medical history, the Arbitrator finds that the petitioner sustained a compensable accident when she was struck by a falling whiteboard on October 28, 2009. However, the Arbitrator also notes that the petitioner's initial complaints were more than sufficiently evaluated by several providers and no objective findings substantiating the subjective complaints were noted in those records. The Arbitrator specifically notes Petitioner's negative x-ray and CT of the brain on the day after the injury occurred. In addition, an MRI of Petitioner's brain from January 7, 2010 was also essentially normal.

The Arbitrator also finds Petitioner's testimony insufficiently credible to satisfy her burden of proof on the issue of continued causal connection in this case. Accordingly, Petitioner's long history of subjective complaints, contradicted by the multiple objective studies, requires a medical opinion in support of how the ongoing subjective complaints are causally related to the October 28, 2009 accident. The Arbitrator finds Petitioner has offered no medical opinions to support a causal connection after the March 13, 2010 Section 12 examination. Moreover, the Arbitrator finds Dr. Salehi's medical opinions as supported by the objective medical evidence more credible than the testimony of Petitioner at trial. Accordingly, the Arbitrator finds causal connection for Petitioner's condition of ill-being through the date of her exam by Dr. Salehi on March 13, 2010.

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? N. Is Respondent due any credit?

The Arbitrator finds that there is no causal connection between the October 28, 2009 accident and her medical condition subsequent to March 13, 2010. Accordingly, the Arbitrator finds the medical treatment provided to Petitioner prior to March 13, 2010 is reasonable and necessary and causally related to Petitioner's accident and injury of October 28, 2009. The Arbitrator notes that although Petitioner received physical therapy after March 13, 2010 and specifically from April to June 2010, the Arbitrator finds that Respondent shall pay for only the first six physical therapy sessions received during that time period pursuant to the findings and recommendations of Dr. Salehi.

Specifically, the Arbitrator finds Respondent liable for the following medical bills pursuant to Sections 8 and 8.2 of the Act:

1. Union Health Services for dates of service from 10/29/09 through 1/11/10 only;
2. Dr. Weislaw Wojnarski for dates of service from 2/11/10 and 2/23/10 only;
3. Dr. Greenberg for date of service 3/10/10 only; and
4. Advocate Illinois Masonic Medical Center for dates of service 10/30/09 through 1/7/10.
5. Balance Centers of America for dates of service 4/27/10 through 5/14/10.

In denying medical expenses subsequent to March 13, 2010 other than the 6 PT visits, the Arbitrator reiterates the findings on causal connection and further notes that Petitioner has offered no evidence to support a chain of referrals as it relates to the multiple medical providers from which she received non-emergency medical treatment after her first two allowable choices under the Illinois Workers' Compensation Act. The Arbitrator specifically finds that Petitioner's choice of Dr. Krzysztof Siemionow of Weiss Memorial Hospital and Dr. Herba of Michigan Avenue Medical Associates exceeded her allowable choice under the Act.

Accordingly, the Arbitrator awards only those medical bills listed above pursuant to Sections 8 and 8.2 of the Act. The Arbitrator also finds Respondent is entitled to a credit for payment made on any of the awarded medical bills.

L. What is the nature and extent of the petitioner's injury?

The Arbitrator notes that the date of accident pre dates September 1, 2011 and therefore no AMA evaluation was submitted at trial. Based on Petitioner's testimony and the medical evidence the Arbitrator finds Petitioner sustained a minor head contusion and neck sprain as a result of this undisputed accident. Petitioner treated conservatively for her initial complaints and condition prior to her exam by Dr. Salehi on March 13, 2010. Her treatment and complaints thereafter are not causally related to the accident.

Based on the foregoing findings, the Arbitrator notes that Petitioner was 52 years old on the date of accident. Although Petitioner testified that she is not currently working, the Arbitrator notes that her current work status is not related to her accident or her causally related injury. Therefore, no weight is given to her age at the time of the accident or her future earning capacity.

Finally, in considering the evidence of disability corroborated by the treating medical records the Arbitrator again notes that Petitioner treated conservatively for her minor head contusion and neck sprain receiving physical therapy, pain medications and anti-depressants through the date of her visit with Dr. Salehi. Treatment thereafter is not causally related to the stipulated accident. Accordingly, the Arbitrator finds that Petitioner sustained a 7% loss of use of the person as a whole pursuant to Section 8(d)(2) of the Act. No evidence of wage loss pursuant to Section 8(d)(1) of the Act was proffered at trial and thus not considered by the Arbitrator.

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

STATE OF ILLINOIS,
ILLINOIS WORKERS' COMPENSATION COMMISSION,
INSURANCE COMPLIANCE DIVISION

Petitioner,

vs.

NO. 11 INC 150

EDWARD PUDLO, JR., individually and as President of NORTHWEST SUBURBAN DRIVING SCHOOL, INC.,

15IWCC0871

Respondent,

DECISION AND OPINION RE: INSURANCE COMPLIANCE

Petitioner, the Illinois Workers' Compensation Commission, Insurance Compliance Division, brings this action, by and through the Office of the Illinois Attorney General, against the above-captioned Respondent, alleging violations of Section 4(a) of the Illinois Workers' Compensation Act (the Act) and Section 7100.100 of the Rules Governing Practice Before the Industrial Workers' Compensation Commission (the Rules), codified as 50 Illinois Administrative Code, Chapter 11. Proper and timely notice was given to all parties.

An Insurance Compliance Hearing on the Merits was held before Commissioner Michael J. Brennan on May 29, 2015 in Chicago, Illinois.

The Commission, after considering the record in its entirety and being advised of the applicable law, finds that Respondent, EDWARD PUDLO, JR., individually and as President of NORTHWEST SUBURBAN DRIVING SCHOOL, INC., willfully and knowingly violated Section 4(a) of the Act and Section 7100.100 of the Rules during the period January 1, 2003 through March 25, 2011 and May 11, 2012 through May 14, 2012, representing 1,787 days of non-compliance with the Act.

As a result, the Respondent shall be held liable for his non-compliance with the Act and shall pay a penalty in accordance with Section 4(d) of the Act and 7100.100(b)(1) of the Rules. The Commission hereby assesses the penalty of $893,500.00 against the above-named Respondent for the reasons set forth below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds: 15IWCC0871

1) On January 21, 1999, Articles of Incorporation were filed on behalf of Northwest Suburban Driving School, Inc. PX.2.

2) By way of the various annual reports, Ed Pudlo was listed as the Director and President of Northwest Suburban Driving School, Inc. PX.3.

3) Per the Illinois Department of Employment Security, the Respondent had in excess of 30 employees. PX.5.

4) On June 6, 2014, Maria Sarli-Dehlin, of the Illinois Workers' Compensation Commission Office of Self-Insurance, certified that no certificate of approval to self-insure was issued by the Illinois Workers' Compensation Commission to Northwest Suburban Driving School. PX.4.

5) On November 24, 2014, Esteban Ortiz, Proof of Coverage Analyst for NCCI Holdings, Inc., conducted a thorough search of the NCCI database. The search revealed that the Respondent, Northwest Suburban Driving School, Inc., did not have workers' compensation insurance from January 1, 2003 through March 25, 2011, May 11, 2012 through May 14, 2012, and October 27, 2013 through the present. PX.1.

6) The Illinois Workers' Compensation Commission has designated NCCI Holdings, Inc. as its agent for the purpose of collection proof of coverage information on Illinois employers who have purchased workers' compensation insurance from carriers. PX.1.

7) On July 18, 2014, an Order of Default was entered against the Respondent, EDWARD PUDLO, JR., individually and as President of and KATHLEEN PUDLO, Individually and as Secretary of NORTHWEST SUBURBAN DRIVING SCHOOL, INC. PX.11.

8) On May 29, 2015, an Agreed Order to Dismiss Default Order against Kathleen Pudlo, Individually and as Secretary of Northwest Suburban Driving School was entered by the Commission, and Kathleen Pudlo was dismissed as a party respondent.

9) This matter proceeded to hearing on May 29, 2015. The Office of the Illinois Attorney General indicated that Northwest Suburban Driving School was no longer operating as of October 27, 2013 and, therefore, penalties were not appropriate from October 27, 2013 to the present. T.8. Edward Pudlo, Jr. appeared pro se. Mr. Pudlo was again advised of his right to counsel. Mr. Publo acknowledged that he understood his right and elected to precede pro se. T.4-T.6.

10) Mr. Pudlo testified that there were numerous other employees injured in the course of their employment with Northwest Suburban Driving School. T.64.

11) Mr. Pudlo testified that he did not have workers' compensation insurance during the above period as he was unaware it was necessary. T.65. However, Mr. Pudlo testified that he was offered worker's compensation insurance by insurance companies on numerous occasions. *Id.*

Pursuant to Section 3 of the Act, the provisions of this Act shall apply automatically to all employers engaged in any department of the following enterprises...: 15) Any business or enterprise in which electric, gasoline or other power driven equipment is used in the operation thereof. The Commission finds that Respondent's business falls under Section 3(15) of the Act. By application of Section 3, Respondent was required to maintain workers' compensation insurance. The Respondent has offered no evidence to the contrary.

The Workers' Compensation Commission's authority and jurisdiction over insurance non-compliance cases is authorized by the Act, as well as the Rules. Under Section 4 of the Act, all employers who come within the auspices of the Act are required to provide workers' compensation insurance, whether this is done through being self-insured, through security, indemnity or bond, or through a purchased policy. Under Section 4(d):

> Upon a finding by the Commission, after reasonable notice and hearing, of the knowing and willful failure of an employer to comply with any of the provisions of paragraph (a) of this Section . . . , the Commission may assess a civil penalty of up to $500 per day for each day of such failure or refusal after the effective date of this amendatory Act of 1989. Each day of such failure or refusal shall constitute a separate offense. The minimum penalty under this Section shall be the sum of $10,000. The Commission may assess the civil penalty personally and individually against the corporate officers and directors of a corporate employer, the partners of an employer partnership, and the members of an employer limited liability company, after a finding of a knowing and willful refusal or failure of each such named corporate officer, director, partner, or member to comply with this section. The liability for the assessed penalty shall be against the named employer first, and if the named employer refuses to pay the penalty to the Commission within 30 days after the final order of the Commission, then the named corporate officers, directors, partners, or members who have been found to have knowingly and willfully refused or failed to comply with this Section shall be liable for the unpaid penalty or any unpaid portion of the penalty.

Section 7100.100 of the Rules codifies the language of the Act, and additionally describes the notice on noncompliance required, as well as the procedures of the

Insurance Compliance Division, and how hearings are to be conducted. Reasonable and proper notice, as noted above, has been provided to Mr. Edward Pudlo, Jr. Section 7100.100(d)(3)(D) of the Rules indicates that "A certification from an employee of National Council on Compensation Insurance stating that no policy information page has been filed in accordance with Section 7100.30 shall be deemed prima facie evidence of that fact." Petitioner's exhibit 1 contains the certification from NCCI Holdings, Inc. indicating that Mr. Edward Pudlo, Jr. did not have workers' compensation insurance from January 1, 2003 through March 25, 2011 and May 11, 2012 through May 14, 2012. Mr. Edward Pudlo, Jr. failed to offer any evidence of compliance with the Act.

In *State of Illinois v. Murphy Container Service, et al.*, 2007 Ill.Wrk.Comp.LEXIS 1216, the Commission considered the following factors in assessing penalties against an uninsured employer: 1) the length of time the employer had been violating the Act; 2) the number of workers' compensation claims brought against the employer; 3) whether the employer had been made aware of his conduct in the past; 4) the number of employees working for the employer; 5) the employer's ability to secure and pay for workers' compensation coverage; 6) whether the employer had alleged mitigating circumstances; and, 7) the employer's ability to pay the assessed amount.

In the instant case, the Commission finds that the length of time in which the Respondent had been violating the Act in failing to obtain workers' compensation insurance was significant. The Respondent failed to have insurance for 1,787 days. The Respondent employed a significant number of employees and, by way of Mr. Pudlo's testimony, there were numerous workplace injuries. Despite this, Respondent elected to not obtain workers' compensation insurance. The Respondent's only argument was that he was unaware of his requirement to obtain workers' compensation insurance. The Commission does not find credence in his argument as the Act unequivocally requires Respondent to maintain workers' compensation insurance. Having reviewed the record, the Commission finds no legitimate mitigating circumstances.

The Commission finds that the Respondent, Mr. Edward Pudlo, Jr. knowingly and willfully failed to comply with the Act. Based on the significant period of time that Mr. Edward Pudlo, Jr. failed to comply with the Act, the Commission assesses a penalty of $893,500.00 ($500.00 per day for 1,787 days) against EDWARD PUDLO, JR., individually and as President of NORTHWEST SUBURBAN DRIVING SCHOOL, INC.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent, EDWARD PUDLO, JR., individually and as President of NORTHWEST SUBURBAN DRIVING SCHOOL, INC., is found to be an employer who was in non-compliance with the insurance provisions of Section 4(a) of the Act and Section 7100.100 of the Commission Rules, and is hereby ordered to pay the Commission a fine of $893,500.00 pursuant to Section 4(d) of the Act and Section 7100.100 of the Commission Rules.

Pursuant to Commission Rule 7100.100(f), once the Commission assesses a penalty against an employer in accordance with Section 4(d) of the Act, payment shall be made according to the following procedure: 1) payment of the penalty shall be made by

15IWCC0871

certified check or money order made payable to the State of Illinois. Payment shall be mailed or presented within thirty (30) days of the final order of the Commission or the order of the court of review after final adjudication to:

Illinois Workers' Compensation Commission
Fiscal Office
100 West Randolph Street, Suite 8-328
Chicago, Illinois 60601
1-312/814-6625

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: NOV 2 4 2015
MJB/tdm
D: 11-23-15
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

WILLIAM P. BRENNAM,

Petitioner,

15IWCC0878

vs.

NO: 11 WC 33275

CERRO FLOW PRODUCTS,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by both the Respondent and Petitioner 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, 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 testified that his work activities involved extensive use of his hands and arms in operating machinery for 70% to 80% of his working day. Petitioner's treating doctor, Dr. Mirly, testified that Petitioner's work activities involved repetitive and forceful use of the hands and arms and that those work activities were a factor in his development of bilateral cubital carpal syndrome and bilateral carpal tunnel syndrome. Respondent's section 12 medical examiner, Dr. Strecker, opined that neither condition of bilateral carpal tunnel syndrome nor cubital carpal syndrome was causally related to his work activities.

Dr. Mirly performed bilateral surgery for both carpal tunnel syndrome and cubital tunnel syndrome. He deemed the bilateral carpal tunnel syndrome surgery as "elective" because condition was extremely mild in nature, but he thought the surgery was reasonable because it would likely be needed in the future and doing the carpal tunnel syndrome surgery simultaneously with the cubital tunnel syndrome would reduce recuperation time.

15IWCC0878

The Decision of the Arbitrator appears to be internally inconsistent. It seems that the Arbitrator's intent was to award compensation for cubital tunnel syndrome but not carpal tunnel syndrome. However, the body of the decision is contradictory. In the award section he wrote that Petitioner's bilateral carpal tunnel syndrome and cubital tunnel syndrome arose out of and in the course of his employment. Similarly, in his analysis section the Arbitrator wrote "Petitioner's condition of ill-being, bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome, is causally connected to his employment with Respondent." However, he also wrote that while he found Dr. Mirly's opinion more persuasive than that of Dr. Strecker regarding the cubital tunnel syndrome, he found Dr. Strecker more persuasive regarding the carpal tunnel syndrome. The Arbitrator then denied medical expenses associated with the carpal tunnel syndrome and awarded permanent partial disability benefits only for the arms and not for the hands.

The Commission finds the testimony and opinions of Dr. Mirly to be more persuasive that that of Dr. Strecker. In reviewing the record in its entirety, the Commission finds that Petitioner did sustain his burden of proving that his work activities were a causal factor in his developing both bilateral cubital tunnel syndrome and bilateral carpal tunnel syndrome. Therefore, the Commission modifies the Decision of the Arbitrator to award medical expenses incurred for treatment of his carpal tunnel syndrome.

The Arbitrator awarded Petitioner 75.9 weeks of permanent partial disability benefits representing loss of 15% of the use of both his right and left arms. The record is clear that both Petitioner's bilateral cubital tunnel syndrome and bilateral carpal tunnel syndrome were mild in nature. In fact while the EMG showed some sensory deficit in his carpal tunnel there was no associated motor deficit noted.

Petitioner testified that the surgeries resolved his symptoms. He was returned to full duty work, which he testified involved repetitive and forceful use of his hands and arms, within six weeks of his last surgery. In assessing the record in its entirety, the Commission finds that a permanent partial disability award of 71.1 weeks, representing loss of the use of 10% of each arm and 5% of each hand is appropriate. Therefore, we modify the Decision of the Arbitrator accordingly.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $442.33 per week for a period of 11 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 $398.10 per week for a period of 71.1 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of the use of 10% of each arm and 5% of each hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the necessary and reasonable medical expenses incurred for treatment of Petitioner's bilateral cubital tunnel syndrome and bilateral carpal tunnel syndrome under §8(a) of the Act pursuant to the applicable medical fee schedule.

15IWCC0878

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 $35,000.00. 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: NOV 2 4 2015

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
O-10/20/15
46

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0878

BRANNAM, WILLIAM Case# **11WC033275**

Employee/Petitioner

CERRO FLOW PRODUCTS

Employer/Respondent

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
NATHAN A BECKER
3673 HWY 111 PO BOX 488
GRANITE CITY, IL 62040

0507 RUSIN & MACIOROWSKI LTD
THEODORE POWERS
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

15IWCC0878

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

Case # 11 WC 033275

Consolidated cases: _____

William Brannam
Employee/Petitioner

v.

Cerro Flow Products
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **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. ☒ 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 _____

15IWCC0878

FINDINGS

On **11-01-2010**, 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 $**34,502.00**; the average weekly wage was $**663.50**.

On the date of accident, Petitioner was **51** years of age, *married* with **0** children under 18.

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 $ for TTD, $ for TPD, $ for maintenance, and $**any paid by Respondent's short-term disability policy** for other benefits, for a total credit of $.

Respondent is entitled to a credit of $**any amounts paid by stipulation of parties** under Section 8(j) of the Act.

ORDER

Petitioner's accident arose out of and in the course of his employment with Respondent. The Arbitrator finds that Petitioner had bilateral carpal tunnel and bilateral cubital tunnel syndrome, which arose out of and in the course of his employment with Respondent.

Petitioner's condition of ill-being, bilateral carpal tunnel and bilateral cubital tunnel syndrome, is causally connected to his employment with Respondent. The Arbitrator bases this opinion on the testimony of Petitioner and Dr. Mirly. Regarding the arms, Arbitrator finds the testimony of Dr. Mirly to be more credible than that of Dr. Strecker.

Respondent shall pay reasonable and necessary medical services pursuant to the medical fee schedule (Section 8(a) and 8.2 of the Act) as follows: Belleville Hand Surgery $335.80; Memorial Hospital of Belleville $301.68 and $596.08; Anesthesia Associates of Belleville $45.00 and $50.00 less that part, if any, of those bills attributable to the carpal tunnel releases.

The Arbitrator finds Petitioner's symptoms of bilateral cubital tunnel syndrome were relieved by the surgeries performed by Dr. Mirly. This is based on the medical records and the testimony of Petitioner. These facts not only confirm the diagnosis of said syndrome, they show the treatment was reasonable and necessary it.

Respondent shall receive an 8(j) credit for any amounts actually paid by Respondent's group insurance.

Respondent shall pay Petitioner temporary total disability benefits of $442.33/week for 11 weeks, commencing 12/5/2011 through 2/19/2012, as provided in Section 8(b) of the Act. Respondent shall receive a credit for amounts paid by Respondent's short-term disability policy.

The Respondent shall pay Petitioner PPD benefits of $398.10 for 75.9 weeks because the injury sustained caused 15% loss of use of each arm as provided by Section 8e of the Act.

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

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

Signature of Arbitrator

12/12/14
Date

JAN 5 - 2015

William Brannam vs. Cerro Flow Products
11 WC 033275

The Arbitrator hereby finds the following:

Petitioner, William Brannam, is a 54 year-old male employed as a head straightener/operator and crane hooker for Respondent, Cerro Flow. He claims a repetitive trauma injury to his left and right elbows and hands resulting in bilateral cubital tunnel and bilateral carpal tunnel syndrome. Respondent is disputing accident, causation, reasonableness of medical treatment, TTD benefits and nature and extent.

On November 11, 2010, Petitioner was sent to Midwest Occupational Medicine by Respondent. (PX1, 1) He reported a one week history of numbness and tingling down the fourth finger that radiates into the palm of the hand and into the hypothenar eminence. These symptoms were waking him up at night, at least four times a night. (Id) It was noted, Petitioner had seen the physical therapist at work a week earlier and was given wrist splints. He was working full duty as a crane hooker. (Id) Petitioner's physical exam showed positive Phalen's. (PX1, 1)

The Midwest Occupational staff recorded Petitioner's history of injury as: "He states he gauges tubing, hooks cranes, runs machinery and straighteners. He reports last month they did a special order that was gauging tubing at a much higher, steadier rate and he developed an increase in these symptoms." (PX1, 1)

Petitioner was instructed to continue the therapy program provided by the work physical therapist and to continue to use the wrist splints. It was noted by the Midwest Occupational staff Petitioner should utilize the wrist supports during the day because the activities he was doing during the day may aggravate his symptoms. (PX1, 2) Petitioner declined to wear the wrist supports during the day because they would not fit with his work gloves. (Id)

Petitioner sought medical treatment with Dr. Harvey Mirly, on November 11, 2010. (PX2, 1) The history documented by Dr. Mirly was Petitioner had bilateral hand numbness, present for about a month, with an onset of symptoms after doing an increased amount of gauging at work. (PX6, 8) Dr. Mirly felt his symptoms were consistent with cubital tunnel syndrome, with pins and needles in the ring and small finger. (Id) Physical exam showed positive Tinel's at the ulnar nerve. At the conclusion of the November 11, 2010 office visit, Dr. Mirly diagnosed Petitioner with cubital tunnel syndrome. (PX6, 10) The plan was for conservative treatment with instructions for Petitioner to avoid flexing the elbow. (PX6, 11)

Petitioner was given a form to complete to document his response to conservative treatment. This information was provided to Dr. Mirly. Petitioner's symptoms did not cease with conservative care, therefore, Dr. Mirly ordered a NCS. (PX6, 11-12) The NCS was performed on December 21, 2010. It showed bilateral median neuropathy and bilateral ulnar neuropathy. (PX3, 1)

Petitioner and Dr. Mirly reviewed the NCS on December 30, 2010. (PX6, 12) Dr. Mirly testified the pertinent findings of the NCS were prolonged left and right median and ulnar nerve sensory nerve action potential peak latencies, which he believed to be mild at the time. (PX6, 12-13) The treatment plan as of December 2010 continued to be conservative care. A follow up visit was set for three months. (PX6, 14)

On March 7, 2011, Petitioner followed up with Dr. Mirly. Petitioner reported continued symptoms, including nigh symptoms, in the ulnar and median nerve distributions in both hands. (PX6, 15) Dr. Mirly continued to recommend conservative treatment. (PX6, 16)

On May 17, 2010, Petitioner followed up with Dr. Mirly and reported worse symptoms on the right, which was bothering him more frequently. (PX6, 16) Cubital tunnel transposition was recommended. (PX6, 17)

On October 24, 2011, Petitioner once again saw Dr. Mirly. At that point bilateral carpal and cubital tunnel releases were scheduled. (PX6, 17) Dr. Mirly testified his rationale for performing the carpal tunnel release was: "...[Petitioner] reported occasional symptoms in the median nerve distribution as well. Again, we spent time discussing the difference between the nerves. His, the reason was so that he would not have to come back and take time off again. To, you know, in a quote, kill two birds with one stone, going to have simultaneous recovery." (PX6, 18) Given Petitioner's subjective complaints and NCS findings, Dr. Mirly testified it was reasonable to perform bilateral carpal tunnel releases and bilateral cubital tunnel transpositions. (PX6, 20 & 28)

Petitioner testified his symptoms initially were mostly in his little and ring fingers, but he also had symptoms in his index and middle fingers. From the date of the accident to the time of surgery Petitioner continued to perform regular full duty. He testified his symptoms progressively worsened from the date of accident to the time of surgery.

Petitioner underwent right carpal tunnel release and right cubital tunnel transposition on December 5, 2011. (PX4, 1-2) Petitioner reported very good relief of his symptoms on the right following surgery. (PX6, 22) Petitioner underwent left carpal tunnel release and left cubital tunnel transposition on January 4, 2011. (PX5. 1) Once again, Petitioner reported good relief of his symptoms at the post-op visit on January 12, 2012. (PX6, 24) Petitioner testified that the numbness and tingling in all of his fingers was relieved by the surgeries. At the time of trial Petitioner continued to be symptom free.

Petitioner was released to full duty on February 20, 2012. (PX6, 24) In total, Petitioner was held off of work completely from December 5, 2011 to February 20, 2011. (PX6, 25)

At trial, Petitioner described the job functions of a crane hooker, a straightener machine operator, an ACR machine operator, and gauging. Petitioner testified he sought medical treatment for this arm and hand symptoms after doing a special gauging job for one week straight, eight hours each day. He stated he gauged about 200 copper tubes a day while processing that special job. In general, Petitioner testified he spent 70%-80% of his time as a straightener machine operator, approximately 10% of his time as a crane hooker, and approximately 10% of his time gauging (with the exception of the special gauging job).

Regarding causation, Dr. Mirly testified he had been on a tour of Respondent's facility in order to review job duties to determine what jobs could be done while on light duty. (PX6, 33) Dr. Mirly was asked a hypothetical question, which matched Petitioner's testimony, to address causation or aggravation. (PX38-43) In response, Dr. Mirly testified:

> My opinion is based on the patient's reported development of symptoms following an activity, that is the increasing amount of gauging. In my first clinic note, he clearly stated he reported onset of symptoms after doing increased gauging. The Midwest Occupational Medicine, again, symptoms developed after increase with the gauging. It is based on that temporal

> relationship, the onset of symptoms following the increased activity of that nature is where I draw my connection or my relationship. I would say that those work activities would be of a contributing nature but not solely causative. I don't think every individual or any individual you subject to those same duties would necessarily develop the symptoms over the set period of time. But I think outside injuries, all those contribute. But it's based on the temporal onset of his symptoms with activity of increased gauging as clearly reported by [Petitioner] to me and also referenced in the Midwest Occupational note is where I draw my contributory or contribution of his work duties to development of this cubital tunnel syndrome. (PX6, 43-44)

Dr. Mirly testified that Petitioner's carpal tunnel syndrome would have been aggravated by his general job duties spelled out in the hypothetical. (PX6, 44-45)

Conclusions of Law:

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

Petitioner's accident arose out of and in the course of his employment with Respondent. The Arbitrator finds that Petitioner had bilateral cubital tunnel syndrome, which arose out of and in the course of his employment with Respondent.

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

Petitioner's condition of ill-being, bilateral carpal tunnel and bilateral cubital tunnel syndrome, is causally connected to his employment with Respondent. The Arbitrator bases this opinion on the testimony of Petitioner and Dr. Mirly. Regarding the arms, theArbitrator finds the testimony of Dr. Mirly to be more credible than that of Dr. Strecker. Regarding the carpal tunnel syndrome the Arbitator finds Dr. Strecker to be more creditable.

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

Respondent shall pay reasonable and necessary medical services pursuant to the medical fee schedule (Section 8(a) and 8.2 of the Act) as follows: Belleville Hand Surgery $335.80; Memorial Hospital of Belleville $301.68 and $596.08; Anesthesia Associates of Belleville $45.00 and $50.00 less that part, if any, of those bills attributable to the carpal tunnel releases.

The Arbitrator finds Petitioner's symptoms bilateral cubital tunnel syndrome were relieved by the surgeries performed by Dr. Mirly. This is based on the medical records and the testimony of Petitioner. These facts not only confirm the diagnosis, they show the treatment was reasonable and necessary to treat Petitioner's work related condition. However regarding the necessity of the carpal tunnel releases, the Arbitator finds Dr. Strecker to be more creditable.

Respondent shall receive an 8(j) credit for any amounts actually paid by Respondent's group insurance.

Issue K: Is Petitioner entitled to TTD benefits?

Respondent shall pay Petitioner temporary total disability benefits of $442.33/week for 11 weeks, commencing 12/5/2011 through 2/19/2012, as provided in Section 8(b) of the Act. Respondent shall receive a credit for amounts paid by Respondent's short-term disability policy.

Issue L: Nature and Extent of injury?

Respondent shall pay Petitioner permanent partial disability benefits because the injury sustained caused 15% loss of use of the right arm, and 15% loss of use of the left arm as provided in Section 8(e) of the Act.

Date: 12/12/14

Honorable Edward Lee

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michelle Quertermous,
Petitioner,

vs. NO: 11 WC 34109

State of Illinois/DHFS,
Respondent.

15IWCC0866

DECISION AND OPINION ON REVIEW

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

The Arbitrator found that Petitioner sustained the permanent partial loss of use of 15% of her left hand pursuant to §8(e) of the Act. The record shows that Petitioner suffered left carpal tunnel syndrome as a result of her accident on December 23, 2010 and underwent a left carpal tunnel release on June 3, 2011. She received post-operative physical therapy and was released to return to full duty work on July 14, 2011. Petitioner was off work for 6-3/7 weeks and returned to her regular job on July 17, 2011. Dr. Young subsequently released her from care on August 3, 2011. Petitioner has had no other care relative to the injury since that date. She currently complains of weakness in her left hand, but continues to perform her regular duties for Respondent, including extensive typing on a computer. Based on the above, and the record taken as a whole, the Commission modifies the Arbitrator's decision to find that Petitioner sustained the permanent partial loss of use of 12.5% of the left hand pursuant to §8(e)9 of the Act.

All else is hereby affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $634.19 per week for a period of 6-3/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

15IWCC0866

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $570.77 per week for a period of 25.625 weeks, as provided in §8(e)9 of the Act, for the reason that the injuries sustained caused the loss of use of 12.5% 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 injury.

DATED: NOV 2 4 2015

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-10/21/15
jdl/po
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

QUERTERMOUS, MICHELLE
Employee/Petitioner

Case# **11WC034109**

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
Employer/Respondent

15IWCC0866

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:

0283 JELLIFFE FERRELL DOERGE PHELPS
KELLY R PHELPS
PO BOX 406
HARRISBURG, IL 62946

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 6M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

0558 ASSISTANT ATTORNEY GENERAL
FARRAH L HAGAN
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

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 21 2015

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MICHELLE QUERTERMOUS
Employee/Petitioner

v.

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
Employer/Respondent

Case # 11 WC 34109

Consolidated cases: _____

15IWCC0866

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin, Illinois**, on **11/14/2014**. 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 **12/23/2010**, 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 $**49,467.00**; the average weekly wage was $**951.29**.

On the date of accident, Petitioner was **38** years of age, ***married*** with **3** dependent children.

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

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

Respondent shall be given a credit of $**4,077.06** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**4,077.06**.

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 $634.19/week for 6 3/7 weeks, commencing 06/03/2011 through 07/17/2011, as provided in Section 8(b) of the Act.

Respondent shall be given credit for $4,077.06 for TTD benefits paid under Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $570.77/week for 30.75 weeks, because the injuries sustained caused the 15% 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.

Carl Lee
Signature of Arbitrator

1/12/15
Date

JAN 21 2015

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

15IWCC0866

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MICHELLE QUERTERMOUS,

Employee/Petitioner,

vs. 11-WC-34109

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES,

Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On December 23, 2010, petitioner was employed by respondent. On this date, petitioner claims she sustained a repetitive trauma injury to her left hand arising out of and in the course of her employment with respondent.

Prior to December 23, 2010, petitioner worked for respondent since 1999. During this 11 year time period, petitioner's job duties included continuous computer work, data entry, and typing. Petitioner worked 7 1/2 hours per day, 5 days per week for respondent. She spent most of her day typing on the computer. Petitioner's job title was "Child Support Specialist I." A "Demands of the Job" form for a "Child Support Specialist I" indicates that petitioner would use her hands for fine manipulation (typing, good finger dexterity) for 6-8 hours per day (RX 5).

Petitioner experienced numbness and tingling in her hands while doing her computer work. Her numbness and tingling progressed to the point where she sought medical treatment at her family physician's office, Alexander Family Practice, on December 23, 2010. (PX 1). At

this office visit, petitioner gave a history of numbness and tingling in her hands, left worse than right. Carpal tunnel was suspected so a nerve conduction study was ordered.

The nerve conduction study was performed on January 18, 2011. (PX 2). This study revealed mild carpal tunnel syndrome of the left hand.

Petitioner completed a written accident report on January 21, 2011. (RX 1). This report gives an accident date of December 23, 2010. It also states that petitioner suffers from left carpal tunnel due to several years of working daily on computer.

Also on January 21, 2011, petitioner's supervisor, Sherrie Runge, completed a supervisor's report of injury or illness. (RX 3). Runge's report gives an accident date of December 23, 2010. It describes petitioner's injury as left carpal tunnel.

Petitioner was examined by Dr. Steven Young, orthopedic surgeon, on February 8, 2011. (PX 3). On this date, petitioner was complaining of numbness and tingling in both her wrists, left worse than right. She stated that her symptoms had been ongoing for the past 8 months to a year. She gave a history of doing computer work for the State of Illinois for the last 7 1/2 years. In Dr. Young's work history questionnaire form, petitioner described her job duties as continuous computer work/case management/ filing. A physical examination was performed. It revealed a positive Tinel's on the left wrist and left cubital tunnel area. The nerve conduction study was reviewed and noted as showing mild left median neuropathy at the wrist. Dr. Young's diagnosis was left carpal tunnel syndrome. He scheduled her for carpal tunnel release. Dr. Young also noted at the end of this office note that petitioner "does work utilizing quite a bit of computer work, which could be attributing to her symptoms." (PX 3).

Dr. Young performed surgery on petitioner on June 3, 2011. (PX 4). The procedure was left carpal tunnel release. The post-operative diagnosis was left carpal tunnel syndrome.

Petitioner continued under Dr. Young's care post-operatively. (PX 3). On July 14, 2011, Dr. Young released petitioner to return to work full duty. (PX 3). She returned to her regular job of "Child Support Specialist I."

On August 3, 2011, Dr. Young examined petitioner. (PX 3). She was experiencing slight sensitivity in the incision site but was otherwise doing well. Dr. Young released her from his care.

On March 18, 2013, petitioner was examined by Dr. Patrick Stewart at the request of respondent pursuant to Section 12 of the Act. (RX 9, 10). Dr. Stewart reviewed petitioner's prior treatment records and performed a physical examination. Dr. Stewart's assessment was status post left carpal tunnel release.

Petitioner is still currently working as a "Child Support Specialist I." She is able to perform her job duties. Her left hand feels weaker than her right. She is right hand dominant.

CONCLUSIONS OF LAW

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

Petitioner has met her burden of proof that she sustained an accident that arose out of and in the course of her employment by respondent. Petitioner was employed by respondent for nearly 11 years performing continuous typing and computer work. She spent 6 or more hours a day, 5 days a week, doing continuous typing. She experienced numbness and tingling while performing her job duties of typing and computer work. Petitioner gave her treating physician, Dr. Young, an accurate and complete history of her repetitive activities at work. (PX 3). Dr. Young opined that this type of repetitive activity causes or contributes to carpal tunnel syndrome. (PX 7, p. 8, 17). She sought medical treatment for her symptoms on December 23,

2010. After this examination, carpal tunnel syndrome was suspected and a nerve conduction study was ordered.

The date of December 23, 2010, is a proper accident date for petitioner's repetitive trauma injury because this is the date that it can be said that her injury manifested itself. The Illinois Supreme Court has held that the date of manifestation is the date of an accidental injury in a repetitive trauma case. *Peoria County Belwood Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 106 Ill.Dec. 235, 505 N.E.2d 1026 (1987). "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 become plainly apparent to a reasonable person. *Id.*

Based on the foregoing, the Arbitrator finds that petitioner sustained an accident arising out of and in the course of her employment by respondent on December 23, 2010.

Issue E: Was timely notice of the accident given to Respondent?

The Arbitrator finds that timely notice of the accident was given to respondent. As set forth above, the Arbitrator found that petitioner sustained an accident arising out of and in the course of her employment by respondent on December 23, 2010. Petitioner completed a written accident report on January 21, 2011. (RX 1). Section 6(c) of the Act requires an employee to give an employer notice of an accident within 45 days of the accident. *820 ILCS 305/6(c).* Petitioner gave notice of her accident within 29 days of her accident. Hence, timely notice was given to respondent.

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

The Arbitrator finds that petitioner's current condition of ill-being is causally related to the injury. Petitioner worked for respondent for nearly 11 years performing continuous typing and computer work. She typed for 6 or more hours a day, 5 days a week. She experienced

numbness and tingling while performing her job duties of typing and computer work. Petitioner gave her treating physician, Dr. Young, an accurate and complete history of her repetitive activities at work. (PX 3). Dr. Young testified to a reasonable degree of medical certainty that petitioner's repetitive activities at work caused or contributed to her left carpal tunnel syndrome. (PX 7, p. 8). The Arbitrator finds Dr. Young's testimony credible and persuasive.

Respondent offered the report and testimony of Dr. Stewart in support of its claim that petitioner's left carpal tunnel was not caused by her repetitive job activities. (RX 9; RX 10). The Arbitrator notes that Dr. Stewart examined petitioner more than a year and a half after she had already been treated and released from Dr. Young's care. Dr. Stewart opined that petitioner's left carpal tunnel was idiopathic, i.e., of unknown cause. (RX 10, p. 36). Dr. Stewart's opinion rested entirely upon a 2001 study completed by the Mayo Clinic concerning the causal link between carpal tunnel and keyboarding. (RX 10, p. 22-23). This study concluded that people performing keyboarding work were not at an increased risk of developing carpal tunnel syndrome. (RX 10, p. 23).

The reliability of the Mayo Clinic study, however, is questionable. First, the Mayo Clinic study is old. It was nearly 13 years old at the time of Dr. Stewart's deposition. (RX 10, p. 38-39).

Second, the Mayo Clinic study reached its conclusion by citing to and relying upon a Dutch study done in the early 1990s that did not even assess computer use in its analysis. (RX 10, p. 40). Dr. Stewart agreed that since the early 1990s, the use of computers in the workplace has increased dramatically. (RX 10, p. 40).

Third, in addition to relying upon the Dutch study, the Mayo Clinic study also relied upon a more recent Swedish study. (RX 10, p. 39-40). By relying upon those studies, the Mayo

Clinic study assumed that the populations of Sweden and the Netherlands were representative of the population of the United States. Dr. Stewart agreed, however, that it is unknown whether the populations of Sweden and the Netherlands are representative of the population of the United States. (RX 10, p. 41).

Fourth, the Mayo Clinic study provided no occupational history for the employees discussed in the study except that they worked at a data processing center at the Mayo Clinic in Arizona. (RX 10, p. 41). In other words, the workers studied in the Mayo Clinic study were its own employees. (RX 10, p. 41).

Fifth, the hours of computer work cited in the Mayo Clinic study were self-reported by the workers and not independently verified. (Rx 10, p. 42.).

Sixth, Dr. Stewart acknowledged that there are criticisms and critiques of the Mayo Clinic study that feel that its sample was relatively small and might not be representative of general office workers. (RX 10, p. 41-42.)

Seventh, Dr. Stewart also acknowledged that there are other academic studies finding a causal relationship between excessive computer work and carpal tunnel syndrome. (RX 10, p. 39).

Finally, Dr. Young was specifically asked about the Mayo Clinic study and he disagreed with the findings of that study testifying that he believed keyboarding contributes to carpal tunnel syndrome. (PX 7, p. 17).

Because Dr. Stewart's causation opinion relies entirely upon the Mayo Clinic study and the reliability of that study is debatable, the Arbitrator give more weight to the causation opinion of Dr. Young than to Dr. Stewart.

Based on the foregoing, the Arbitrator finds that petitioner's current condition of ill-being is causally related to her injury on December 23, 2010.

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 dispute by the parties that the medical services provided to petitioner were reasonable and necessary. Respondent has paid all appropriate charges for the medical services provided to petitioner.

Issue K: What temporary benefits are in dispute?

Petitioner claims that she was temporarily and totally disabled due to her injury from June 3, 2011, through July 17, 2011, or 6 3/7 weeks. Respondent paid petitioner TTD benefits for that time period. Respondent, however, is seeking repayment of those TTD benefits from petitioner because it disputes accident and causation.

Given the Arbitrator's findings regarding accident and causation, the Arbitrator finds that petitioner was temporarily and totally disabled from June 3, 2011, through July 17, 2011, or 6 3/7 weeks, due to her injury. Therefore, petitioner is entitled to the TTD benefits she was paid by respondent for that time period. Since respondent already paid petitioner TTD benefits for that time period, respondent is given credit for the TTD paid. Respondent, however, is not entitled to be repaid any monies for TTD from petitioner.

Issue L: What is the nature and extent of the injury?

Petitioner sustained left carpal tunnel syndrome as a result of her accident on December 23, 2010. As a result, she underwent a left carpal tunnel release surgery. She was temporarily and totally disabled because of this injury for 6 3/7 weeks. Petitioner has returned to her regular job duties. Her left hand is weaker than it was before her injury. Based on the foregoing, the

Arbitrator finds that petitioner suffered a permanent and partial disability in the amount of 15% loss of use of the left hand pursuant to Section 8(e)(9) 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

Juan C. Hipolito,

Petitioner,

vs. NO: 11WC 44490

Dezurik Apco Valve and Primer, Inc.,

15IWCC0873

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 7, 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 $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: NOV 2 4 2015
o111915
DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

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

HIPOLITO, JUAN C
Employee/Petitioner

Case# **11WC044490**

DEZURIK APCO VALVE AND PRIMER INC
Employer/Respondent

15IWCC0873

On 5/7/2015, 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:

5317 CASTANEDA & STIBERTH PC
JOHN J CASTANEDA
47 DuPAGE COURT
ELGIN, IL 60120

0210 GANAN & SHAPIRO PC
JULIE M SCHUM
210 W ILLINOIS ST
CHICAGO, IL 60654

☐	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

JUAN C. HIPOLITO
Employee/Petitioner

Case #11 WC 44490

15IWCC0873

v.

DEZURIK APCO VALVE AND PRIMER, 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 Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on April 21, 2015. 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 22, 2011, 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 $24,560.12; the average weekly wage was $472.31.

- At the time of injury, the petitioner was 40 years of age, single with one child under 18.

- The parties agreed that the respondent paid $1,594.20 in temporary total disability benefits.

- The respondent agreed that the petitioner is entitled to temporary total disability benefits from February 23, 2011, through March 8, 2011, and from March 22, 2011, through April 11, 2011, (5 weeks).

ORDER:

- The respondent shall pay the petitioner temporary total disability benefits of $314.87/week for 5 weeks, from February 23, 2011, through March 8, 2011, and from March 22, 2011, through April 11, 2011, which are the periods of temporary total disability for which compensation is payable. The amount due the petitioner is reduced by the $1,594.20 in benefits previously paid to him by the respondent. The petitioner's request for temporary total disability benefits after November 7, 2013, is denied.

- The medical care rendered the petitioner for his lumbar spine through November 7, 2013, 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.

- The petitioner's request for prospective medical care, 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

May 7, 2015

Date

MAY 7 - 2015

FINDINGS OF FACTS:

On February 22, 2011, the petitioner, a laborer, felt lower back pain while lifting and dislodging a heavy object from a skid. He received medical care at Northwest Community Hospital with Dr. Manoj Patel, whose assessment was low back strain for which medication and light duty were prescribed. X-rays of his back were negative for fractures or disc space narrowing. The petitioner had three follow-ups through March 8th, at which time he reported feeling much better with only a small bit of tightness in his left lower back. The doctor noted a full range of motion and no radicular symptoms and released him without restrictions.

On March 22nd, he returned to Dr. Patel and reported that his back pain increased over time and that the previous day he bent over while cleaning some parts and felt a sudden pinch in his back and worsening back pain. Dr. Patel prescribed physical therapy, medication and light-work duty. The petitioner reported improvement at follow-ups but on May 7th reported sharp pain radiating down his left buttock. Dr. Newberg opined at a follow-up on May 13th that an MRI revealed a very mild bulging disc at L4-5 and L5-S1 with no encroachment. The diagnosis was sacroiliitis bilaterally and bulging discs from L4-S1. On October 21st, the petitioner saw Dr. Shashikant Patel at the Elgin Medical & Dental Center for severe back pain that began the day before that prevented him from getting out of bed. The diagnosis was chronic lumbar pain and he recommended a second orthopedic opinion.

On January 5, 2012, the petitioner saw Dr. Lorenz at Hinsdale Orthopaedics and reported an increase in back pain in October 2011. An MRI on January 16th revealed disc space narrowing and desiccation at L4-5 and L5-S1, a shallow protrusion at L4-5 and a

left paracentral disc protrusion/annular tear at L5-S1. On February 8th, Dr. Lorenz opined that the MRI revealed disc herniation at L4-5 and L5-S1 with axial back pain. The petitioner requested conservative care and was placed on medication and work restrictions. He reported continuing back pain at follow-ups with Dr. Lorenz on March 12th and April 4th, at which time the doctor noted that the petitioner was a surgical candidate. Dr. Lorenz noted complaints of severe back pain with bilateral radiation, left greater than the right, on May 24th. Dr. Pittman at Hinsdale Orthopaedics opined on August 8th that an MRI showed spondylosis central disc herniation at L4-5 and L5-S1 and an annular tear at L5-S1 and that a discogram was concordant for pain at L4-5 and L5-S1. The doctor discussed a lumbar fusion with the petitioner.

On February 4, 2013, the petitioner declined the surgery and was discharged with a permanent lifting restriction of ten pounds. The petitioner saw Dr. Dasgupta of Premier Pain Specialist on June 3, 2013, who gave him a lumbar epidural steroid injection on August 6th. On August 26th, the petitioner reported complete relief for two days and an overall relief of 50%. The petitioner received lumbar transforaminal injections on the right and left at L5-S1 on September 9th. He reported on October 7th that the injection provided a 40% relief of his leg pain.

On February 20, 2014, the petitioner returned to Dr. Shashikant Patel and reported back pain from an injury on February 22, 2011, and a second injury on November 7, 2013. A cervical MRI on April 4th revealed bulging discs at C3-4, C4-5 and C5-6. A thoracic MRI on April 7th was unremarkable. Dr. Tom Stanley of Midwest Bone & Joint released the petitioner with a five-pound lifting restriction for his back on May 5, 2014. He followed up with Dr. Patel for back pain on May 13th, June 5th and July 18th. On July

22, 2014, the petitioner was evaluated by Dr. Candido at the request of the respondent. Dr. Candido opined that there was symptom magnification and positive Wadell's signs and that the petitioner was at MMI and could work at a medium duty level. He followed up with Dr. Patel for back pain on October 25th and December 19th.

At his last follow-up with Dr. Patel on January 27, 2015, the petitioner requested a referral to a neurosurgical specialist. On March 11, 2015, the petitioner saw Dr. Ross and reported his initial injury and a slip-and-fall on November 7, 2013. He reported experiencing low back, bilateral leg and neck pain after his second incident. The petitioner had full range of motion in his neck and a 45-degree limit of forward flexion of his lumbar spine. Dr. Ross opined that the petitioner's symptoms suggested cervical, thoracic and lumbar strains and possible L4-5 and/or L5-S1 nerve impingement for which he recommended a discogram.

FINDING REGARDING WHETHER THE MEDICAL SERVICES PROVIDED TO PETITIONER ARE REASONABLE AND NECESSARY:

The medical care rendered the petitioner for his lumbar spine through November 7, 2013, was reasonable and necessary and is awarded. The medical care rendered the petitioner after November 7, 2013, was not reasonable or necessary and is denied.

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 his condition of ill-being with his lumbar spine through November 7, 2013, was causally related to the work injury. Since his initial injury on February 22, 2011, the petitioner has re-injured and aggravated his lumbar spine several times that has resulted in a progressive worsening of his lumbar spine condition. The petitioner's initial diagnosis at Northwest

Community Hospital was a low back strain. He had no radicular symptoms. His back pain and range of motion improved with therapy and medication and he was released without restrictions. The petitioner reported a sudden pinch in his back and worsening back pain after bending over to Dr. Patel on March 21, 2011. The MRI at that time revealed a very mild bulging disc at L4-5 and L5-S1 with no encroachment. On October 21, 2011, the petitioner reported to Dr. Shashikant Patel severe back pain that began the day before. On January 5, 2012, the petitioner reported to Dr. Lorenz an increase in back pain in October 2011 while lifting. An MRI on January 16, 2012, revealed disc space narrowing and desiccation at L4-5 and L5-S1, a shallow protrusion at L4-5 and a left paracentral disc protrusion/annular tear at L5-S1. After lumbar epidural steroid injections on August 6 and October 7, 2013, the petitioner reported 50% relief of his back pain and a 40% relief of his leg pain. On November 7, 2013, the petitioner re-injured his back after falling and complained to Dr. Patel of significant low back, bilateral leg and neck pain. The petitioner's injury on November 7, 2013, supersedes his initial injury on February 22, 2011. The petitioner's request for benefits after November 7, 2013, is denied.

FINDING REGARDING THE AMOUNT OF COMPENSATION DUE FOR TEMPORARY TOTAL DISABILITY:

The petitioner is entitled to temporary total disability benefits from February 23, 2011, through March 8, 2011, and from March 22, 2011, through April 11, 2011. The petitioner worked from April 12, 2011, through October 24, 2014. The petitioner's request for temporary total disability benefits after November 7, 2013, is denied.

The respondent shall pay the petitioner temporary total disability benefits of $314.87/week for 5 weeks, from February 23, 2011, through March 8, 2011, and from

March 22, 2011, through April 11, 2011, 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 any prospective medical care is reasonable medical care necessary to relieve the effects of the February 22, 2011, work injury. The petitioner's request for prospective medical care is denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mario Robles ,

Petitioner,

vs. NO: 11WC 47907

15IWCC0874

Watersaver Faucet,

Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 10, 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.

15IWCC0874

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $30,700.00. 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: NOV 2 4 2015
o111915
DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ROBLES, MARIO
Employee/Petitioner

Case# 11WC047907

WATERSAVER FAUCET
Employer/Respondent

15IWCC0874

On 6/10/2015, 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:

0147 CULLEN HASKINS NICHOLSON
JOSE M RIVERO
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERT E MACIOROWSKI
105 W ADAMS ST SUITE 2200
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

Mario Roble
Employee/Petitioner

v.

Watersaver Faucet
Employer/Respondent

Case # 11WC 47907

15IWCC0874

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **May 15, 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 **Admissibility of Petitioner's treating records**

FINDINGS

On **07/21/2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**25.823.20**; the average weekly wage was $**496.60**.

On the date of accident, Petitioner was **28** years of age, ***married*** with **0** dependent children.

Petitioner ***has in part*** received reasonable and necessary medical services.

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

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

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

ORDER

The Arbitrator declines to modify the evidentiary rulings she made at the hearing – see the attached and RG Construction Services v. IWCC, 2015 Ill. LEXIS (Ill. May 27, 2015).

At the hearing, Respondent accepted responsibility for the claimed bills from Physicians Immediate Care and Dr. Gleason. To the extent that any outstanding charges from either Physicians Immediate Care or Dr. Gleason remain due, after the payments reflected in RX 7, Respondent shall pay same. Respondent shall also pay the following reasonable and necessary medical expenses, pursuant to the medical fee schedule: 1) Illinois Bone and Joint (Dr. Fisher), $591.00; 2) Health Benefits Pain Management, $1,620.00 (charges relating to the 7/25/12 FCE); 3) Illinois Physicians Network (Dr. Kiokemeister), $2,257.00 (charges relating to the 3/12/12 injection); and 4) Presence St. Joseph Medical Center, $2,452.00 (charges relating to the 3/12/12 injection), with Respondent receiving credit for the $911.27 payment reflected on the bill, as provided in Sections 8(a) and 8.2 of the Act. See the attached decision for further details concerning the medical award.

Respondent shall pay Petitioner temporary total disability benefits of $331.07week for 11 2/7 weeks, commencing June 6, 2012 through August 23, 2012, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $297.96/week for 70 weeks, because the injuries sustained caused the 14% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

The Arbitrator declines to award penalties and fees, for the reasons set forth in the attached decision.

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 E Mason
Signature of Arbitrator

6/9/15
Date

JUN 10 2015

Mario Robles v. Watersaver Faucet
11 WC 47907

15IWCC0874

Arbitrator's Findings of Fact

Petitioner testified through a Spanish-speaking interpreter.

The parties agree Petitioner sustained an accident while working for Respondent on July 21, 2011. Arb Exh 1. Petitioner testified he began working for Respondent about 10 or 11 years before July 2011. T. 15. As of the accident, he worked in the shipping and receiving department, moving boxes, putting skids together and loading trucks. T. 15. He received pre-packed boxes from other employees. He weighed and labeled these boxes and put them on skids. He used a hand jack to move the skids. T. 16. The boxes varied in size and weight. T. 16. Some weighed as little as 2 pounds. The largest weighed between 40 and 45 pounds. T. 17.

Petitioner testified that, on July 21, 2011, he was using a hand jack to maneuver a loaded skid off of an elevator when the hand jack got stuck in a gap between the floor and the elevator. As he tried to pull the hand jack backward, in order to dislodge it from the gap, he stepped on a piece of wood, slipped and fell backward. T. 17. He landed on his back on a concrete floor. T. 17. After he fell, he felt a hot sensation in his back. He also felt a similar sensation and some pain in his left buttock and the back of his left leg. T. 17-18.

Petitioner testified he reported the accident to his supervisor. He completed an accident report the following day. [Notice is not in dispute. Arb Exh 1.]

Petitioner testified that his symptoms worsened after he went home on July 21, 2011. T. 18. By the following morning, his pain was "very strong" but he went to work. T. 18. At Respondent's direction, he went to Physicians Immediate Care. T. 18.

The records from Physicians Immediate Care (PX 1) reflect that Petitioner saw a physician's assistant, Jack Enter, PA-C [hereafter "Enter"], on July 22, 2011. Enter noted that Petitioner complained of 5/10 left-sided lower back pain and difficulty performing his usual duties secondary to a work accident the previous day. Enter also noted that Petitioner denied any non-work-related event or incident.

On initial examination, Enter noted a normal gait, negative Waddell's signs x 5, spasm and tenderness in the left side of the paraspinous muscles, at approximately L4/5/S1 and a somewhat decreased range of lumbar spine motion. He ordered lumbar spine X-rays, which were interpreted as normal. He diagnosed a work-related lumbar strain. He prescribed a back support, Biofreeze and medication. He released Petitioner to light duty with no squatting, no lifting over 10 pounds from floor to waist and use of the back support. He instructed Petitioner to return on July 26th. PX 1, p. 6.

Petitioner returned to Physicians Immediate Care on July 26, 2011 and saw Carl Gustas, Sr., D.O. Dr. Gustas noted that Petitioner reported improvement but was still complaining of 6/10 pain in a localized area of the left lower back. On examination, the doctor noted no abnormalities other than palpable point tenderness at the left lumbosacral junction. He diagnosed a lumbar strain. He instructed Petitioner to continue using the back support, start taking Methocarbamol and continue the other medication. He continued the previous work restrictions and instructed Petitioner to return in two days. PX 1, p. 8.

At the next visit, on July 28, 2011, Petitioner again saw Dr. Gustas. The doctor noted that Petitioner described his pain as "now localized to the right lumbosacral area" and "no longer radiating down the leg." On examination, the doctor noted localized tenderness at the right lumbosacral junction. He diagnosed an improving lumbar strain. He prescribed physical therapy, started Petitioner on Prednisone and continued the previous work restrictions. PX 1, p. 8.

On August 5, 2011, Petitioner returned to Physicians Immediate Care and saw Melissa Lind, PA-C. Lind noted that Petitioner complained of 4/10 intermittent lower back pain that increased with lifting and other activities. Lind noted no abnormalities on examination. She continued the previous regimen and work restrictions. She instructed Petitioner to return on August 11th. PX 1, p. 9.

Petitioner went back to Physicians Immediate Care on August 11, 2011 and again saw Dr. Gustas. On examination, the doctor noted that Petitioner complained of localized pain to the left superior iliac spine with extension of the lumbar spine. He also noted that Petitioner had not yet started therapy. He continued the previous regimen and advanced Petitioner to no lifting over 20 pounds from floor to waist, waist to shoulder and overhead. He directed Petitioner to continue wearing the back support and return on August 25, 2011. PX 1, p. 10.

At the next visit, on August 25, 2011, Dr. Gustas noted localized tenderness at the left lumbosacral junction. He described the remainder of the examination as within normal limits. He noted Petitioner had not yet started therapy. He continued the previous regimen and work restrictions. He directed Petitioner to return on September 7, 2011. PX 1, p. 11.

On September 7, 2011, Dr. Gustas noted that therapy had been approved but that Petitioner had not yet started attending therapy due to scheduling conflicts. He noted no abnormalities on examination. He continued the back support, medication and therapy and advanced Petitioner to full duty with use of the back support until re-check. PX 1, p. 12.

On September 27, 2011, Petitioner underwent an initial physical therapy evaluation at Accelerated Rehabilitation. T. 19. The evaluating therapist recorded a consistent history of the work accident and noted that Petitioner complained of pain in a focalized area in the left upper gluteal region as well as pain and numbness in his left hamstring with prolonged walking. He described Petitioner as "working in shipping and receiving" and "doing a lot of repetitive lifting, carrying, pushing and pulling up to 75-100#."

The therapist described Petitioner's gait as mildly antalgic with decreased left stance time. PX 2, pp. 5-6.

In a progress note dated October 26, 2011, the therapist noted that Petitioner complained primarily of localized lower back pain but was still experiencing occasional numbness and pain in his left leg. PX 2, pp. 7-8.

Petitioner returned to Physicians Immediate Care on October 31, 2011 and again saw Dr. Gustas. The doctor noted that Petitioner described himself as pain-free at the end of a therapy session but symptomatic at the end of a workday. The doctor noted no abnormalities on examination. He recommended a lumbar spine MRI "to rule out disc herniation" and continued use of the back support. He imposed "more stringent work restrictions" of no lifting over 15 pounds floor to waist, waist to shoulder and overhead, with use of the back support. He instructed Petitioner to return on November 14, 2011. PX 1, p. 13.

In a progress note dated November 9, 2011, the therapist indicated that Petitioner remained symptomatic, had "recently changed duties" and was currently not performing any lifting. The therapist recommended that Petitioner be discharged to a home exercise program. PX 2, p. 9.

Petitioner underwent the recommended lumbar spine MRI on November 14, 2011. The MRI, performed without contrast, showed a 3 mm left paracentral herniation/protrusion at L4-L5 with left lateral recess narrowing, a 2 mm annular disc bulge at L4-L5 with mild neuroforaminal narrowing and mild narrowing of the central canal and mild lumbar spondylosis. PX 1, p. 5.

On November 14, 2011, Dr. Gustas noted that Petitioner had undergone the MRI earlier that day and that the results were not yet available. He also noted that Petitioner complained of persistent pain, rated 3/10, localized in the left lumbosacral area. He noted no abnormalities on examination. He recommended continued therapy and use of the back support. He also continued the previous 15-pound restriction. He directed Petitioner to return on November 28, 2011. PX 1, p. 14.

On November 28, 2011, Dr. Gustas reviewed the MRI results and noted that Petitioner complained of persistent left-sided lower back pain and slight tingling and numbness radiating down his left leg. On examination, the doctor noted an area of localized pain at the left lumbar spine. He referred Petitioner to Dr. Cherf for a consultation, continued the 15-pound restriction and directed Petitioner to return on December 5, 2011. PX 1, p. 15.

On November 29, 2011, Petitioner was discharged from therapy "due to lack of further authorization from physician and insurance." PX 2, p. 11.

Petitioner testified he saw Dr. Cherf at Physicians Immediate Care. T. 19. PX 7 consists of a subpoena for any and all records, bills, etc., directed to Dr. Cherf (returnable on September 3, 2012), a cover letter dated August 3, 2012 from Petitioner's attorney to Dr. Cherf, some miscellaneous documents and a Weiss Memorial Hospital bill in the amount of $434.00 for lumbar spine X-rays performed on December 5, 2011 per Dr. Cherf. No treatment notes authored by Dr. Cherf are in evidence. Nor are any lumbar spine X-ray reports dated December 5, 2011. RX 7, Respondent's payment print-out, reflects that Respondent paid Dr. Cherf $174.30 and Weiss Memorial Hospital $195.91 for services rendered on December 5, 2011.

Petitioner returned to Physicians Immediate Care on December 5, 2011 and again saw Melissa Lind, PA-C. Lind noted that Petitioner reported having seen Dr. Cherf earlier that day, with the doctor purportedly recommending an epidural. Lind indicated that the company "is going to schedule a second opinion before sending the patient for epidural." Lind also indicated that Petitioner complained of persistent lower back pain radiating into his left leg with prolonged standing but denied numbness or tingling. On examination, Lind noted no area of tenderness and a full range of back motion with pain on extension and rotation to the right and left. She refilled Petitioner's medication, continued the 15-pound restriction and instructed Petitioner to return on December 26, 2011. PX 1, p. 16.

On December 27, 2011, Petitioner returned to Physicians Immediate Care and saw a different physician's assistant, Mark Mering, PA-C. Mering noted that Petitioner reported having a "second opinion scheduled with an orthopedist on January 4, 2012." Mering also noted that Petitioner denied any loss of strength in his left leg but was still experiencing pain in his low back radiating into the left leg, worse with standing, walking and sitting. He refilled Petitioner's medication, continued the previous 15-pound restriction and directed Petitioner to return on January 9, 2012. PX 1, p. 17.

Petitioner saw Dr. Gleason, an orthopedic surgeon, on January 3, 2012. Dr. Gleason is associated with the Illinois Bone & Joint Institute. Petitioner testified he saw Dr. Gleason at Respondent's request. T. 20.

In the first paragraph of his report, Dr. Gleason indicated he examined Petitioner at the request of Employer's Claim Service. He recorded a consistent history of the work accident and subsequent care. He noted that Petitioner had been referred to an unnamed doctor who recommended an epidural steroid injection "as an option." He also noted that Petitioner denied having any back problems or injuries before the work accident and was currently working light duty. He indicated that Petitioner complained of constant low back pain with occasional tingling over the posterior aspect of the left thigh with prolonged standing or walking.

On examination, Dr. Gleason noted that Petitioner's gait was non-antalgic and that he could stand on his toes and heels bilaterally. He also noted a "mild right thoracic left lumbar convexity," no paraspinal spasm or tenderness, negative straight leg raising bilaterally and intact sensation to pin prick over the L4-L5 and S1 nerve root distributions. He noted a right

thigh circumference of 18 inches, versus 17 ½ inches on the left, equal circumferences of both knees at 14 ½ inches, a right calf circumference of 14 inches, versus 13 ¾ inches on the left, and equal circumferences of both ankles at 8 ¼ inches.

Dr. Gleason obtained lumbar spine X-rays. He interpreted the films as suggesting a "left ilio transverse process" and mild disc space narrowing at L5-S1 relative to L4-L5. He reviewed a CD-ROM of the November 14, 2011 MRI and interpreted it as showing mild degenerative disc disease at L4-L5 with a left paracentral bulge/protrusion, mild facet arthropathy and associated foraminal narrowing. He described the MRI as "otherwise unremarkable."

Dr. Gleason indicated he reviewed a description of an Assembler C job dated January 13, 2011, a description of a shipper job requiring lifting up to 50 pounds, records from Physicians Immediate Care and Accelerated Rehabilitation and an Employer's First Report of Injury.

Dr. Gleason reached the following diagnoses: 1) "findings as reflected in diagnostic studies, including the MRI"; and 2) "no positive objective findings on physical examination relative to the low back and lower extremities." He opined that Petitioner's current complaints were not causally related to any alleged injury or work duties. He described the treatment to date as "excessive." He encouraged a home exercise program and recommended no additional formal treatment other than occasional use of over the counter or anti-inflammatory medication. He did not believe that Petitioner required an epidural steroid injection. He found Petitioner capable of full duty and indicated there was no evidence of permanency. With respect to causation, he further commented as follows: "The patient denies any prior low back complaints or injury, although obviously an individual 30 years of age will have some pre-existing degenerative disease as reflected in the MRI scan, which conceivably was temporarily aggravated at the time of the initial reported incident of July 21, 2011." RX 3.

On January 23, 2012, Jeffery Waldron of Employer's Claim Service wrote to Physicians Immediate Care acknowledging receipt of a bill for services performed on January 9, 2012 and advising that no treatment rendered after that date would be covered. Waldron directed Physicians Immediate Care to send any additional bills to Petitioner's group carrier.

On the basis of the foregoing, the Arbitrator concludes that Petitioner returned to Physicians Immediate Care on January 9, 2012, as he had been told to do. The Arbitrator notes, however, that no records concerning this visit are in evidence.

On January 26, 2012, Petitioner consulted Dr. Fisher, an orthopedic surgeon affiliated with the Illinois Bone and Joint Institute. T. 20. Under cross-examination, Petitioner acknowledged he learned of Dr. Fisher from his attorney.

Dr. Fisher's initial note sets forth a consistent history of the July 21, 2011 work accident. The doctor noted that Petitioner complained of lower back pain and recurrent left posterior thigh numbness. He also noted that Petitioner was performing light duty and reported deriving no benefit from physical therapy. He described Petitioner's past medical history as negative.

On initial examination, Dr. Fisher noted no abnormalities but indicated Petitioner pointed to the left L4-L5 and L5-S1 paraspinous muscles as his point of maximum pain.

After reviewing the MRI and obtaining lumbar spine X-rays, Dr. Fisher diagnosed L4-L5 facet hypertrophy, mild spinal stenosis, a small disc herniation at L4-L5 and recurrent left lower extremity sciatica. He recommended an epidural steroid injection along with a continued exercise program. He allowed Petitioner to continue working light duty and instructed Petitioner to return to him "after the injection." On a separate work/school status report, he imposed restrictions of no lifting over 15 pounds and no repetitive bending, twisting or lifting. PX 4, pp. 11-12, 27, 45.

On March 12, 2012, Petitioner underwent an L4-L5 interlaminar lumbar epidural steroid injection at L4-L5. Dr. Kiokemeister administered this injection. PX 5, pp. 10-11.

As noted above, Dr. Fisher instructed Petitioner to return to him "after the injection" but, following March 12, 2012, Petitioner next saw Dr. Fisher on June 6, 2012.

Petitioner testified he continued working for Respondent until March 15, 2012, at which point he was terminated because he failed to provide certain documents that Respondent requested. T. 22.

On March 21, 2012, Sunny Anderson of Respondent sent Petitioner a letter notifying him he had been terminated, effective March 16th, due to allegedly providing two different dates of birth on his "employment eligibility verification forms" and failing to produce acceptable valid documentation for these forms. Anderson indicated she was enclosing Petitioner's final paycheck, including accrued vacation. RX 8.

Dr. Kiokemeister administered a second injection, this time at the L5-S1 level, on March 26, 2012. PX 5, pp. 8-9. T. 20.

On April 6, 2012, Petitioner saw Dr. Kiokemeister and reported that his pain was unchanged following the two injections. On examination, the doctor noted no significant motor or sensory deficits in either leg. He recommended transforaminal injections "at the appropriate levels indicated by MRI at L4-L5 and L3-L4." PX 5, pp. 4-5.

On April 16, 2012, Dr. Kiokemeister administered a left L4-L5 transforaminal epidural steroid injection. PX 5, pp. 6-7. T. 20.

Petitioner testified that the injections helped in the sense that they relieved pain he had been experiencing in a specific area of his back. T. 21.

On May 4, 2012, Petitioner returned to Dr. Kiokemeister. The doctor noted that Petitioner reported 20% resolution of his pain but had been experiencing itching and slightly

elevated blood pressure since the last injection. The doctor also noted that Petitioner "has not done any physical therapy to this point." On re-examination, the doctor noted slight paraspinal muscle tenderness in the lumbosacral area but no significant motor or sensory deficits. He recommended that Petitioner attend physical therapy twice a week for four weeks and then follow up with Dr. Fisher. PX 5, pp. 2-3.

On May 10, 2012, Respondent's counsel wrote to Petitioner's counsel, acknowledging receipt of counsel's request for payment of bills from Illinois Bone & Joint. Respondent's counsel indicated he was relying on Dr. Gleason's opinion that Petitioner did not require any additional care as of his examination. Respondent's counsel also indicated he had scheduled Dr. Gleason's deposition, planned to object to "any medical opinions on need for care or causal connection" and was not waiving his right to cross-examine the treating physician. He asked Petitioner's counsel to schedule the deposition of the physician on whose opinions he intended to rely. RX 5.

Petitioner underwent an initial therapy evaluation at Total Rehab, P.C. on May 16, 2012. The evaluating therapist described Dr. Kiokemeister as the prescribing physician. He noted that Petitioner complained of well-localized left-sided lower back pain that radiated into his left thigh after twenty minutes of standing or sitting. The therapist also noted that Petitioner previously undergone about ten therapy sessions with "no improvement." PX 6, pp. 3-4.

Petitioner continued attending therapy thereafter. PX 6. On June 6, 2012, he returned to Dr. Fisher. The doctor noted that Petitioner reported improvement of his leg symptoms but was still experiencing lower back pain. On re-examination, the doctor noted tenderness in the paraspinous muscles at L5-S1, left side greater than right, and increased pain with lumbar spine range of motion testing, particularly extension and rotation. Dr. Fisher recommended a course of work conditioning, a home exercise program and occasional use of non-steroidal anti-inflammatory medication. PX 4, pp. 8-9. He again imposed restrictions of no lifting over 15 pounds and no repetitive bending, twisting or lifting. PX 4, p. 44.

After seeing Dr. Fisher on June 6th, Petitioner attended three additional therapy sessions on June 8, 12 and 14. On June 14, a therapist noted that Petitioner was being advanced to work conditioning. PX 6, pp. 12-14.

Petitioner testified he underwent work hardening at Total Rehab at Dr. Fisher's recommendation. T. 21.

On July 25, 2012, Petitioner underwent a functional capacity evaluation at Total Rehab. Scott Wolff, PT conducted this evaluation. In his report of August 1, 2012, Wolff indicated the evaluation consisted of two phases totaling 140 minutes. He indicated the first phase consisted of Petitioner sitting for an hour while performing various fine motor tasks. He stated that Petitioner changed positions during this phase but "overall, demonstrated very little difficulty in sitting for the entire duration." He indicated the second phase consisted of Petitioner standing for 80 minutes while performing various squatting, lifting, carrying and climbing tests. He

indicated that Petitioner's pain complaints increased significantly over time and that he complained of left leg numbness and tingling after the climbing portion. With respect to the standing phase, he concluded that Petitioner's limitation was "found to be consistently at or near 25 pounds." PX 6, pp. 16-27.

Dr. Gleason testified by way of evidence deposition on July 31, 2012. Dr. Gleason is a board certified orthopedic surgeon. He is also a certified independent medical examiner. RX 6 at 6. He is affiliated with Illinois Bone and Joint Institute. Gleason Dep Exh 1.

Dr. Gleason testified he devotes about 5 to 10% of his time to medical-legal consulting and the remainder to patient care. RX 6 at 6.

Dr. Gleason testified he examined Petitioner on January 3, 2012. He relied on his examination report while testifying. RX 6 at 7. At the time of the examination, Petitioner provided a history of the work accident and his subsequent care. Petitioner indicated that, after undergoing an MRI, he saw a physician who recommended an epidural steroid injection "as an option." RX 6 at 8. Petitioner reported taking Naproxen and Cyclobenzeprine, although not on the day of the examination. He also indicated he was performing light duty. He denied any back complaints or injuries before the work accident. RX 6 at 8-9. He complained of constant low back pain with occasional tingling over the posterior aspect of the left thigh while standing, sitting or walking. RX 6 at 9.

Dr. Gleason testified he reviewed documents, including two job descriptions, in connection with his examination. RX 6 at 4. On examination, he noted Petitioner walked with a non-antalgic gait and could stand on his toes and heels bilaterally. Observation revealed a mild right left lumbar convexity. Lumbar spine range of motion was normal, as was straight leg raising. RX 6 at 11-12. There was no suggestion of nerve root irritation. RX 6 at 12. Sensation was intact to pinprick throughout the lower extremities. RX 6 at 12. Strength was normal throughout the muscles related to the hips, knees, ankles and feet. RX 6 at 13.

Dr. Gleason testified he obtained various lumbar spine X-rays after he examined Petitioner. Certain views suggested a left ilio transverse process and mild disc space narrowing at L4-L5. RX 6 at 13. He reviewed a CD-ROM of the lumbar spine MRI of November 14, 2011. He interpreted the scan as showing mild degenerative disc disease of L4-L5 with a left paracentral bulge/protrusion, mild facet arthropathy and associated foraminal narrowing. The scan was "otherwise unremarkable." RX 6 at 14.

Dr. Gleason diagnosed Petitioner with the findings reflected in the diagnostic studies and "no positive objective findings on physical examination relative to the low back and lower extremities." RX 6 at 14.

Dr. Gleason opined that Petitioner was capable of unrestricted full-time work. RX 6 at 15. He further opined that Petitioner required no additional formal care. He indicated Petitioner should pursue his home exercise program and take over the counter medication or a

non-steroidal anti-inflammatory as needed. RX 6 at 15. In his opinion, Petitioner did not require an epidural steroid injection as of the examination. RX 6 at 16. This is because Petitioner's complaints were related to his low back. Petitioner did not complain of radiculopathy and there were no physical findings suggestive of radiculopathy. In the short term, a person with radicular symptoms might benefit from an epidural steroid injection, although the evidence-based medicine in that regard is "not robust and somewhat shaky." There is "no good evidence-based medicine at all to support consideration of epidural steroid injection in a person with strictly low back pain in the absence of radiculopathy." RX 6 at 16. He believes Petitioner was at maximum medical improvement as of his examination. RX 6 at 17. Petitioner has no residuals from the work accident. Any treatment Petitioner might be undergoing is unrelated to the accident. RX 6 at 17. He has not re-examined Petitioner since January 3, 2012. RX 6 at 17.

Under cross-examination, Dr. Gleason testified he has no idea what treatment Petitioner might have undergone since his examination. He has reviewed the records from Physicians Immediate Care that were provided to him. He disagrees with that facility's diagnosis of "lumbar strain with disc herniation." RX 6 at 17. Petitioner might have had a lumbar strain early on, while undergoing care at Physicians Immediate Care, but had neither a lumbar strain or a disc herniation as of his own examination. RX 6 at 18. In his opinion, the treatment rendered by Physicians Immediate Care was "somewhat excessive" and "to a large degree probably unnecessary." RX 6 at 18. He reviewed Lind's note of December 5, 2011 indicating Petitioner had seen "Dr. Turf" [sic] earlier that day. If this doctor recommended an epidural, he would disagree with the recommendation. RX 6 at 20. The work accident conceivably temporarily aggravated Petitioner's pre-existing degenerative disc disease. RX 6 at 20. When he uses the term "temporary aggravation," he contemplates a duration of two to three months. RX 6 at 21. He knows Dr. Fisher. Dr. Fisher is one of his partners but he does not work directly with Dr. Fisher. They are in different "sub-groups" at Illinois Bone & Joint.. RX 6 at 21. From what he knows, Dr. Fisher is a good doctor. He is not sufficiently familiar with Dr. Fisher to say whether he is known to recommend unreasonable or unnecessary treatment. RX 6 at 22. He has been with Illinois Bone & Joint since 1995. Dr. Fisher is a younger partner or associate. He did not have a say in Dr. Fisher's hiring. RX 6 at 22. He has heard some good things about Dr. Fisher that would make him believe Dr. Fisher is competent. RX 6 at 23. He did not review Dr. Fisher's records and cannot say whether he disagrees with the doctor's recommendation of epidural steroid injections. RX 6 at 23. It is possible that the need for these injections surfaced after his January 3, 2012 examination. RX 6 at 24. Anyone might experience an episode of radiculopathy that might suggest the need for an epidural steroid injection. RX 6 at 24. He does not know how he came to be selected to examine Petitioner. RX 6 at 25. If he is asked to testify live at a hearing, he tries to make himself available. He has testified at the Commission and at Circuit Court. RX 6 at 26. He might testify at a hearing six times per year. RX 6 at 27. He has never told Respondent's attorneys he cannot appear at the Commission. He would attempt to make himself available to appear if necessary. RX 6 at 28. He would need to check his schedule but could try to appear at the Commission if he had a month or two months' advance notice. RX 6 at 28.

On redirect, Dr. Gleason testified that, if Dr. Fisher was treating Petitioner for radiculopathy, that condition would not be related to the work accident. RX 6 at 29. If Dr. Fisher recommended epidurals, such epidurals would not be related to the work accident. RX 6 at 29. It definitely would be inconvenient for him to go to the Commission but he values the arbitration system and would do his best. RX 6 at 29-30. There is nothing preventing a patient from seeing a second physician at Illinois Bone & Joint. RX 6 at 30. Typically, he would only find out that a patient had seen one of his partners if the patient returned to him after doing so. RX 6 at 30. Illinois Bone & Joint now has electronic medical records. If Petitioner saw Dr. Fisher several months after seeing him, Dr. Fisher might have been aware that he took X-rays of Petitioner on January 3, 2012. RX 6 at 31. Illinois Bone & Joint uses a different billing code if a patient has already seen one of the physicians on staff. RX 6 at 31.

Under re-cross, Dr. Gleason testified he would not be surprised if his report was in Dr. Fisher's chart. He did not treat Petitioner. He was hired as an expert to review Petitioner and his care. RX 6 at 32. He is aware that, when he undertakes to perform this task, he might be required to testify before the Commission. RX 6 at 32.

Petitioner returned to Dr. Fisher on August 23, 2012, with the doctor noting that the functional capacity evaluator documented consistent effort. He also noted that Petitioner "reports he still has full strength and can lift 150 pounds but then will have severe pain in his lower back afterward."

On re-examination, Dr. Fisher again noted mild tenderness in the paraspinous muscles at L5-S1 and exacerbated symptoms with extension and rotation. Based on the functional capacity evaluation and his own examination, the doctor found Petitioner capable of lifting "25 pounds maximum with no repetitive lifting, bending or twisting." He further found Petitioner to be at maximum medical improvement. He recommended that Petitioner continue exercising at home and taking Naprosyn as needed. He released Petitioner from care on a PRN basis. PX 4, pp. 4-5.

Petitioner testified he did not work between March 15, 2012 and August 23, 2012. T. 23. He further testified he began working for his current employer, Precision Dialogue, in October or November 2012. T. 23. At this company, he drives a golf cart from one point to another, delivering envelopes and packages. T. 23. The packages he delivers are not heavy. At most, he might have to lift a box weighing 25 to 30 pounds. T. 24. He currently works 40 hours per week and earns $8.25 per hour. Over Respondent's objection, he testified he would be earning about $16.00 per hour if he were still working for Respondent. T. 25. He can say this because he received annual raises per a union contract while working for Respondent and was earning very close to $15.00 per hour as of the accident and when he was terminated. T. 25. To his recollection, the union contract called for an annual raise of $.25 per hour. T. 27. [Later in the hearing, Petitioner's counsel clarified he was not seeking a wage differential award.]

Petitioner denied having any back problems or undergoing any back-related care prior to the work accident. T. 27. He testified that, at one point during the winter of 2014-2015, he

slipped and felt as if he injured his back "a little bit more." T. 28. He had difficulty walking fast and bending for a week after this incident. T. 28. He did not seek any formal care. He addressed his increased symptoms by taking pain pills. T. 28.

Petitioner testified he still experiences pain with extended sitting or standing or repetitive bending/twisting. He also experiences pain when he moves heavy boxes at work. His biggest problem is the discomfort he experiences at night, while trying to sleep. He has to changes positions in order to get comfortable. T. 29.

Petitioner testified he has not returned to Dr. Fisher since August 2012. T. 30.

Under cross-examination, Petitioner testified he initially worked as an assembler for Respondent. As an assembler, he handled parts that ranged in weight from less than one pound to ten pounds. He could sit or stand as needed. He was later transferred to the shipping department, where he stayed until his accident. After the accident, he was placed on light duty and resumed working as an assembler. He assembled small parts until he was terminated on March 15, 2012. He acknowledged receiving a termination letter (RX 8) from Respondent. His union was "with him" while the termination was in process but he does not know the results of any grievance the union might have pursued on his behalf. He could not recall whether he told Dr. Fisher about his work activities at the initial visit on January 26, 2012. He could not recall whether the doctor allowed him to continue light duty. He does not have any of Dr. Fisher's notes. After Respondent terminated him, he did not immediately start looking for work. He started looking in October 2012 and found his current job right away. He never asked Respondent for vocational assistance. He never underwent a vocational assessment. All of the treatment he underwent after Dr. Gleason's examination was administered or directed by Dr. Fisher.

Javier Correa testified on behalf of Respondent. T. 43. Correa testified he has worked for Respondent for 18 ½ years. T. 44. He is currently employed as Respondent's production manager. T. 44. He is familiar with Petitioner. Petitioner used to work for Respondent as an assembler. T. 44. Respondent produces valves and faucets. The assembly process involves several sub-assemblies. Assemblers work while standing. The parts involved in a needle valve assembly weigh between ½ pound and 1 pound. The parts involved in a water valve assembly weigh between 1 ½ and 2 ½ pounds. T. 45.

Correa recalled that Petitioner worked in the shipping department in approximately September 2011, before a remodeling project, but he would not disagree if told Petitioner was working in that department as of his accident. T. 45. Petitioner was trained to perform various functions in the production department. He believes Petitioner was placed in the shipping department on a temporary basis after another employee in that department quit or was fired. Petitioner worked as an assembler after his accident. T. 46. He worked in "assembly C," putting O-rings in sub-assemblies or assembling small plastic or brass parts. Each part weighed less than 1 pound. The job involved some sitting and some standing. T. 47.

Correa testified that, when Petitioner worked in the shipping department, he handled and labeled boxes, loaded the boxes onto skids and transferred the skids to a freight elevator via a pallet jack. Petitioner received the boxes from packers, who were instructed to limit the weight of each box to 35 pounds. On occasion, a box might weigh as much as 40 pounds but was supposed to max out at 35 pounds. The lightest box might weigh only 5 pounds. Petitioner also handled freight shipments, which varied between 150 and 700 pounds.

Correa testified that Respondent terminated Petitioner via a letter that had to do with the verification of identity-related documents. Respondent's human resources department was involved in the termination. Correa clarified he does not work in human resources but had occasion to act as a translator for that department, since he is bilingual. He spoke with Petitioner in both Spanish and English. Petitioner understands both of these languages. T. 50. There is a large Hispanic population at Respondent. T. 50.

Under cross-examination, Correa testified that each department has a scale. T. 50. The packers weigh each box to make sure the box does not weigh more than 35 pounds. T. 51. He does not know how much Petitioner earned. T. 51.

Arbitrator's Credibility Assessment

The fact that Petitioner worked for Respondent for over a decade weighs in his favor, credibility-wise. None of the physicians who treated or examined Petitioner noted any positive Waddell's signs or symptom magnification.

Overall, the Arbitrator found Petitioner credible.

Arbitrator's Conclusions of Law

Did the Arbitrator properly overrule Respondent's hearsay objections to the treatment records marked as PX 4, 5, 6 and 7?

Respondent's counsel raised hearsay objections to various treatment records offered by Petitioner. The Arbitrator overruled those objections, relying on RG Construction Services v. IWCC, 2014 Ill. App. LEXIS 957, a case in which the Appellate Court held, in relevant part, that certified treatment records are admissible "as evidence of the medical and surgical matters" contained therein. The Arbitrator gave the parties leave to address the appropriateness of this ruling in their proposed findings, based on Respondent's counsel's representation that a petition for leave to appeal in RG Construction was still pending as of the hearing. The Arbitrator notes that the Illinois Supreme Court denied this petition shortly after the hearing, on May 27, 2015, 2015 Ill. LEXIS 549 (Ill. May 27, 2015). The Arbitrator relies on this result and declines to re-visit the evidentiary rulings she made at the hearing.

Respondent's counsel separately argued that the Total Rehab functional capacity evaluation report is inadmissible hearsay as it does not constitute a Section 16 treatment

record. In support of this argument, Respondent cited W. B. Olson v. IWCC, 2012 Ill. App. LEXIS 907 (1st Dist. 2012). In the Arbitrator's view, Respondent's reliance on W. B. Olson is misplaced. That case involved the parameters of Section 12 and 19(c) examinations, not the admissibility of records, with the Appellate Court concluding, in part, that a Section 12 or 19(c) examiner is not entitled to order or otherwise obtain a functional capacity evaluation.

Essentially, Respondent maintains that a functional capacity evaluation report is not a treatment record contemplated by Section 16 since it is created by a non-physician. While it is true that a functional capacity evaluation is typically performed by a physical therapist, it is also typically prescribed and reviewed by a physician, as was true in the instant case. At the hearing, the Arbitrator ascertained that the evaluation Petitioner underwent was prescribed by a physician (Dr. Fisher) and not obtained by Petitioner's counsel for purposes of litigation. T. 65. Were Respondent's argument to be extended to its natural conclusion, certified physical therapy, pharmacy and prosthesis-related records would also be inadmissible because physicians do not directly administer therapy, fill prescriptions or fit prosthetic devices.

Did Petitioner establish a causal connection between his undisputed work accident and his claimed current lumbar spine condition of ill-being?

Petitioner's accident of July 21, 2011 is not in dispute. Arb Exh 1. The Arbitrator finds that this accident resulted in a lumbar strain, a disc protrusion and other pathology at L4-L5 and intermittent left-sided radicular symptoms, with those symptoms worsening after Dr. Gustas of Physicians Immediate Care advanced Petitioner to a trial of "full duty" with use of a back support on September 7, 2011. PX 1 at p. 12. Correa, Respondent's production manager, recalled Petitioner working as a shipper rather than an assembler in September 2011, before a remodeling project. T. 45. That recollection is borne out by the Accelerated Rehabilitation therapy note of September 27, 2011, which describes Petitioner as working in shipping and receiving, performing "a lot of repetitive lifting, carrying, pushing and pulling up to 75 – 100#." PX 2, p. 5.

Based on Dr. Gustas's subsequent note of November 28, 2011 and the physician assistants' notes of December 5 and 27, 2011, all of which document complaints of pain radiating into the left leg, along with Dr. Gleason's sworn admission that an individual with radicular symptoms could benefit from an epidural steroid injection, the Arbitrator also finds causation as to the need for the L4-L5 epidural steroid injection that Dr. Fisher prescribed and that Dr. Kiokemeister administered on March 12, 2012, along with post-injection follow-up care and the functional capacity evaluation. See further below for a discussion as to the two injections administered after March 12, 2012.

Finally, the Arbitrator finds that Petitioner established causation as to the need for the restrictions Dr. Fisher imposed on August 23, 2012.

The Arbitrator finds Dr. Gleason's opinions as to diagnosis, treatment needs and work capacity unpersuasive. At his deposition, Dr. Gleason claimed to have reviewed the records

from Physicians Immediate Care yet described Petitioner as exhibiting no complaints or findings suggestive of radiculopathy. Dr. Gleason failed to acknowledge that three providers at Physicians Immediate Care noted radicular complaints during the month before his own examination, i.e., on November 28, December 5 and December 27, 2011. PX 1, pp. 15-17. Under cross-examination, Dr. Gleason conceded that Dr. Fisher, his colleague, has a good reputation and that a patient might experience an episode of radiculopathy "at any time", with such an episode suggesting the need for an epidural steroid injection. RX 6 at 24.

The Arbitrator also notes that Dr. Gleason's opinion as to work capacity is inconsistent with the 15-pound restriction imposed by the providers at Physicians Immediate Care, a facility of Respondent's selection. There is no evidence indicating that any provider affiliated with that facility lifted the 15-pound restriction after Dr. Gustas put this restriction back in place on October 31, 2011. PX 1, p. 13.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims medical expenses from various providers as well as Dr. Gleason. On the Request for Hearing form, Respondent indicated it was objecting to this claim, arguing that the underlying services were not related, reasonable or necessary. Arb Exh 1. During the hearing, Respondent's counsel accepted responsibility for the claimed charges from Physicians Immediate Care and Dr. Gleason. T. 54, 68.

Based on the foregoing, the Arbitrator finds Respondent liable for the claimed $1,472.76 in charges from Physicians Immediate Care, subject to the fee schedule and with Respondent receiving credit for any payments it has made to that facility. The Arbitrator also finds Respondent liable for any outstanding charges from Dr. Gleason. It appears to the Arbitrator that Dr. Gleason billed Petitioner in error, perhaps due to some initial confusion as to whether he was a "second opinion" physician or a Section 12 examiner. He was in fact the latter.

The Arbitrator declines to award the claimed $5,186.00 bill from Accelerated Rehabilitation Centers, relating to therapy performed in October and November 2011, because the bill in evidence shows a $0 balance after a $2,175.52 payment (by Employee Claim Services) and a $3,010.48 adjustment. PX 2, pp. 3-4.

The Arbitrator awards the $591.00 bill from Illinois Bone & Joint (Dr. Fisher), based on the foregoing causation-related findings and subject to the fee schedule.

With respect to the $7,083.16 bill from Health Benefits Pain Management (which includes some of the same charges set forth in the IPN bill addressed immediately below), the Arbitrator awards only the $1,620.00 in charges relating to the functional capacity evaluation, subject to the fee schedule. The Arbitrator declines to award the charges relating to the therapy administered at Total Rehab in May and June of 2012, for the following reasons: 1) the initial course of therapy at Accelerated Rehabilitation did not provide relief; 2) Dr. Fisher prescribed a home exercise program rather than formal therapy when he first saw Petitioner on

January 26, 2012 (PX 4 at 45), after noting that earlier therapy did not alleviate Petitioner's symptoms, PX 4 at pp. 11-12; and 3) Petitioner did not testify that he obtained any benefit from the second round of therapy.

With respect to the $7,446.24 bill from Illinois Physicians Network (Dr. Kiokemeister) (PX 6, pp. 46-47), the Arbitrator awards only the $2,257.00 in charges relating to the epidural steroid injection administered on March 12, 2012, subject to the fee schedule.

The Arbitrator declines to award the $434.00 bill which Petitioner describes as "Dr. Cherf's bill." The bill relates to lumbar spine X-rays performed at Weiss Memorial Hospital on December 5, 2011, apparently at Dr. Cherf's direction, but it is not supported by any records. No records from Dr. Cherf or Weiss Memorial Hospital are in evidence. The Arbitrator also notes that Respondent paid $195.91 toward the bill on February 15, 2012, per RX 7.

With respect to the claimed charges of $4,557.84 from Presence St. Joseph Medical Center, the Arbitrator awards only the charges of $2,452.00 relating to the March 12, 2012 injection, subject to the fee schedule and with Respondent receiving credit for the workers' compensation payments/adjustments of $911.27 reflected on the bill. PX 9, pp. 1-2. The Arbitrator declines to award the remaining claimed charges relating to the injections administered on March 26 and April 16, 2012. Dr. Fisher recommended "an" injection at Petitioner's initial visit of January 26, 2012 and directed Petitioner to return to him after this injection. Petitioner offered no explanation as to why he did not return to Dr. Fisher shortly after undergoing the recommended injection on March 12, 2012. By the time he did return, on June 6, 2012, he had undergone a total of three injections. Dr. Kiokemeister, the physician who administered the injections, described Petitioner's pain as "unchanged" on April 6, 2012, following the second injection, yet proceeded to recommend and administer a third injection. PX 5 at PX 4-5. There is no clear evidence that Dr. Fisher appreciated, let alone endorsed, all of Dr. Kiokemeister's treatment decisions.

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims his condition was unstable and he was thus temporarily totally disabled from the time of his termination through August 23, 2012, the date on which Dr. Fisher found him to be at maximum medical improvement. Interstate Scaffolding v. IWCC, 236 Ill.2d 132 (2010). Respondent disputes this claim, citing Dr. Fisher's light duty release of January 26, 2012 and arguing that Petitioner was "working and capable of working as of his termination." Arb Exh 1. Residential Carpentry Inc. v. IWCC, 389 Ill.App.3d 975 (2009).

The Arbitrator has considered these respective arguments but applies a different analysis, based on what she perceives as an unexplained deviation from the plan of care Dr. Fisher recommended on January 26, 2012.

As noted earlier, an epidural injection was under discussion in December 2011 and was recommended by Dr. Fisher on January 26, 2012, with the doctor also imposing certain

restrictions and recommending that Petitioner return to him after the injection. Petitioner underwent the recommended injection on March 12, 2012, prior to being terminated. He did not return to Dr. Fisher at that point, for reasons that remain unclear. Instead, he went on to have two more injections and a course of therapy, as recommended by a different physician, Dr. Kiokemeister. The Arbitrator has previously found that Petitioner established causation as well as reasonableness and necessity as to the first injection but not as to the second and third. The Arbitrator has also found that Petitioner established causation, reasonableness and necessity as to follow-up care with Dr. Fisher. Petitioner did not follow up with Dr. Fisher until almost three months after the recommended injection, i.e., on June 6, 2012, with the doctor recommending work conditioning and, ultimately, a functional capacity evaluation.

The Arbitrator views Petitioner's causally related lumbar spine condition as unstable between June 6, 2012 (the date on which Petitioner returned to Dr. Fisher following the initial evaluation of January 26, 2012) and August 23, 2012 (the date on which Dr. Fisher found Petitioner to have reached maximum medical improvement and imposed final restrictions, based on both his own evaluation and the functional capacity evaluation). PX 4. Accordingly, the Arbitrator finds that Petitioner was temporarily totally disabled from June 6, 2012 through August 23, 2012, a period of 11 2/7 weeks.

What is the nature and extent of the injury?

This is a pre-amendatory case, since Petitioner's accident occurred before September 1, 2011.

Based on the foregoing causation-related findings, along with the functional capacity evaluation, Petitioner's credible testimony as to his ongoing complaints, the job descriptions offered by Respondent and Correa's testimony that Petitioner was trained and called upon to perform various roles in Respondent's production department, the Arbitrator awards permanency equivalent to 14% loss of use of the person as a whole under Section 8(d)2, equivalent to 70 weeks of benefits. The valid functional capacity evaluation demonstrated that Petitioner was functioning at a light demand level, meaning he could occasionally lift up to 20 pounds and frequently lift up to 10 pounds. Following this evaluation, Dr. Fisher imposed restrictions of no lifting over 25 pounds and no repetitive lifting, bending or twisting. PX 4. Based on either set of restrictions, Petitioner would have been physically capable of resuming the assembly job but not physically capable of performing the type of heavier duties he performed while working in shipping and receiving. Respondent's attempt to portray Petitioner as an assembler consistently lifting only lightweight items is belied by Correa's testimony and the fact that Respondent submitted the shipper as well as the assembler job descriptions to Dr. Gleason for his consideration. The Arbitrator concludes that Petitioner's undisputed accident adversely affected his overall function and his access to certain jobs in the labor market.

Is Respondent liable for penalties and fees?

Petitioner seeks an award of penalties and fees on the bills from Physicians Immediate Care and Dr. Gleason. Petitioner filed a Petition for Penalties (PX 3) on May 13, 2015, two days before the hearing. The petition alleges that Respondent failed to pay Physicians Immediate Care, despite having selected this provider. The petition does not reference a specific amount owed this provider. Nor does it reference Dr. Gleason. At the hearing, Petitioner offered into evidence notices and a letter dated November 19, 2012 sent to him by Illinois Bone & Joint seeking payment of Dr. Gleason's unpaid balance of $1,000.00.

As noted earlier, Respondent's counsel accepted responsibility for the two bills at the hearing. Respondent maintains it is not liable for penalties and fees, in part because Petitioner failed to make a timely demand for payment.

The Arbitrator declines to award Section 19(k) penalties and fees in this case, citing the timing and wording of Petitioner's petition, the fact that Dr. Gleason apparently misconceived his role in this claim, thus billing Petitioner rather than Respondent [with collection efforts apparently ending in November 2012, 2 ½ years before the hearing], and the assurances Respondent made at the hearing. As for 19(l) penalties, there is no evidence indicating Petitioner made a "written demand for payment of benefits" prior to May 13, 2015.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CYNTHIA GRAZIAN,

Petitioner,

vs. NO: 12 WC 05001

InBANK,

15IWCC0862

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 permanent partial disability, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below. The Decision of the Arbitrator is attached hereto and made a part hereof.

Findings of fact and conclusions of law

The Commission finds:

1. Petitioner began working for Respondent in 1986 as Corporation Counsel Compliance Officer. She was responsible for Federal and State compliance with the FDIC, the Illinois Department of Banking and the Federal Reserve Bank. She worked for Respondent until 2009. During her time there, she "wore many other hats," and was named Director in 2000. She was named CEO in 2008. She oversaw 75 employees. In 2008 she earned $275,000 plus bonus.

2. Petitioner graduated from the University of Arizona and received her J.D. from Kent College of Law. She is currently a licensed attorney. She has a certificate in commercial bank management from New York Institute of Finance and started a nonprofit Montessori

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school.

3. In 2008 Petitioner and a group of community bankers visited the FDIC to express concerns over entities approving mortgages at a tremendous rate that did not make sense. Payments were being made at a slower rate, which was a bad sign for the economy. Petitioner then brought in a company to appraise Respondent's collateral. In December 2008 the FDIC performed a follow-up audit on Respondent.

4. By early 2009 the economy was falling. Petitioner was working 50-60 hours per week. In March 2009 Petitioner sought medical treatment from Northwestern after she thought she was having a heart attack. She was monitored on an EKG and put in contact with Dr. Dago, a psychiatrist. Dr. Dago referred Petitioner to Dr. Jackie Gollan, a neuroscience and CBT specialist.

5. A March 20, 2009 medical record of Dr. Gollan states that Petitioner has been having a few cocktails every night.

6. A March 27, 2009 note of Dr. Gollan indicates Petitioner had been anxious and depressed for the past year.

7. On April 6, 2009 Dr. Gallo notes that Petitioner felt worse after having travelled to New York with her family. She reported heavy drinking for 2 nights while there.

8. Petitioner's work schedule remained the same. She was managing three bank branches and 75 employees. Petitioner was meeting with potential investors and the FDIC every few weeks to keep them abreast of the banks status. Borrowers began either not paying mortgages or attempting to re-negotiate payments. Petitioner was very tired and worried during this time period.

9. In May 2009 the FDIC came back to Respondent and determined that Respondent needed to raise more capital. This job fell on Petitioner's shoulders.

10. Petitioner occasionally rowed with her daughter, who was on a rowing team. She likely rowed with her daughter in June 2009.

11. On June 7, 2009 Petitioner was in a meeting with an FDIC Regulator and was accused of "mispaying dividends to someone illegally to benefit your father."

12. On June 11, 2009 Petitioner attended her weekly board of directors meeting, and had a morning meeting with a potential investor. The investor asked to speak with Elbert F. Elmore, who is Respondent's chairman of the board, as well as being Petitioner's father. Petitioner took him up to a condominium in Water Tower Place, where her father lived, and also where the investor was interested in purchasing a condo. While there Petitioner's father received a phone call from Respondent's Counsel, and put it on speaker phone. Counsel informed them that the FDIC was demanding Petitioner's resignation. They stated that an audit uncovered some criminal activity and that things

would be hard for the bank if Petitioner was not removed. Petitioner stated that she just collapsed and thought that she did not want to live anymore.

13. A June 11, 2009 record from Northwestern indicates Petitioner felt suicidal for the first time in her life on March 4, 2009.

14. Petitioner was taken to the Northwestern ER, but does not recall what occurred while she was there. She was then taken to a psychiatric ward at North Shore, where she was on suicide watch. She was not allowed to leave the facility.

15. On March 12, 2009 Petitioner was diagnosed with Depression and Anxiety/Panic disorder.

16. On March 13, 2009 Dr. Drago indicated that Petitioner, within the last month, had developed a severe melancholic depression in the context of overwhelming stress.

17. On March 20, 2009 Petitioner indicated that she had suffered from panic attacks at least twice weekly for the past month. She also indicated 6 months of excessive anxiety and worry. She was diagnosed with Major Depressive Disorder and symptoms of General Anxiety Disorder.

18. Petitioner stayed at North Shore for 1 week. After her release she continued treating with Drs. Drago and Gollan. She continued treating with them through the date of trial. She was also involved in actions with the FDIC during this time period.

19. Despite her testimony regarding her subdued state of mind, Petitioner was still exercising at the East Bank Club gym in July of 2009.

20. In August 2009 Petitioner told Dr. Dago that the most pressing thing on her mind was her father's health.

21. On September 11, 2009 Petitioner presented with depressive symptoms, stress with impending legal issues and issues with concentration. Petitioner was diagnosed with Major Depressive Disorder.

22. In March of 2010 Petitioner went on a vacation with her daughter to Israel for 11-12 days.

23. In April 2010 Petitioner indicated that she was assisting her husband with a civil rights case by performing online research.

24. In August 2010 Petitioner was diagnosed with irritable bowel syndrome, which, according to her testimony, she may or may not have had for 4 years at that time.

25. Approximately in October 2010 Petitioner went on a 16 day bike trip to Argentina. Petitioner spent 7 days biking, the other 9 she spent with her daughter, who was living

there at the time. She biked 30 -50 miles per day. The trip was with a group of people in her age group. They stayed at a luxury hotel and socialized together.

26. Petitioner completed 8K races both on April 10, 2011 and again on March 25, 2012. During this time period she was exercising 1-2 hours daily.

27. On August 11, 2011 Petitioner informed Dr. Dago that she was spending 15-20 hours per week working on things related to the closure of InBank. A November 2011 record of Dr. Gollan indicates she was volunteering 60 hours per week for her husband.

28. On January 30, 2012 Petitioner told Dr. Dago that she was leaving for Florida to celebrate her father's birthday and to help out with her mom, who was in the hospital at the time.

29. During the year 2012 Petitioner joined a group of writers called *Indie Writers*, where she edited others writings.

30. On August 21, 2012 Petitioner told Dr. Dago that she was drinking 3 to 4 glasses of wine per day, 4 days a week.

31. Dr. Teich opined that a doctor could not ascertain that the FDIC situation was the cause of Petitioner's symptoms. He noted that binge drinking can lead to depression, and that many of Petitioner's complaints stemmed from the same. Dr. Teich also opined that Petitioner's illness resulted from stresses inherent in the months leading up to and following InBank's failure. These stressful situations evolved over time, not from a singular work experience. Dr. Teich opined that Petitioner's current symptoms are unrelated to her dealings with the FDIC.

32. On March 1, 2013 Dr. Rothke noted that Petitioner had started AA Legal and had begun to work from home closing loans 5-6 hours per week.

33. Petitioner has kept her ARDC license current. She first attempted to find new employment in 2011, but her doctors were not supportive of this decision. She began a second attempt at finding employment in May 2013. She sent resumes to every law firm and consulting firm that worked in the financial sector that did banking and financial services law. She applied for 700 jobs. She took classes in the Northwestern School of Education creative writing program, but only finished 2 classes, quitting a third as she was unable to keep up with writing requirements. She also took a financial planning program at DePaul, but testified that she did not finish it because she could not keep up with the work. She also helps her husband, an attorney, pay bills, file and clean the carpet.

34. Petitioner hired a company called *reputation.com* to improve her image after being fired. The company flooded the internet with positive stories about her in order to push the negative information down on the search results. This was done in an attempt to assist her in gaining employment.

35. AA Legal Cash Advance is a company that gives loans to Plaintiffs in workers' compensation lawsuits. Petitioner's daughter was the initial incorporator of the company. This company helped her daughter receive a position with Deloitte, and she was named outstanding entrepreneurial student at George Washington University. Petitioner's daughter has since left the company to work for Deloitte full time. Petitioner never received any wages from AA Legal, but she is listed as the company's Managing Partner.

Based on the testimony presented and medical records in evidence, the Commission reverses the Arbitrator's ruling and finds that Petitioner has failed to sufficiently allege a work-related accident, and that her condition was not causally related to her work duties. Petitioner experienced the same risk that every employee faces due to a downturn in the economy. The fact that her position as CEO came with stress cannot be used to lower the threshold required under the Act to meet the requirements of compensability for mental-mental cases without physical injury.

Mental-mental injuries with no physical harm must be caused by sudden, severe and emotional shock traceable to a definite time and place, and not from the same tensions that all employees face. **Pathfinder Company v. Industrial Commission, 343 N.E.2d 913 (Ill. 1976).** In **Pathfinder**, a claimant was instructing a coworker on how to operate a machine press, when the coworker severed her hand in the press. The claimant pulled the coworkers hand out of the machine and fainted at the sight of it. She subsequently sought medical treatment for anxiety and psychological symptoms. The court found that these psychological injuries were compensable, as the claimant had suffered a sudden, severe emotional shock, traceable to a definite time, place and cause, which caused psychological injury. **Id**. Seeing a severed hand is not a risk common to all employees, and is not analogous to the case at bar. Despite Petitioner's dramatic reaction in the case at bar, demotion or termination is a risk common to all employees.

Additionally, the ruling in **General Motors Parts Division v. Industrial Commission, 168 Ill.App.3d 678 (1988)** supports the Commission's ruling. In **General Motors**, the claimant alleged psychological injuries from his supervisor verbally assaulting him, and using profanity and racial slurs. In denying compensation, the court noted that ***Pathfinder*** did not stand for the permission of recovery for every nontraumatic psychic injury from which an employee suffers merely because there is some identifiable stressful work-related episode which contributes to their depression or anxiety. **Id**. Anxiety, emotional distress or depression which develops over time in the normal course of an employment relationship does not constitute a compensable injury within the holding of ***Pathfinder***. **Id**.

Petitioner and her husband both testified that she was aware the bank was being investigated by the FDIC beginning in 2008. Therefore, it could not be a sudden surprise on June 11, 2009 for Petitioner to learn that the FDIC was concerned about the bank's finances. This is especially true considering that just 4 days prior, Petitioner had been accused in a meeting with an FDIC Regulator of "mispaying dividends to someone illegally to benefit your father."

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In March of 2009,which was 3 months prior to her amended accident date of June 11, 2009, Petitioner was found passed out on her bathroom floor by her husband. She underwent psychiatric evaluation by Dr. Dago, and informed him of her severe melancholic depression due to stress over the last month. She also complained of anxiety and suicide ideation. She was constantly worried about her financial institution. Thus, with a history of psychological symptoms that pre-date the amended accident date, it is difficult to determine that Petitioner suffered a sudden, severe emotional shock traceable to a definite time, place and event on June 11, 2009.

The threat of demotion or termination is not exclusive to certain employees in Illinois. Everyone is subject to this possibility. Thus, it cannot be said that, upon learning of her impending termination, Petitioner suffered a sudden, severe emotional shock. Furthermore, it is unlikely that Petitioner would be shocked when learning of her potential termination, when just 4 days prior the FDIC informed her of their concerns about her "mispaying dividends to someone illegally to benefit her father."

Moreover, Petitioner was diagnosed with depression in March 2009, 3 months prior to the accident date, and had claimed that her depression stemmed as far back as February 2009. These were the same symptoms she suffered from after the alleged accident date as well. Accordingly, her claim must be denied, as there is no definite time, place or event that she can point to as the catalyst for her psychological condition. If in fact her work did cause or contribute to her condition, it did so gradually over time, which does not fall within the necessary parameters for compensation under a mental-mental claim. This conclusion is supported by the Independent Medical opinion of Dr. Teich.

Accordingly, since Petitioner is unable to sufficiently allege accident and causal connection, the Commission reverses the Arbitrator's ruling and finds that Petitioner failed to prove a work-related accident.

With a finding of no accident and no causal connection, the awards for the remaining issues of medical expenses, temporary total disability and permanent partial disability are hereby vacated.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner failed to prove she sustained an accident arising out of and in the course of her employment with Respondent on June 11, 2009.

IT IS FURTHER ORDERED BY THE COMMISSION that no medical expenses, temporary total disability benefits or permanent partial disability benefits be awarded to Petitioner.

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: NOV 2 4 2015
O: 9/24/15
DLG/wde
45

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GRAZIAN, CYNTHIA
Employee/Petitioner

Case# **12WC005001**

INBANK
Employer/Respondent

15IWCC0862

On 1/26/2015, 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:

1702 GRAZIAN & VOLPE PC
RICHARD S VOLPE
5722 W 63RD ST
CHICAGO, IL 60638-5508

2337 INMAN & FITZGIBBONS LTD
THOMAS JOHN FITZGIBBONS
33 N DEARBORN ST SUITE 1825
CHICAGO, IL 60602

15IWCC0862

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

Cynthia Grazian
Employee/Petitioner

v.

InBank
Employer/Respondent

Case # **12** WC **5001**

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 **George Andros**, Arbitrator of the Commission, in the city of **New Lenox**, on October 10 and 11, 2013; December 11, 2103; and October 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. ☒ 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 Should petitioner be allowed to amend the date of accident?

FINDINGS

On March 7, **2009** and June 11, 2009, 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 June 11th, 3009 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 **$275,600.00**; the average weekly wage was **$5,300.00**.

On the dates of accidents, Petitioner was **49** years of age, ***married*** with **1** dependent children.

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 $ 1231.41 /week for 276 & 6/7ths Weeks commencing June 12th, 2009 through, October 1st, 2014, as provided in Section 8(b) of the Act;

Respondent shall pay Petitioner permanent and total disability benefits of $ 1231.41 /week for life, commencing October 2nd, 2014 as provided in Section 8(f) of the Act.

Commencing on the second July 15th after the entry of the Award, Petitioner may become eligible for cost - of - - living adjustments, paid by the RATE ADJUSTMENT FUND, as provided in Section 8 (g) of the Act.

Petitioner is allowed herein by this Award to amend the Application for Adjustment of Claim per the Interlocutory Order issued in the case at bar, Reviewed to the Commission, and remanded back to this Arbitrator. That Order is incorporated herein by reference for purposes of issuing that Order now as part of the Award 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.

#01 George J. Andros
Signature of Arbitrator

January 22, 2015
Date

JAN 26 2015

FINDINGS OF FACT & CONCLUSIONS OF LAW 12 WC 05001

The Petitioner testified that she began working for the Respondent in 1986 upon graduation from law school, as the corporation counsel and compliance officer. At that time it was a small community bank. She was responsible for compliance with state and federal regulations as well as FDIC (Federal Deposit Insurance Corporation) matters. When she started work for the Respondent it was a small community bank. (TR. pp 7-8)

Petitioner explained that after five years she was named vice president of the loan department. She performed business development and underwriting in addition to her duties as corporation counsel. (TR.9) The Respondent continued to expand its business; Petitioner was responsible for establishing two additional branch banks. Petitioner was appointed to the Board of Directors of the bank in 2000. Upon opening the third branch banking center Petitioner was named Vice President of Marketing in addition to her other positions. (TR.10) Petitioner further expanded the bank's business from consumer lending to commercial banking. (TR.11)

Petitioner was named chief executive officer (CEO) of the Respondent in 2008. In her position as CEO she was responsible for seventy-five employees and a loan portfolio of two hundred million dollars. Her salary was $275,000 plus bonus. (TR.12) In 2008 Petitioner was entertaining offers from others to purchase the bank plus was planning for a fourth branch in New Lenox, Will County. (TR.13)

Petitioner's husband John Grazian testified that he met Petitioner while in law school and they married in September 1988. (TR.169) Before the events of 2009 unfolded Petitioner was an extremely hard worker, diligent in all tasks, could handle complex matters and overcome obstacles very well. Petitioner was a very honest and ethical person. She actually had a code of ethics or core values that they posted on their refrigerator for themselves and their children. Honesty, hard work, fair play, charity and kindness to others. (TR.171) Mr. Grazian described his wife's progression through the bank. Starting as a compliance officer and corporation counsel moving on to sales and marketing of the bank. He noted that when Petitioner started work for Respondent they were a bank with about one million dollars in assets. By 2008 the bank was at two hundred fifteen to two hundred twenty-five million. (TR.171)

Mr. Grazian testified that there were six other loan officers while Petitioner generated triple the business of the entire rest of the bank combined. While being a business dynamo Petitioner was involved in the community, volunteering for Infant Welfare Society, Service League Society, and as an advocate for battered woman at the (Circuit Court of Cook County) Markham Courthouse. (TR.172)

Petitioner did all of this while raising two children, a daughter who graduated top in her class at an eastern university and daughter who is presently a pre-med major in college. (TR.174) Mr. Grazian had firsthand knowledge of the (business) activity at the Respondent because he too acted in a professional capacity as an attorney for the Respondent and attended Board of Director meetings. (TR.178, 179)

Petitioner testified that in 2008 she and a group of community bankers visited with the local FDIC officers. Their purpose was to express concern that mortgages were being approved at a tremendous rate that made no sense. All banks were subject to audits by the FDIC and Petitioner had been through them before. (TR.14) In April, one month after she was made CEO of the bank the FDIC audit resulted in a follow up audit being scheduled for December 2008. (TR.15) This was unusual as audits were done annually. Petitioner hired a company approved by the FDIC to value the collateral of the bank. Then on September 23, 2008 everything crashed. (TR.16) The American economy crashed.

In October or November 2008 Petitioner had hired Benjamin Shapiro, a former FDIC counsel, to liaison with the FDIC. The FDIC came into the bank in December 2008 for a progress check and was generally pleased. (TR.17). Petitioner's work schedule now included actually going through loan files in addition to her regular duties. She was also discussing both merger and acquisition prospects. (TR.18) The economy continued to fall, and she was working very hard. In March of 2009 the bank was scheduled for another FDIC audit which was now occurring every three months.

On March 12th of 2009 Petitioner was seen in the emergency room of Northwestern Hospital. She thought she was having a heart attack. (TR.21) John Grazian testified he came home and found his wife on the bathroom floor and she told him that she passed out. (TR.180) He took her to the emergency room at Northwestern. He said she was very stressed out but handling it. However he requested she be seen by a psychiatrist. (TR.181) He hoped this would help her cope. Petitioner was totally focused on work and he felt that a doctor could help her to keep perspective. (TR.182) She was not suicidal. (TR.183) Notably, she went right back to work and continued at the same pace as always. (TR.184)

The records of Northwestern Memorial Hospital (PX2) and Northwestern Medical Faculty Foundation (PX3) reveal that Petitioner was seen in the emergency room on March 12, 2009 where a complete blood and urine work up was ordered. (PX2 p.156) Petitioner was seen in the ER by Dr. Dago. She was medically evaluated which included TSH which was unremarkable. Bipolar disorder was ruled out and Petitioner was diagnosed with major depressive disorder - severe, with melancholic features. She felt calmer the next morning but was referred for counseling. (PX3 p2)

Petitioner was treated by psychologist Dr. Jackie Gollan on March 20, 2009. (on staff at the Northwestern Medical School per document in evidence) She had no significant history of depression but an acute worsening of mood over last four months, no interest in former activity, work week intense, no suicidal ideation. (PX3 p5) The psychologist initially felt Petitioner had generalized anxiety disorder and depressive disorder. Petitioner was handling this best she could, had numerous resources, internal resiliencies, and supportive options which will be helpful in resolving her current condition. The doctor recommended sixteen therapy sessions over sixteen weeks. (PX3 p7) By March 20, 2009 Dr. Dago noted Petitioner's anxiety gone. (PX3 p14)

Petitioner testified that this incident did not affect her work schedule. She continued to manage three branches, seventy-five employees, the FDIC process plus meeting with potential purchasers of the bank. (TR.22) She was a bit worried and customers were nervous. (TR.23) The medical records corroborate that Petitioner continued to work (PX3 p17) and her job remained stressful. (PX3 p20) However she was found by both Dr. Dago and Dr. Gollan to be much improved in April (PX3 p28), May (PX3 p33), and June. (PX3 p8)

Petitioner testified that the FDIC auditors were to come back in May 2009 and her plan was to raise capital as real estate values fell. (TR.24) She felt it was going good and that the FDIC was satisfied with the Bank's progress. (TR.25)

Her husband John Grazian testified that the consultant hired by the bank re-valued the real estate collateral of the loans and found that the bank needed to raise four to five million in new capital to secure the loans within the FDIC guidelines. This was not a problem. (TR.187) Notwithstanding, the Federal Deposit Insurance Company (FDIC) came in April or May of 2009 and then required 25 million in capital. Petitioner repeatedly asked that the FDIC provide a logical explanation of why the Bank needed to raise so much more capital than was estimated by the company she hired and the FDIC approved. It was an impossible number, for which the auditors refused to give an explanation. (TR.188)

Petitioner testified that June 11, 2009 was a normal work day. She had had a business meeting with an individual who was willing to invest up to twelve million in the bank. That person wanted to meet the Chairman of the Board, her father, Mr. Elmore. (TR.p26) While there at Mr. Elmore's home a call came from the attorney for the Bank, James Ashack. Mr. Ashack advised that the FDIC was demanding Petitioner's resignation from the Bank. (TR.p.25) Additionally, see stipulation in record for the admission of business correspondence from Bank's attorney Ashack to Petitioner PX.1. (TR.p25) Petitioner collapsed upon hearing those words. (Tr.p30) She was taken directly to Northwestern Hospital by her husband, although she has very little memory of the event. (TR.p31) From Northwestern she was taken by ambulance to NorthShore Hospital, being enrolled in a locked psychiatric ward where she was not free to leave. (TR.p32) She believes she was in that institution for one week. (TR.p38)

Her husband testified that after the FDIC advised his wife that the amount of money she needed to raise was twenty-five million dollars as opposed to five, she demanded to know where the FDIC came up with those numbers. (TR.188) She was insistent. (TR.189) Even going over the auditors heads. That was when the episode of June 11, 2009 occurred. (TR.190) Mr. Grazian was present during the business meeting at Mr. Elmore's home when they received the call from bank attorney Ashack. (TR.192) Mr. Grazian told Mr. Ashack to find out why the FDIC demanded his wife's resignation, but there was no answer to that question. (TR.195) He observed his wife turn ashen and the life go out of her eyes. She collapsed and started shaking uncontrollably. (TR.196) He tried to console her, to no avail. He took her to the emergency room of Northwestern. He had never seen his wife like this before. She wanted to kill herself. (TR.200). In the emergency room they took away all her clothes and belongings, put her in a room with a minder and awaited transportation to a secured psychiatric ward. (TR.203)

Petitioner was taken to NorthShore Hospital where she was kept for just shy of a week. (TR.204) When she was released she was a broken human with no hope. She slept constantly, had a blank stare, and looked like someone who is not hearing or understanding you. (TR.205) He took precautions that she live. He had his brother move into the house and stay with her to watch her when he had to work. (TR.206)

The records of Northwestern reflect that on June 11, 2009 Petitioner was directed by Dr. Dago to the ER. Patient (was) removed from her position as CEO by governmental authority. Feels suicidal. (PX2 p142) Precipitant appears directly related to her removal from CEO position, which is catastrophic. (PX2 p143)

Petitioner was admitted to the ER with acute suicidal ideation, feels worthless, hopeless and worn out. Husband recommended she seek psychiatric help. No substance or ETOH abuse. Escalating amounts of stress over the last year. Admit to psychiatric hospital for acute stabilization. (PX2 p146)

The records of NorthShore Hospital reveal that Petitioner was admitted to that facility on June 11, 2009. (PX4 p2) Many problems due to the economy culminated in sudden and unexpected removal of patient by the FDIC. Patient was deeply shamed although she did not do anything wrong or illegal, led to suicidal ideation. (PX4 p3) Her current symptoms are sufficiently severe that no lower level of care than a locked inpatient psychiatric unit would be safe or clinically appropriate. Husband is concerned with patient's thought process and feels she should be in a safe place. (PX4 p12, 13, 14) Patient feels ashamed even though she made all the right decisions at her job. (PX4 p16) It was noted that the doctor felt her judgment was diminished. (PX4 p11, 24)

Petitioner testified that there are FDIC rules for removal of bank executives which were not followed in her case. See below. (TR.36) She was removed from all positions with the bank as of June 30, 2009. (TR.35) No civil action was ever filed against her by the FDIC. No criminal charges were brought against her by the FDIC. No suit by bank shareholders was brought against her. (TR.37) She was involved in actions with the FDIC from 2010 through 2013 and never prosecuted for anything. (TR.39) She never resigned her position with the bank. (TR.70, 72) Mr. Grazian corroborated that his wife was never charged with any crime, nor civil action brought against her as a result of her actions as CEO of the bank. Just the opposite was true, the FDIC gave her a clean bill of health. (TR.224) The Arbitrator at attorney's request takes judicial notice of 12 C.F.R. section 308.163.

Petitioner continued under the care of Dr. Dago and Dr. Gollan after her release from the psychiatric ward. The effect of her mental collapse continues to affect her ability to perform functions of daily life. (TR.40) She feels very frightened and guilty. (TR.41) There was a lot of negative press and things about the FDIC asking the Board to fire her appeared on the internet. (TR.52) She applied for about 700 jobs. (TR.51) Her job search made her feel useless. She has taken classes at DePaul and Northwestern but doesn't finish. (TR.53) She finds she does not have consistent moods. She goes in and out. She has a very hard time following through and finishing anything. She sometimes uses the wrong words and cannot sleep without medication. (TR.57) She takes anti-depressants and sees Dr. Gollan monthly. She no longer volunteers because people need to depend on you. (TR.58) She is flaky. She has never been given a written authorization to return to work. (TR.59)

However, not long after her release from the psychiatric hospital her husband began bringing her to his law office. He bought a desk and put it next to his own desk for the purpose of keeping an eye on her and getting her out of bed. (TR.207) He tried to motivate her to keep up her law license. (TR.210) He created a loan company with his daughter Ari. (TR.211) He used the paperwork from 8 to 9 different loan companies and put it on Quick books. (TR.212) Petitioner did take an interest in that but only in a passive way. The company only makes loans to his own firm's clients plus a few friend's firms. Petitioner has not sold a single loan. She sits passively by. The first loan was January of 2010. This was something he wanted his daughter and wife to do together. It didn't work out. She doesn't finish things. (TR.216) The Arbitrator deems this sympathetic employment and or benevolent employment.

In October 2011 an employee retired who paid the bills in the firm and did filing for about 12 to 16 hours a week. Mr. Grazian gave that responsibility to his wife. His idea was that it would give her a sense of purpose, a place to put on business clothes and go to an office. (TR.221) Petitioner had problems; she would write checks in the wrong amount or send them out without signatures. (TR.222) Mr. Grazian also gave his wife the additional task of entering internet blogs on the company's behalf. (TR.5A)

This consists of condensing articles provided by Mr. Grazian from Bar journals or reports. (TR.6A) Petitioner can do this at her leisure; work is checked by Mr. Grazian. (TR.7A) He finds if the articles are complex he has to re-write or edit heavily her work. Mr. Grazian would expect an associate attorney to accomplish in 8 to 10 hours per week what his wife accomplishes. (TR.10A) She has never been paid (remuneration) for any of this (activity). (TR.224)

Two employees of Mr. Grazian's office were called as witnesses for the Respondent at bar via subpoena. Office personnel Lisa Segura and Nancy Strid gave testimony under examination by Respondent trial counsel. Lisa Segura testified that she has worked at his office from January 2013. Mr. Segura works five days a week. Ms. Segura sees Petitioner once a week at the office, if that, where she writes checks and sometimes answers the phone. Nancy Strid testified that she, Ms. Strid, worked at the office for the past 10 years. She works from 8:30 a.m. to 4:30 p.m. four days per week. Ms. Strid sees Petitioner in the office once a week, sometimes twice but Petitioner always arrives after Nancy starts work and leaves before Nancy leaves. Petitioner pays bills and if the phones are busy helps answer them. Ms. Strid testified that sometime in 2010 Mr. Grazian put a desk in his own office for his wife because he was concerned for her. However, since 2011 Petitioner works from the spare office when she is at the office.

Her husband testified that a common occurrence is that when faced with any stressful situation Petitioner can't perform tasks well. (TR.222) As example, the day before the arbitration at bar was scheduled, (10/10/2013), she was in the office for preparation wherein it was stressful for her to recount her story. Later in the day he gave her written and verbal instruction to write him two checks for a Judge's fund raiser, payable to the same person, one for $180.00 and one for $250.00. He later received from her one check for $185.00. This is a typical ongoing thing with her. If she has to be someplace at a certain time, and accomplish certain tasks in a time period she makes mistakes. (TR.223)

These symptoms expressed by Petitioner and Mr. Grazian are corroborated by the records of Dr. Gollan and Dr. Dago. The recordation contained within those doctors' records reflecting Petitioner's continued disability are numerous and cover the period from June 9, 2011 through June 21, 2013 (PX3)

Petitioner was examined by Dr. Steven Rothke on February 19th, 2013 at Respondent's request pursuant to Section 12 of the Act. Dr. Rothke found that on a mental status examination, Petitioner had an overall score of 25 out of 30, normal being 26 or better. (PX7 p.5) Petitioner had a very prominent degree of anxiety noted and persecutory thinking (likely related to her experience with the FDIC). Relative to casual connection, He concluded that her "MDD (major depressive disorder) is due to the actions of the FDIC. Nothing in her current findings or history suggests that her present clinical presentation represents an aggravation of or is due to pre-existing conditions."

Her psychiatric and psychological care have been reasonable, necessary, and related to the FDIC investigation. He suggested that as preparation for an eventual return to work, two session of vocational rehabilitation be provided.
He further concluded that between June 2009 and present there would be periods where she could not meet the demands of full time employment. (PX7 p6)

After the first Respondent's section 12 expert examination and report issued were favorable to the Petitioner, Respondent undertook a second section 12 exam by a different, this time by Dr. Jeffrey Teich. He too is highly credentialed per his CV. He disagreed with the opinions of the two treating doctors from Northwestern plus he disagreed with Respondent's own expert witness, namely Dr. Dago, Dr. Gollan and Dr. Roethke. (RX3 p101) The treaters' records show they are both on staff at Northwestern and Dr. Gollan is a professor at the medical school.

The very first point Dr. Teich deemed significant upon testifying at Rx.3 pages 6- 11 was not the total clinical picture over months of therapy by treating doctors nor the Northwestern Hospital's own serum blood chemistry test results (all negative) - but – he focused, not on clinical entries or blood chemistry, but one of the hospital discharge patient education packets. In those form-type handouts of 8 pages, the last four of which are educational bullet points on alcohol abuse. In evaluating the weight of that evidence it is important to underscore not one page contained in the educational packet nor referenced any official discharge order was there any reference of a referral to a drug or alcohol program, addiction evaluation or even an ETOH educational center at the same hospital or another resource.

In referencing Northwestern treatment about 3 months before (Dep p.13) Dr. Teich found the treating psychiatrist's records significant that she denied any alcohol abuse. The testimony continues that " In fact, they (Northwestern) did a screen, it was negative (for ETOH) for that date which was the twelfth (March 12, 2009)".

Secondly, Dr. Teich then addressed the care of the treating doctor, a Northwestern psychiatrist Dr Dago. The Arbitrator underscores the testimony at page 16, lines 12-16 , page 17, lines 22 - 44 and page 20, lines 9 - 16. Dr. Teich discussed Dr. Dago's office notes especially page 5 cited at page 16: 12-16. Dr. Teich testified that in a note she (Petitioner) links her anxiety attacks which were occurring daily and chest discomfort with the news that her bank will be liquidated by the FDIC or at least that is her expectation. Dr. Teich acknowledged at page 17: lines 22 - 24 the treating clinical diagnosis over time is " Major Depressive Disorder, severe, with melancholic features".

In studying this expert witness testimony thus far, this Arbitrator perceived the fork in the road at this point as a fork, so to speak, to either explain how the treating doctors at Northwestern are just plain wrong – or - critique their medical protocol and clinical judgment.

Well, the fork chosen was to explain how the treating doctor(s) did not meet their "obligation". Dr. Teich said in haec verba: Dr. Dago is a psychiatrist and part of his obligation is to address such problems (alleged alcohol abuse) and treat or at least recommend treatment. Page 20: lines 9-16.

Shifting to the causation view held by the Petitioner at bar, at page 21 Dr. Teich addressed the opinion of Dr. Gollan. In Dr Gollan's report of Septmber 6, 2012 at page two, she (Dr. Jackie Gollan not Cynthia Grazian) attributed causation to "...exceedingly high stress more than expected in a workplace environment. Thereafter at page 22: 13-23 Dr. Teich agreed to a small extent that she was greatly upset at having to vacate her position as CEO of the bank. The disagreement with Dr. Gollan's opinion as expressed by Dr. Teich at page 23: 1-2 was " Well, this term employment conditions, I am not quite sure what that means because it does not refer to anything specific." Dr. Teich questioned at page 28 how Dr. Rothke knew FDIC was at fault of her problems as an underpinning of his own (Dr. Rothke's) opinion. The record contains Dr. Rothke's clinic notes specifically citing the FDIC.

As to "binge drinking or any drinking" can frankly produce depression" at page 29: Line 8-16, the Arbitrator finds the basis of Dr. Teich's focus on drinking is essentially post – accident. In the post-accident condition Petitioner was surely in the MDD state per both treating doctors and corroborated by the first expert of the Respondent. The Petitioner readily admitted she was depressed post-accident.

Moreover, as to Dr. Teich's emphasis of her fall(s) as accounted for on the basis of drinking, the records and testimony show the Petitioner fell on icy sidewalk while walking in heels becoming entangled in a dog leash. This history was born out at the emergency room followed by surgery. No ETOH evidence was found by blood analysis or formal clinical medical judgments at that exact point of service. Dr. Teich confirms that we (physicians) have the obligation to check it out (alcohol abuse). Yet, nothing in the record shows failure in that regard by the treating doctors at Northwestern or Northshore Hospital.

The Arbitrator finds that the formal blood testing read as negative for ETOH or illicit drugs, lack of ordering any addictive behavior evaluation by any practitioner during all the encounters shown in the record plus direct monitoring of her condition by two doctors over time failed to show "alcohol abuse" as a causative factor in the Petitioner's condition of ill being.

Based upon the preponderance of the evidence, the Arbitrator gives no weight to and rejects the second expert's diagnosis of "general anxiety disorder and episodic alcohol abuse" posited at page 42: lines 11-17. In a different stage of his testimony at page 45: Dr. Teich essentially said so I figured financial and legal matters were the biggest stressors.

When asked how her conditions came about Dr. Teich replied that the general anxiety disorder probably began earlier in her life because she did have this period, which she was pretty sketchy about, but when she had to take the paxil. The Arbitrator did find forthright explanation by the Petitioner that at one prior point in time far in the past that she had family counseling when they were having problems with their father, then president of the Respondent bank.

As to her ability to work, Dr. Teich established at page 52 that Petitioner was in fact actually working, as the basis for his opinion given the Petitioner's expression she was working fifty to sixty hours a week. Yet, the testifying witnesses all expressed she was physically in the office at times so that her husband- attorney can keep watch on her. However, while present she did very little, accurate, productive tasks.

As to the issue of gainful employment, the Arbitrator finds by the preponderance of the evidence as follows: minimally, this is simply a family health watch. At best, its deemed her husband's effort at therapeutic, sympathetic / benevolent employment.

As to the actual medical care rendered by Doctors Dago and Gollan plus the hospitals and emergent care providers, Dr Teich opined Petitioner's treatment and medications were reasonable and necessary. Pages 55: lines 10-15 & 21-22. It is contrarian to agree the treatment was reasonable and necessary yet totally disagree with the diagnosis for which that "reasonable and necessary treatment" was rendered. Some of Dr. Teich's opinions are based upon speculation. (RX 3, p80).

The report of Petitioner's treating physician, Dr. Pedro Dago, dated September 14, 2012 states that he first saw Petitioner in March 2009. He noted at that time she was in extreme emotional distress and diagnosed her as having major depressive disorder, severe, with melancholic features. It was his opinion that her depression was precipitated and perpetuated by an unusual level of occupational stress. She recovered from that episode. However, she has had a number of break through episodes, some severe. When symptomatic- Ms. Grazian feels hopeless, demoralized, helpless and agitated. Her self-confidence drops dramatically. Her functioning becomes impaired. (PX5)

Dr. Jackie Gollan a licensed clinical psychologist and professor authored a report concerning Petitioner. Petitioner was first seen by Dr. Gollan on March 20, 2009 and was diagnosed with Major Depressive Disorder and Generalized Anxiety Disorder. Petitioner's symptoms were not part of another mental disorder and were not due to a substance or medical issue. (PX6 p1) "On June 11, 2009 Ms. Grazian was asked to step down from her position as CEO of Bank, and the abrupt onset of the firing, the absence of explanation and authority for this action and the stressful circumstance of the workplace environment had a clear and negative psychiatric impact on Ms. Grazian.

Ms. Grazian experienced major deterioration of her condition. She has suffered significant anguish related to her loss of skills in organizing, complex decision making, and attention and memory. Given the chronicity of these difficulties, I would opine that she will continue to struggle with these cognitive features.

Petitioner was deemed disabled for purposes of Social Security Disability effective June 11, 2009. (TR.45)

(C) In Support Of The Arbitrator's Decision As To Whether The Petitioner Sustained An Accident Which Arose Out of and in the and Course of her Employment with Respondent , (D) Whether said Accident Date is June 11, 2009, and (O) Whether Petitioner Be Allowed to Amend the Date of Accident at Time of Hearing, The Arbitrator Makes The Following Findings:

Petitioner initially filed an Application for Adjustment of Claim containing a date of accident of March 7, 2009. A subsequent Amended Application was filed on June 12, 2012. The matter was initially heard on October 10, 2013. Received in evidence as Arbitrators Exhibit #1 was a Request for Hearing containing a date of accident of June 11, 2009. Petitioner prior to close of evidence requested leave to amend the date of accident on the Application for Adjustment of Claim to June 11, 2009. The Respondent objected plus the Arbitrator deemed the objection as continuing one. All objections were renewed at close of proofs. The issue was briefed followed by an oral argument on the same resulting in written Interlocutory Order allowing amendment. Being mindful of due process, that said Order further allowed Respondent additional time and opportunity to submit any additional evidence upon a further hearing which Respondent felt necessary to cure any prejudice the amendment may cause. Upon Review of said Order to the Commission, The Commissioner ruled upon that Interlocutory Order then remanded the case back to this Arbitrator. Said Order is part of the Commission file. Said written Order to Amend is now made a part of this Award with terms incorporated herein by reference as the Final Order regarding the Motion to Amend the Application plus Award (Decision) of the Arbitrator.

Without a subsequent motion by Respondent to admit further evidence or seek a fifth hearing to avail itself of additional evidence as provided for in the Interlocutory Order, both sides requested by agreement through a Request for Hearing that the matter be heard at the Arbitrator's next assigned venue to close proofs. From the time this matter was heard over various hearing dates, the 2011 Act mandated this Arbitrator and all others downstate be transferred after two years into another set of three venue (commonly known as a new supervenue).

Thus, at both parties mutual request and agreement, legal proofs were closed by their request on October 1, 2014 in a different venue than the one assigned by the IWCC itself via first notice from the Commission. Both parties were given extensive time for proposed findings which totaled over 80 pages between the two attorneys.

The Arbitrator had the opportunity to observe and listen to the Petitioner when she testified both on direct and cross examination. The Arbitrator concludes that the Petitioner is a very credible albeit loquacious witness to the details of the circumstances regarding the alleged accident. She appeared to be a detailed historian of facts relating to the bank. Although she was easily diverted off the point of many questions she, upon composing herself and focusing on the question asked perhaps a second time, did provide direct answers. Based upon my experience and observations plus given the diagnoses from the treating doctors I infer great stress on the witness's part in recounting all pre and post-accident events as to treatment, family interaction and presentation to her husband's office. The Petitioner's testimony was believable and compelling regarding the accident; her statements regarding the banking events are accepted as accurate.

Neither the primary bank attorney Ashack nor bank consultant Mr. Shapiro, agents of respondent, were called to rebut. No FDIC agent testified. Focusing on the Petitioner, throughout her testimony her demeanor changed at times from intense, focused and hyper to immediately appearing flat and emotionally blunted at times. The changes both seemingly physically observable and heard in person in terms of voice inflection, tone and variant speech pattern occurred while intertwined in the questions regarding the psychic trauma itself, treatment, effect on career and behavior in general.

Her testimony concerning the events leading to her June 11, 2009 collapse were corroborated by her husband. Mr. Grazian is a licensed Illinois attorney. As such his statements must be given the weight accorded an Officer of the Court as he is held to the standards of truthfulness required by the Code of Professional Responsibility. Mr. Grazian's forthright, assertive testimony was subject to intense, insightful, long cross examination by defense. Both the on point questioning and the responses bore well on all the issues brought forth during his lengthy examinations.

The Arbitrator concludes from the totality of the evidence Petitioner at bar was under an extreme amount of occupational stress as the CEO of the bank of far greater demensions than the day to day emotional strain which all employees must experience.

This stress led to Petitioner having a syncopal event which necessitated medical care in March of 2009. She returned to work the very next day. Her two treating doctors opined she was much improved. Her husband recommended she seek counseling to help her deal with the stress, which she did.

It is exceedingly rare, if not a unique circumstance where a worker's compensation claim involves the actions of quasi-governmental agencies involvement with private sector business plus the effect that it can have on employees of that business. As stated above, the level of occupational stress placed upon Petitioner on June 11, 2009 was clearly of greater dimensions than that which any worker would face in a typical work place environment.

This is not a termination case that may open floodgates, as asserted by defense in closing arguments. Moreover, it is sacrosanct that each and every case must be dealt with on its own merits within the four corners of the record.

In this particular case Petitioner was not a factory worker seeing an arm severed as in Pathfinder, nor a factory worker enduring terrible insults as in General Motors. Yet, a highly educated person is entitled to as much protection under the law as a lesser educated person. Recent cases of Diaz regarding stress on a police officer found compensable plus Ameritech regarding a highly educated petitioner with an MBA coupled with psychological disability affirmed by the Appellate Court as well deeming compensability , are well noted herein in addressing many issues at bar.

Moving on in time while the Petitioner was working, on June 11, 2009 Petitioner was in the process of meeting with a potential investor in her role as CEO of the Bank. The meeting attendees via speaker phone received a call from one of the Banks attorneys. The Arbitrator finds at that moment Petitioner was acting in the course of her employment, doing something from which the employer would derive a benefit. When Petitioner heard that officials of the FDIC were calling for her to resign from the bank she collapsed. Petitioner was taken to the emergency room and transferred to a locked psychiatric ward. Mr. Grazian inter alia was in attendance in his roll as a bank attorney in some aspects of its business of banking.

Both of the treating physicians and Respondents expert Dr. Rothke concur that it was the FDIC action that led to Petitioner's mental collapse.

It was not "her termination" that led to her collapse. In fact by letter dated July 7, 2009 Petitioner was advised much later that "on June 30, 2009, the Board passed a resolution removing you from all positions with InBank effective as of June 30, 2009." (PX1) Both Petitioner and her husband testified she never resigned. (TR.p70, 72, 10A) Mr. Grazian testified Petitioner conveyed that she would do whatever necessary in the best interest of the bank, if that is meant resigning she would. (TR.10A) This distinction is critical. Petitioner was not "terminated" by her employer. Rather, the preponderance of the evidence shows that Ms. Grazian was waging a letter and personal campaign to force the FDIC to provide her with a logical explanation of why the Respondent bank needed to raise much more capital that was foisted upon it than was previously assigned by the FDIC.

The FDIC asked that she be removed from her CEO position with the Bank. She never quit. It was testified to that the FDIC has a process for removal that was not followed. See the judicial notice above.

The Arbitrator relies on the wisdom of the Appellate Court in Northwest Suburban Special Educ. v. Ind. Comm., 312 Ill. App. 3rd 783 (2000) at page 787, last paragraph, in explaining in judicial precedent when psychological injuries are compensable plus what three factors must be established for recovery in mental – mental cases.

The Arbitrator finds as a matter of fact and as a conclusion of law the call from the Bank's attorney regarding the FDIC received in the bank meeting on June 11, 2009 caused Petitioner to suffer a sudden, severe emotional shock traceable to a definite time, place and event. Petitioner's termination from the employer was not effective until nineteen days later. (PX1)

Thus, based upon the totality of the evidence, the Arbitrator finds as a matter of fact and law the Petitioner at bar sustained an accident in the scope and course of her employment as alleged on June 11th, 2009.

In Support Of The Arbitrator's Decision Whether Timely Notice of the Accident Was Given to Respondent (E) the Arbitrator Finds as Follows:

The Arbitrator finds that the events of June 11, 2009 took place during a business meeting of the bank within the presence of Mr. Elmore the Chairman of the Board of InBank (TR.28) As such Based upon the totality of the evidence, the Arbitrator concludes Respondent at bar had actual notice of the occurrence. Further, the letter from one of the attorneys for the Bank (PX1) reflects that Respondent was so aware.

In Support Of The Arbitrator's Decision That Petitioner's Current Condition Of Ill-Being Is Causally Related To This Injury (F), The Arbitrator Finds as Follows:

The Arbitrator adopts the opinions expressed by Petitioner's treating physicians that her present condition was caused by her intersect/dealings with the FDIC via the telephone call of June 11th, 2009. Further the Arbitrator finds most persuasive and adopts the opinion of Respondent examining physician Dr. Steven Rothke that Petitioner's MDD is due to the actions of the FDIC, and nothing in the records or findings suggest preexisting conditions. (PX7 p7) The Arbitrator further adopts the opinions of both Dr. Dago and Dr. Gollan of Northwestern Medical Center.

Petitioner presented to Northwestern Hospital emergency room on June 11, 2009 with acute suicidal ideation, no substance or ETOH abuse with referral for admission to a psychiatric hospital for acute stabilization. (PX2 p146)

Dr. Gollan found Petitioner's condition of MDD and GAD were not due to substance or medical issue nor any stressors other than the actions of the FDIC. (PX6)

Based upon the totality of the evidence, the Arbitrator finds as a matter of fact and a conclusion of law that Petitioner's current condition of ill being is causally connected to the accident in the case at bar of June 11th, 2009.

G. In Support of the Arbitrator's Decision As To Petitioner's Earnings During The Year Preceding The Injury.

The Arbitration finds by stipulation, the average weekly wage under section ten was $5,300.00 and the section 10 earnings for the year before the accident was $275,600.00

In Support Of The Arbitrator's Decision Relating To What Temporary Benefits May Be In Dispute (K), The Arbitrator Finds as Follows:

The Arbitrator finds that Petitioner was paid no temporary total disability by Respondent as stipulated on Arbitrator's Exhibit #1 in evidence. Petitioner testified that she last worked for Respondent on June 11, 2009. She was in a locked psychiatric ward for one week thereafter (PX4) and could not have worked.

Petitioners treating physicians found that Petitioner was not capable of returning to work and so noted in their records on November 16, 2009, February 23, 2010, September 17, 2010 and May 6, 2011. (PX3) Dr. Gollan noted on June 21, 2013 that Petitioner was still suffering from careless mistakes, difficulty with attention, trouble concentrating when spoken to and trouble wrapping up finished details. (PX3p438).

Respondents examining physician Dr. Rothke under section 12, their expert, found Petitioner during the interval of 2009 to present was unable to meet the time and productivity demands of full time gainful employment. (PX6 p7) John Grazian testified that although Petitioner performed tasks for him, she was never paid for any work . The Arbitrator deems him bringing his wife under his watchfulness in office, as an attempt of therapeutic activity, not even rising to benevolent employment, most importantly to prevent a relapse into potential suicidal ideology. (TR.224)

Petitioner testified that she first tried to return to work in 2011 but that the doctors were not supportive of that at that time. Petitioner started a job search on May 20, 2013 which included using a resume service and sending them out to every law firm with financial service departments. (TR.49) She applied for over 700 jobs (TR.51) but her job search made her feel useless again. (TR.53) This resulted in her doctor noting her cognitive abilities were diminished.

Accordingly the Arbitrator finds that enough circumstantial and direct evidence exists to support a finding that; no TTD was paid to Petitioner, that Petitioner was temporarily totally medically unable to work for the period June 11, 2009 through the date of hearing October 10, 2013. That Petitioner was not gainfully employed at any time during that period.

Based upon the totality of the evidence, the Arbitrator finds as a matter of fact and conclusion of law that Petitioner is entitled to payment from the Respondent for TTD in the amount of 225 6/7 weeks.

In Support Of The Arbitrators Decision As To The Nature And Extent Of Petitioner's Injury (L), The Arbitrator Finds as Follows:

Petitioner is a 52 year old female who spent virtually her entire adult life working in and building the business of the Respondent, a bank, begun by her father, Mr. Elmore. She holds a license to practice law in Illinois, although, she has never practiced law to any degree outside of her work as compliance officer and corporation counsel to the Respondent.

Petitioner had been waging a highly stressful endeavor to save the bank from FDIC closure amidst an American economic collapse of epic and historic proportion. The Arbitrator infers from the testimony and actions that Petitioner had garnered the ill will of FDIC auditors by going over their heads so to speak and refusing to accept as reasonable FDIC auditors apparently changing evaluations of capital needed to adequately collateralize loans made by the Respondent before the deadline that she intended to make given the original amount and the new investor. By testimony, in an unjustified manner the FDIC on June 11, 2009 summarily, demanded she be removed from her position as CEO of the Respondent. The bank attorney and Bank consultant were not called in rebuttal. See the judicial notice of statute infra.

The action of the FDIC caused Petitioner to suffer a sudden, severe emotional shock traceable to a definite time, place, event and cause. Petitioner after being hospitalized in a locked psychiatric unit has suffered permanent loss of cognitive function. (PX6) Whenever she is placed in a situation involving constraints on time or place she begins to lose the ability to function.

There are two areas that Respondent spent much time inquiring of Petitioner on cross examination which this Arbitrator finds have little to do with Petitioner's current psychic disability. First is the issue of Petitioner's physical abilities, such as biking. Second is her history of family vacations after June 11, 2009. Petitioner freely admitted that she bicycles 15-30 miles a day whenever possible (TR.120) and that she has been on vacations with her family to Argentina (TR.91) and Israel (TR.86). The Arbitrator finds that neither of these activities are the types of things which would be affected by Petitioner's mental disability. Her disabling condition is of the mind and is exacerbated by stress. She has never claimed a physical incapacity. The physical exercise Petitioner engages in is actuality therapeutic. Petitioner "needs exercise". (TR.208) accordingly, the Arbitrator finds these points not keenly probative especially since the Arbitrator did not find major assertions of agoraphobia or claims of physical infirmity in evidence.

Petitioner first attempted to return to work in May of 2013. She asked a friend who owned a resume company to help her gather the name of every Chicago law firm to send a resume that works in any financial services. She applied to over 700 jobs. (TR.49) The Arbitrator deems this a diligent job search given her medical condition and given it's a self-directed job search.

Unfortunately, there was much negative press which would adversely negatively affect Petitioner's ability to be hired in the financial service market place. (TR.52) Petitioner hired reputation.com in an attempt to repair her reputation. (TR.132) However, Petitioner noted that the job search made her feel useless. (TR.53) Petitioner feels she is unable to follow through and finish anything. (TR.53) Petitioner does not have consistent moods and uses wrong words when under stress. (TR.51) Her husband noted these same deficiencies. (TR.215, 216, 217, 222)

These are precisely the same variables and issues found by Respondent's examining physician Dr. Steven Rothke (PX7) as well as Petitioner's treating physicians Dr. Dago and Dr. Gollan. (PX3)

There is persuasive evidence by the adopted testimony of Attorney Grazian of Petitioner's inability to function either as she did in the past, or at a bare minimum, the level that any employer would expect in the work place. Petitioner's husband, a personal injury attorney, established a loan company that makes loans on personal injury claims. (TR.211) This endeavor was handed off to Petitioner, a person with a 25 year history in banking. Yet the loan company didn't work out. (TR.216) Petitioner attended to it passively and did not grow the business. (TR.215)

Beginning in 2010, Petitioner was also tasked with paying bills at her husband's law firm, a position for which she is not paid. (TR.221) This is done one day per week at most. She makes mistakes, writing checks for incorrect amounts or sends them out without signing before mailing. (TR.222)

Petitioner also helps her husband by publishing blogs on the internet. This consists of being given articles provided by her husband, his partner or lawyers at the firm and reducing it to a much shorter version. (TR.6A) This can be done at her leisure, from anywhere at any time. (TR.7A) However, the work has to be checked by Mr. Grazian or another attorney and often rewritten. (TR.9A) Petitioner told Dr. Gollan that she helps at her husband's law office 50 to 60 hours per week. (PX3 p332) Mr. John Grazian testified that's not possible as he does not even work that many hours. (TR9A) Nancy Strid, the office manager at his law firm testified that she sees Petitioner in the office one or sometimes two days a week but Petitioner arrives after her (Strid at 8:30 a.m.) and Petitioner leaves before her (Strid at 4:30 p.m.). (TR.163) Lisa Segura an administrative assistant testified she sees Petitioner at the office once a week. (TR.137) Petitioner's statement is consistent with the findings of her physicians that her judgment is diminished and she overweighs her own coping skills. (PX4 p11, 24) Mr. Grazian testified that he would expect an associate to accomplish what his wife does in eight to ten hours per week. (TR.10A)

The Arbitrator finds that the services which Petitioner performs at her husband's firm are not something which should be deemed gainful employment for which a readily stable job market exists; It is not even deemed benevolent employment.

. Notwithstanding, Petitioner has undertaken a extremely, proficient, diligent job search applying for more than 700 jobs yet found no employment. Petitioner was found to still have symptoms indicating careless mistakes difficulty with attention, trouble concentrating when spoken to, difficulty wrapping up final details on June 21, 2013. (PX3p438) Respondent's examiner conducted a mental examination of Petitioner on February 19, 2013 and she scored 25 out of 30, 26 or better being normal. (PX6p5) Dr. Gollan feared Petitioner would continue to struggle with chronic suicidality which will require treatment and monitoring. (PX6p2) This medical finding supports Attorney Grazian's action and intent of bringing her to his office to keep watch over his wife.

Accordingly, the Arbitrator finds as a matter of fact and law this Petitioner to have sustained permanent total disability effective October 1st, 2014 under what the higher Courts have deemed the odd lot theory.

STATE OF ILLINOIS)
) SS
COUNTY OF WILL)

15IWCC0862

ILLINOIS WORKERS COMPENSATION COMMISSION

CYNTHIA GRAZIAN, Petitioner, vs. IN BANK, et al Respondents.	No. 12 WC 005001

INTERLOCUTORY ORDER

THIS MATTER having been heard on December 11, 2013 on Petitioner's Motion to Amend the Application for Adjustment of Claim, the Arbitrator finds as follows:

An Application for Adjustment of Claim was filed on January 4, 2012 asserting that Petitioner sustained an accident during the course & scope of her employment on March 7, 2009. A subsequent Amended Application for Adjustment of Claim was filed on June 12, 2012. Testimony was heard on October 10th and 11th of 2013.

Pursuant to IWCC Rule 7030.60, evidence depositions were completed prior to the two days of lay testimony . In addition to evidence depositions, Petitioner provided to Respondent reports from her treating doctors. These reports and evidence depositions were received in evidence on October 10th and 11th 2013 and were essentially as follows:

1. A report from Dr. Pedro Luis Dago, Petitioner's treating psychiatrist, who treated Petitioner since March of 2009 (PX5);

2. A report from Dr. Jackie Golan, Petitioner's treating psychologist, which directs to occurrences of March 20, 2009 plus June 11, 2009 (PX6);

3. A report of Dr. Steven Rothke, Respondent's expert witness by way of a Section 12 exam. It indicates the date of her claim as March 7, 2009 but also references June 2009 (RX4);

4. A report dated July 22, 2013, it's addendum plus evidence deposition of Dr. Jeffrey Tiech, Respondent's expert witness by way of a Section 12 examination; It references a record review beginning with Petitioner's records of Northwestern University on March 12, 2009 through 2013. Dr. Teich was questioned extensively during his deposition about the events of both March 20, 2009 and June 11, 2009 (RX1 ,2, 3); In the context of the Motion to Amend at bar, said deposition was studied in depth by this Arbitrator along with the other evidence. Based upon his lengthy testimony he confirms that the entity that engaged his Section 12 services (Chubb Insurance) never send him North Shore Hospital records including emergency room and in-patient psychiatric records regarding events on or about June 2009 and or June 11, 2009. However, those dates were manifested in the aforementioned documents two through 4 above. Without subscribing any legal significance or lack thereof to those last two referenced dates including 6/11/2009, it is important in ruling on this Motion to Amend that Dr. Teich at his deposition was shown 2009 (Rush) North Shore Hospital records then asked and answered questions on cross examination regarding history of June and June 11th, 2009 events, plus findings and causation references in said hospital records, particularly at deposition page seventy six (76).

5. The medical records of Petitioners treatment at Northwestern University Medical Center from March 2009 through 2013 (PX2).

The focus of the analysis is to correlate the evidence including significant dates in the histories provided, the doctors' findings, the Petitioner's activities between the two dates plus the opinions of the doctors that may be probative on the Motion at bar. Petitioner alleges in her Motion for Leave to Amend the Application that a scrivener's error resulted in the date of June 11, 2009 not being included on the Application for Adjustment of Claim. Petitioner argues that the motion at bar is supported by both the entirety of the medical records and the fact that the Petitioner's Attorney at the close of lay testimony on October 11, 2013 made reference to an Amended Application having been filed. This statement on the record was followed by the subsequent written Motion to Amend the Application to conform to the proofs already in the record.

Importantly, the "Request for Hearing" i.e. the hearing stipulations required by the Rules Governing Practice Before the Illinois Workers' Compensation Commission, 50 Ill. Admin. Code, Ch. II, section 7030.40, received in evidence as Arbitrators Exhibit #1 at the beginning of the case contained the allegation that *June 11, 2009* (emphasis added) was the date of accident. On that exhibit, Respondent denied the same.

The Respondent formally replies in writing that the Petitioner's motion to change the date of accident is more than a formal requirement and touches the substantial rights of fair play and should be denied, citing Mora v. Industrial Commission, 312 IL. App. 3d. 255, 1st District (2000).

The *Mora* Court found that a proposed amendment affected the substantive rights of Respondent and therefore the Court relied on the civil practice law and applicable case law. 735 ILCS 5/2-616(c) the Code of Civil Procedure permits the amendment of pleadings at any time, before or after final judgment, to conform the pleadings to the proofs.

This Arbitrator does not believe nor find by the facts or as a matter of law that the decision of *Mora* applies to the factual circumstances in the case presently at bar. In *Mora*, after the close of testimony before the Arbitrator, the hearing was continued ostensibly to clarify some confusion regarding exhibits. Meanwhile, Petitioner through counsel without seeking leave of the Judicial Officer, filed an Amended Application naming an additional and new Employer-Respondent. When the case reconvened some two months later for purposes of closing arguments the Arbitrator was first made aware that an Amended Application had been filed in the interim naming a Respondent Employer who had not previously been a party. The Arbitrator in *Mora* denied Petitioner's oral motion for leave to amend the Application to add a new Respondent. The Commission on Review later denied claimant's motion to amend his application to add parties, finding there was no evidence to support the motion. The *Mora* court as a holding specifically found, Petitioner's failure to seek leave to file his proposed amendment from the Arbitrator rendered the proposed amendment a nullity (*Mora* Pg. 275). This Arbitrator totally agrees with the fate given Petitioner counsel in *Mora.*

Returning to 12 WC 05001, This Arbitrator concludes that the facts and circumstances in the case at bar are not at all those of *Mora*. The attempt by the attorney to add a new party without leave , deserved its fate by the Court under those "bad" facts.

Nevertheless, if the Court's analysis of when amendment should be allowed set forth in *Mora* are applied to the case at bar , Petitioner's (Grazian) motion should be allowed herein. The proposed amendment would cure a defective pleading, Petitioner acted timely in moving to Amend, a previous opportunity to amend can be identified (the claimed scriveners error), and finally the Arbitrator does not find any prejudice to Respondent, as amplified in part two of the Order below.

It has long been established law that both the adjective and substantive law in Workers' Compensation take its tone from the beneficent and remedial character of the legislation (A. Larson, Workmen's Compensation Law).

The Arbitrator considers the case law and reasoning of Reliance Elevator Company v. Industrial Commission 171 IL.App.3d 18, (1988) and McLean Trucking Co. v. Industrial Commission 96 ILL.2d 213 (1983) to be much more appropriate to the case at bar. In these cases the Commission allowed amendment of the date of accident on the Application **after** Arbitration. (emphasis added). The amendment was allowed because it merely changed the pleadings to conform to the evidence already in the record.

WHEREFORE, IT IS HEREBY ORDERED as a matter of law and material fact based upon the totality of the evidence as follows:

1. Petitioner is granted Leave to Amend the Application date to include June 11, 2009.

2. The Arbitrator sue sponte orders that this case be specially set by agreement or Motion for a date certain for the purpose of allowing Respondent to offer any additional evidence concerning the June 11, 2009 alleged date of accident in light of this Order granting Petitioner's Motion to Amend the date of Accident.

#01 George Andros — 2.20.2014

Arbitrator — Date

STATE OF ILLINOIS)
) SS.
COUNTY OF)
JEFFERSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CARL T. McCOY,

Petitioner,

15IWCC0876

vs.

NO: 12 WC 11151 & 14 WC 20899

OLIN CORP.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, and vocational rehabilitation, 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 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).

Findings of Fact and Conclusions of Law

1. Petitioner testified the highest education he had was the 7th grade. He worked for Respondent, which manufactures ammunition, for 15 years. After he injured his low back on September 26, 2011 Respondent referred him to Dr. Rutz for treatment. He performed a microdiscectomy on December 7, 2012 at L5-S1 and then a revision and fusion for recurrent disc herniation on October 16, 2013. Respondent accepted Petitioner's condition as being work related. During this entire time he was receiving temporary total disability benefits and there is no claim for medical expenses.

15IWCC0876

2. Petitioner also testified that Dr. Rutz released him to light duty around January 7, 2014. His job was "picking shelves," which he was able to do. A functional capacity evaluation ("FCE") performed on March 11, 2014 rated Petitioner to be able to function at the medium physical demand level, with the ability to at least lift 40 lbs occasionally and 25 lbs frequently, push/pull 80 lbs occasionally, unlimited reaching and sitting and frequent standing, and occasional "lower level movement patterns."

3. Dr. Rutz placed permanent restrictions on Petitioner of occasional lifting of 40 pounds and regular lifting of 25 pounds. Based on those restrictions, Respondent transferred Petitioner to a job as a "B-operator." According to Petitioner the job entailed "reaching, bending, and shaking the flicks." These activities aggravated his back. He went back on temporary total disability after about two weeks in that job.

4. Petitioner testified he returned to that job "in early 2014," but after several days he had a significant increase in his low back pain. The reaching and bending caused his "back to go out." He explained the hardware in his back limits his ability to reach and it causes severe pain. Continuous reaching and bending caused his back to go out. In June of 2014 he was taken to Alton Memorial Hospital by ambulance. He was taken off work and put back on temporary total disability.

5. On July 1, 2014, Petitioner returned to Dr. Rutz and told him that the repeated bending and scooping a 10-pound plate in a bin and shaking with outstretched arms he performed as a B-operator aggravated his back. He would have to reach inside the tub holding the plate and after filling the plate with material he had to shake the plate repeatedly to get the shells inside the plate. That caused extreme pain in his back. Dr. Rutz modified his permanent restrictions to include no repetitive bending or repetitive work with outstretched arms.

6. Respondent directed Petitioner to attend a medical examination with Dr. Cantrell, a physiologist, pursuant to Section 12 of the Act. Petitioner saw him on April 21, 2014; Dr. Cantrell opined that Dr. Rutz' restriction of outstretched reaching was not necessary.

7. Petitioner testified he reviewed videos of the duties of a B-operator, including the one that Dr. Cantrell used in formulating his opinion. They did not accurately depict the work duties of a B-operator. The activity of bending over and handling the 10-15 pound pans was not shown on the video; neither was the body posture of the B-operator. The video also did not show the depth of the bin and how the worker has to bend more as the bin emptied. The videos also did not show "the worker fluxing the plates" or the use of the large forklift.

8. Respondent directed Petitioner to return to his job as a B-operator effective August 14, 2014. He was planning to return to the job. However, on August 9th his back went out while he was at home. He tried to catch himself but came down on his hand and broke the left middle finger. His general practitioner, Dr. Adesara, took him off work because of that injury and released him to work on September 17, 2014.

9. Thereafter, Petitioner returned to his job as B-operator for a 3rd time. On his first day back, he was pushing a cart with 40 plates in it. It caused severe pain in his back and caused "back problems." He estimated the loaded cart weighed 450 to 500 lbs. There was nobody to help him push the cart, which he was supposed to pull about 90 feet. When he previously worked as a B-operator he had to push the cart, but they were only loaded with 15 to 25, 15-pound plates. He was told the cart was loaded with more plates because "the production went up in the department."

10. Petitioner testified he had difficulty performing the job. Dr. Adesara took him off work again on September 22nd, and Dr. Rutz sent him to Dr. Wayne, another physiologist in his office. Dr. Wayne agreed with the weight lifting and alternating sitting and standing restrictions imposed by Dr. Rutz, but disagreed with the restriction against outstretched reaching. Dr. Wayne did not address any restrictions regarding the amount of weigh Petitioner could push/pull.

11. Petitioner did not believe he could return to work as a B-operator. He could no longer repetitively reach and bend like he could before his back injury. He had "extreme problem" performing those activities while shaking and banging a 10-15 pound plate filled with bullets. He cannot push/pull the loaded cart because the weight causes extreme pain in his back. He believed he made a good-faith effort to return to work as a B-operator. He wanted to return to work and would be willing to work for Respondent in a job within Dr. Rutz' restrictions. He wanted to be vocationally retrained to perform a job within his restrictions such as "computers, a pharmacist."

12. On cross examination, Petitioner testified Dr. Wayne was the last "specialist" Petitioner saw regarding his back. He probably worked a total of three to four days as a B-operator from June of 2014 to the time he last worked for Respondent in September of 2014. He agreed that Respondent offered him a permanent position as a B-operator. He told Dr. Wayne about use of the machines as well as the banging of the plates.

13. Petitioner called John Dearing to testify. He also had a workers' compensation claim pending against Respondent. Mr. Dearing's claim concerned a cervical injury for which he had two surgeries. He was also assigned to work as a B-operator while on restricted duty. He agreed with Petitioner that the videos did not correctly depict all the duties of a B-operator. He was unable to perform the duties of a B-operator.

14. Respondent called Robert Sitze to testify. He worked for Respondent for 37 years and as general foreman for about a year. He is familiar with Petitioner and the position of B-operator. He never held that job, but watched it being performed. The videos showed middle aged women who were "actually employed in that department, doing that job." They were performing the same job Petitioner was performing. In his opinion the videos depict what was "representative of a regular shift of a B-operator."

15. Mr. Sitze also testified B-operators are permitted to reduce the number of plates on a cart to reduce the weight. The operator has to move the cart about 50 feet on a concrete floor. Mr. Sitze was informed of Petitioner's restrictions when he was assigned to his department. He believed the job was within those restrictions. The plates are made of graphite. If bullets got stuck in a plate the operator would tap it to dislodge them. If the plates were banged they would break. He could not recall difficulties of other workers working with restrictions in his department.

16. On cross examination, Mr. Sitze agreed that the videos do not show the use of the large forklift. He thought the job was within the restrictions he "got through medical." He seemed to agree that the job did not comply with restrictions of no repetitive bending or working with outstretched arms. If the cart had 40 plates, which weighed 10-12 pounds apiece, the weight would greatly exceed an 80-pound pushing-pulling limit in an FCE.

17. On redirect examination, Mr. Sitze testified that if a cart had 40 loaded plates, the B-operator would be required to remove some of those plates before moving the cart.

18. Dr. Cantrell testified by deposition that he is a doctor specializing in physical medicine and rehabilitation. His training includes evaluating whether impaired employees can safely perform various job tasks, and matching a person's work restrictions with various jobs. He examined Petitioner on April 21, 2014 and prepared a report at the request of Respondent. He was provided a video of the job activities of a B-operator.

19. Dr. Cantrell also noted that Dr. Rutz initially assigned restrictions based on the results of an FCE. It was Dr. Cantrell's understanding that the B-operator job was consistent with those restrictions. Dr. Rutz "later assigned a restriction of limited reaching that was not otherwise specified." That one additional restriction potentially prevented Petitioner from doing that particular job. However, based on his reading of the FCE, Dr. Cantrell did not believe that restriction was necessary and Petitioner would perform the job.

20. On cross examination, Dr. Cantrell testified the Physical demand analysis for the job of B-operator indicated maximum lifting of 10 pounds. However, even if the job required lifting greater than 10 pounds, the FCE indicated Petitioner could lift 40 pounds. Dr. Cantrell agreed with Dr. Rutz' weight lifting restrictions. He would also "definitely agree" with the restriction against repeated bending. Dr. Rutz' only restriction with

which Dr. Cantrell disagreed was the reaching restriction. Dr. Cantrell agreed that in his report he did not specify the activities he saw in the video. According to therapists' definition an activity is "repetitive" if performed at least 2/3 of the work day.

21. Dr. Wayne examined Petitioner on July 29, 2014. He concluded that Petitioner continued to "present with a high level of subjective complaints despite extensive treatment." Based on the FCE, Dr. Rutz' notes, physical therapy notes, and Dr. Cantrell's report, he concluded Petitioner was at maximum medical improvement. He believed he would need a permanent 40 pound occasional and 25 pound frequent lifting restriction. However, he agreed with Dr. Cantrell that there was no justification for restricting reaching in front or limiting his bending. Although Petitioner was "very adamant about feeling like he needs the have restrictions of no reaching in front of him and avoiding bending activities," Dr. Wayne respectfully disagreed with him. He believed that restricting him to that degree would result in limitation of truncal mobility and more weakness of the core muscles.

The Arbitrator found that Petitioner was not physically capable of performing the duties of a B-operator. In arriving at that conclusion he adopted the restrictions imposed by Dr. Rutz and rejected the opinions of Dr. Cantrell and Dr. Wayne. Accordingly, the Arbitrator awarded Petitioner temporary total disability benefits to the date of arbitration and ordered Respondent to pay for vocational rehabilitation evaluation and maintenance benefits thereafter. The Commission disagrees with the conclusions of the Arbitrator which are the bases for his award.

The Arbitrator is correct that Dr. Rutz did include the additional restrictions of no bending and no work with outstretched arms. In addition, those restrictions would appear to preclude Petitioner's return to work as a B-operator. However, he based those restrictions solely on Petitioner's subjective complaints regarding his difficulty in performing those functions. Similarly, Petitioner's claim that he is unable to perform the duties of a B-operator is based solely on his subjective statements. However, his subjective assertion is contradicted by the opinions of Dr. Cantrell and Dr. Wayne, the results of the FCE, the testimony of Mr. Sitze, the job description of the physical demands of the job of B-operator, and whatever information that can be gleaned from viewing the videos. The Commission concludes that the job of B-operator complied with Petitioner's permanent restrictions based on his FCE results and the evaluation of Dr. Cantrell.

Petitioner testified that Respondent offered him a permanent position as B-operator. Therefore, he was not entitled to temporary total disability benefits beyond the date he last could have returned to work as a B-operator. Respondent last offered him the position as of August 14, 2014. However, the Arbitrator found that Petitioner's finger injury was caused by his back condition when he fell because his back "gave out." He based that conclusion on Dr. Adesara's treatment notes which corroborated Petitioner's testimony. The Commission sees no reason to reverse that finding of the Arbitrator. Dr. Adesara released Petitioner to work on September 17, 2014 after the finger injury. Accordingly, the Commission finds that date to be an appropriate

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date to terminate temporary total disability benefits. In addition, because Respondent offered Petitioner an appropriate permanent position, he was not entitled to maintenance or vocational rehabilitation. Therefore, the awards of maintenance and vocational rehabilitation evaluation are vacated.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $725.89 per week for a period of 5 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 compensation for permanent disability, if any.

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 $3,700.00. 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: NOV 2 4 2015

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
O-10/20/15
46

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

15IWCC0876

McCOY, CARL M
Employee/Petitioner

Case# **12WC011151**

14WC020899

OLIN CORPORATION
Employer/Respondent

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:

5362 JOSEPH E HOEFERT ESQ
1600 WASHINGTON AVE
ALTON, IL 62002

0299 KEEFE & DePAULI PC
MICHAEL F KEEFE ESQ
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

15IWCC0876

STATE OF ILLINOIS)
)SS.
COUNTY OF Jefferson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

CARL M. MCCOY
Employee/Petitioner

v.

OLIN CORPORATION
Employer/Respondent

Case # **12** WC **011151**

Consolidated cases: **14-WC-20899**

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 **Mt. Vernon**, on **10/15/14**. 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. [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. [ ] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **Is Petitioner entiled to vocational rehabilitation?**

FINDINGS

15IWCC0876

On the date of accident, **9/26/11 & 6/11/14**, 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 $**56,619.16**; the average weekly wage was $**1,088.83**.

On the date of accident, Petitioner was **30** years of age, ***single*** with **4** 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, $**0** for TPD, $**0** for maintenance, and $**1,870.71** for other benefits, for a total credit of $**1,871.71 for Petitioner's absence from work from 8/14/14 through 9/18/14**.

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

ORDER

1. **Petitioner's current condition of ill-being is causally related to his injuries.**

2. **Respondent shall pay Petitioner temporary total disability benefits of $725.89 per week for 9 weeks, commencing 8/14/14 through 10/15/14, as provided in Section 8(b) of the Act.**

3. **Respondent shall pay for a vocational rehabilitation evaluation of the employee including maintenance costs.**

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

12/19/14
Date

ICArbDec19(b)

JAN 5 - 2015

15IWCC0876

BEFORE THE ILLINOIS
WORKERS' COMPENSATION COMMISSION

CARL MCCOY,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 12-WC-011151**
	)	**Consolidated with**
OLIN CORPORATION,	)	**14-WC-20899**
	)	
Respondent.	)	

MEMORANDUM OF DECISION

THE ARBITRATOR FINDS THE FOLLOWING FACTS:

On Oral Motion the Arbitrator consolidated the above referenced cases at hearing. Further, the parties stipulated that the $1,870.71 paid to Petitioner by Respondent in non-occupational indemnity disability benefits were paid for the period of 8/14/14 through 9/18/14.

Petitioner, a father of four, has worked at Olin for 15 years. Petitioner's educational background is that he graduated from the 7th grade.

Petitioner injured his low back on 9/26/11 while working for Respondent. Petitioner was referred to Dr. Kevin Rutz by Respondent. Dr. Rutz ultimately performed 2 lumbar surgeries upon Petitioner, namely, on 12/7/12 an L5-S1 microdiscectomy and on 10/16/13 an L5-S1 revision and fusion caused from a recurrent herniated disc. (PX.1, pp. 11-12; 21-22). Petitioner was returned to light duty by Dr. Rutz on or about 1/7/14. Petitioner indicates that the light duty offered and accepted was sifting through bullets.

Petitioner underwent a Functional Capacity Evaluation on 3/3/14 at Apex Physical Therapy. It was the evaluator's opinion that Petitioner could lift and handle 40 lbs. occasionally, 25 lbs. frequently, pushing 80 lbs. and pulling 78 lbs. (PX.2, p.1-2).

Petitioner was seen by Dr. Rutz on 3/11/14 and at that time permanent restrictions were placed upon Petitioner of lifting up to 40 lbs., regular lifting up to 25 lbs. and being allowed to change positions as needed. Dr. Rutz opined at that time that Petitioner was at MMI. (PX.1, p.29).

Shortly after 3/11/14, Petitioner was offered the job of a B Operator for Respondent. Petitioner performed the job duties of a B Operator for approximately 2 weeks but was unable to tolerate the physical requirements. Petitioner testified that the constant bending over with arms fully extended while shaking loaded plates coupled with his repeated banging of the plates on a bin to disengage stuck bullets caused him a significant increase in his low back complaints. At that time, Petitioner was taken back off of work and his TTD benefits were reinstated.

In early June, 2014, Petitioner was once again offered the job of a B Operator. Upon returning to the job of a B Operator, on 6/11/14 Petitioner had a significant increase in his low back pain. Petitioner testified that the activity that caused this increased back pain was his bending over with arms outstretched for significant periods of time shaking and banging on plates. On 6/11/14, Petitioner was taken by ambulance to Alton Memorial Hospital. The Alton Memorial Hospital record notes that Plaintiff injured his low back shaking a plate up and felt a sharp pain and pop in his back. (PX.3, p.3). Dr. Rutz's notes of 7/1/14 indicate that Petitioner informed him that the B Operator job does activities which require repetitive bending at the waist as well as one activity where he has to hold a 10 lb. plate and scoop it into a bin and shake it around with his arms outstretched. (PX.1, p.31). After the incident of 6/11/14, Petitioner was taken back off of work and his TTD was reinstated. At the office visit of 7/1/14, Dr. Rutz placed additional permanent restrictions upon Petitioner of no repetitive bending at the waist and no repetitive working with arms outstretched. (PX.1, p.31).

Petitioner was seen by Dr. Russell Cantrell, a physiatrist, on 4/21/14 at the request of Respondent. Dr. Cantrell reviewed a video purportedly demonstrating the job duties of a B Operator in formulating his opinions. Dr. Cantrell agreed with the limitations placed upon Petitioner by his treating surgeon, Dr. Rutz, however, Dr. Cantrell did not believe that the additional restriction of limited reaching was necessary. It is noted that in Dr. Cantrell's report he nowhere indicated that he believed Petitioner could return to the B Operator job and Petitioner's attorney raised a 48-hour objection at the time of the deposition of Dr. Cantrell regarding such testimony. (RX.1, pp.8&14). Petitioner informed Dr. Cantrell that one of the activities that caused him significant discomfort was being in a forward bent position for a prolonged period of time lifting and shaking the loaded plates. Dr. Cantrell acknowledges that this activity was not depicted in the video and he would have preferred to have seen this on the DVD. (RX.1, pp.14-15). Upon exam, Dr. Cantrell noted Petitioner to be limited in lumbar flexion and extension by 50 percent with Dr. Cantrell further opining that Petitioner was not malingering at the exam. (RX.1, pp.16-

18). Dr. Cantrell agreed with Dr. Rutz regarding the restrictions of no repetitive bending activities. (RX.1, p.21). Dr. Cantrell acknowledges that if the B Operator job requires repetitive bending then Petitioner cannot perform that job. (RX.1, p.23). Upon Dr. Cantrell's review of the DVD at his deposition he agreed that said DVD only shows the hands and arms of the worker filling the plates with bullets and it does not show the body or posture. (RX.1, pp.24-25). At the 4 minute 50 second segment of the DVD it showed an employee fluxing the bullets using a bottle and spraying the bullets with the flux material. Dr. Cantrell testified that if that portion of the DVD is not how the job is performed that could surely cause him to change his opinions in this case. (RX.1, pp.31-32). Dr. Cantrell stated that the reason that he does not agree with Dr. Rutz's permanent restriction of limited reaching is because the Functional Capacity Evaluation indicates that the B Operator is unrestricted in reaching for nonmaterial handling of objects. Dr. Cantrell acknowledges that the Functional Capacity Evaluation does not indicate that B Operator position is unrestricted in reaching while handling materials. (RX.1, pp.35-37). Dr. Cantrell acknowledges that nowhere in the DVD did it show the worker repeatedly shaking the loaded trays. (RX.1, p.39). Nowhere in Dr. Cantrell's report did he opine what pushing or pulling restrictions Petitioner was limited to.

Petitioner testified in detail regarding the job requirements of bending over with arms outstretched for prolonged periods shaking the bullet trays. Petitioner testified that the fully loaded tray weighs approximately 15 lbs. and that he was required to bend forward performing this activity for a significant portion of his shifts. Petitioner testified that that particular job duty of the B Operator was not shown on the DVD reviewed by Dr. Cantrell. Petitioner testified that the DVD does not show how deep the bins are and as the bin materials are used and lowered this caused Petitioner to bend over further and further. Petitioner testified that the DVD reviewed by Dr. Cantrell does not accurately reflect the worker fluxing the plates in that he was required to flux the plates by placing them in a spring loaded flux machine and repeatedly press down on the plate. Petitioner testified that nowhere in the DVD reviewed by Dr. Cantrell did it show the shell jackets getting stuck in the plates which required him to bang the plates repeatedly on the side of the bin. At the end of the DVD it shows a lady bending over at approximately 90 degrees to dump a full tray of bullets into a container. Petitioner testified that he is required to perform this activity over 100 times per shift, that this activity causes him great pain and that he had complained to his supervisor and foreman on prior occasions about this increasing his discomfort. Petitioner testified that the DVD did not show the worker using a larger handheld forklift which he testified requires great effort in turning, pushing and pulling the forklift.

Upon receipt of the report from Dr. Cantrell, Respondent then requested that Petitioner return to work as a B Operator effective 8/14/14. Petitioner testified that he was planning on returning to the job as a B Operator effective 8/14/14, however, on 8/9/14 Petitioner fell at his home breaking his left middle finger. Petitioner testified that his back gave out causing him to fall on his outstretched left hand. Petitioner was seen by his primary care physician, Dr. Adesara on 8/11/14 and the history given was "last Saturday his back gave up on him and he fell down and landed on hyper extended fingers on left hand". (PX.4, p.10). On 8/11/14, Petitioner was taken off of work by Dr. Adesara due to his broken finger. Petitioner returned to Dr. Adesara on 9/17/14 upon recovering from his broken finger and he was released on that date to return to work. (PX.4, p.14).

Petitioner reported for work on the midnight shift on 9/18/14 to once again attempt to perform the job of a B Operator. A few hours into Petitioner's shift he was pushing and/or pulling a cart containing 40 loaded plates weighing approximately 10 to 15 lbs. a piece when he reinjured his low back. Petitioner testified that he approximates the weight of this loaded cart to total approximately 500 lbs. Petitioner testified that he was unassisted in attempting to move the cart a distance of approximately 100 feet. Petitioner was unable to push or pull this cart because this caused him a significant increase in his low back pain. Petitioner testified that the first two times he attempted to perform the job of a B Operator he was able to push and/or pull the cart, however, on these prior occasions the cart would be loaded with only 15 to 25 loaded plates. The evening of 9/18/14 Petitioner was attempting to push and/or pull the cart containing 40 loaded plates as Respondent had recently upped the production in that department.

Upon Petitioner experiencing a significant increase in his low back pain on 9/18/14, he went to his foreman, Mr. Brian Huff wherein Petitioner voiced his complaints. Brian Huff then went to the loaded cart with Petitioner acknowledging that there were indeed 40 loaded plates on the cart. Brian Huff then told Petitioner that he does not know why Respondent keeps sending injured employees to work as a B Operator and that a few weeks prior an injured employee had reinjured himself while attempting to push the loaded carts.

On 9/18/14, Respondent called 911 in-house medical who then arrived to consult with Petitioner. A nurse then administered to Petitioner a drug test and breath test, both of which Petitioner passed. Ultimately, Petitioner spoke to the human resources of Respondent and was informed that he should apply for long term disability for which

Petitioner has done. Petitioner was seen by Dr. Adesara on 9/22/14 and at that time was taken off of work. (RX.4, p.15).

Petitioner was seen by Dr. Andrew Wayne, a physiatrist, on 7/29/14. Dr. Wayne saw Petitioner on only this one occasion and he opined that he agreed with Dr. Rutz's restrictions of no lifting over 40 lbs. occasionally, no lifting over 25 lbs. frequently and periodically alternating between sitting and standing. However, Dr. Wayne did not agree with Dr. Rutz's restriction of no working with outstretched reaching and no repetitive bending. (RX.6). It is noted that nowhere in Dr. Wayne's report did he address the weight Petitioner was able to push or pull.

Petitioner testified that he does not believe he is capable of performing all of the job duties of a B Operator on a permanent basis. Petitioner testified that he is unable to push the loaded cart which weighs approximately 500 lbs. and that he is not able to repetitively bend at the waist to lift, shake and bang the plates. Petitioner testified that he believes that he made a good faith effort to perform the B Operator job duties on 3 separate occasions and that he is desirous of returning to work in some capacity. Petitioner testified that he is willing to return to work for Respondent if they offer him a job within Dr. Rutz's restrictions. Petitioner testified that he has worked his entire adult life before injuring his low back. Petitioner has received no compensation since 9/18/14 from either workers' compensation or long term disability and that currently he is not able to support his children. Petitioner testified that he is desirous of being vocationally retrained to be able to find a job within his surgeon's restrictions such as working on computers or in pharmaceuticals.

Petitioner reviewed a second DVD purportedly demonstrating the job duties of the B Operator job dated 7/23/14. Petitioner testified that the second job video does not accurately reflect the B Operator job duties in that it does not show the worker's posture, does not show the worker pushing and/or pulling a 500 lb. loaded cart or the worker being required to use the heavy forklift.

John Dearing testified at the request of Petitioner. Mr. Dearing has worked at Olin for 5 ½ years and previously sustained a neck injury for which he was treated by Dr. Rutz at the referral of Respondent. Mr. Dearing ultimately underwent two cervical surgeries at the hands of Dr. Rutz. In January of 2014, Dr. Rutz released Mr. Dearing at MMI with permanent restrictions of no lifting over 20 lbs. and no overhead lifting. Respondent then offered Mr. Dearing a job in the B Operator department alleging that said job was within Dr. Rutz's restrictions. Mr. Dearing attempted to perform this B Operator job on 7/30/14 and was

unable to complete his shift because of significant increased neck pain caused from bending over, repetitively shaking and banging on the loaded plates. Mr. Dearing confirmed Petitioner's assertion that he was also required to push the loaded cart which weighed in excess of 500 lbs. a distance of approximately 100 feet. Mr. Dearing testified that he was unable to perform this activity. Mr. Dearing was then informed by his foreman that he was to return the next day to Olin medical which he did. On 7/31/14, Petitioner was informed by Respondent's medical department that he was to return to work as a B Operator, however, Mr. Dearing was not able to perform the activities required. Currently, Mr. Dearing testified that he is taking physical therapy and his workers' compensation benefits have been reinstated.

Mr. Dearing viewed the 6 minute DVD purportedly demonstrating the job requirements of the B Operator. Mr. Dearing testified that the video was not accurate and complete in that it does not show the worker scooping the bullets, holding the loaded plates out in front of him with outstretched arms shaking them back and forth and side to side and did not accurately reflect the worker fluxing the bullets. Mr. Dearing testified that he had never met Petitioner until the date of this hearing.

Respondent called Robert Sitze to testify. Mr. Sitze has worked for Respondent for 37 years and for the prior one year has worked as a general foreman. Mr. Sitze testified that he has knowledge of the job duties required of a B Operator. Mr. Sitze acknowledged that if Petitioner is bound by all restrictions of Dr. Rutz, including the restriction of no repetitive bending and no repetitive working with arms outstretched, Petitioner would be unable to perform the B Operator job. Mr. Sitze further acknowledged that in the event Petitioner is limited to pushing and/or pulling no more than 80 lbs. he would be incapable of performing the B Operator job duties.

THEREFORE THE ARBITRATOR CONCLUDES AS FOLLOWS:

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

It is clear that Petitioner's current condition of ill-being is causally related to his injuries in that Petitioner's treating surgeon, Dr. Kevin Rutz, has placed significant permanent restrictions upon him due to his persistent lumbar complaints.

L. What temporary total disability benefits are in dispute?

Respondent shall pay Petitioner temporary total disability benefits of $725.89 per week for 9 weeks, commencing 8/14/14 through 10/15/14, as provided in Section 8(b) of the Act

The Arbitrator adopts the restrictions placed upon the Petitioner by his treating surgeon, Dr. Kevin Rutz, of lifting up to 40 lbs., regular lifting up to 25 lbs., being allowed to change positions as needed, no repetitive bending at the waist and no repetitive working with arms outstretched. It is noted that Dr. Rutz has seen, treated and operated on Petitioner on 20 separate occasions. Dr. Rutz clearly has a better understanding of Petitioner's limitations than does Dr. Cantrell and Dr. Wayne.

The opinions of Dr. Russell Cantrell with reference to Petitioner's need for current restrictions are not supported by the evidence. Dr. Cantrell heavily relied upon his review of the DVD in formulating his opinions with reference to Petitioner's restrictions. Clearly, the DVD which Dr. Cantrell viewed does not accurately reflect the job duties of a B Operator.

With reference to Dr. Wayne, he saw Petitioner on only one occasion and did not address Petitioner's restrictions in regards to pushing or pulling.

The evidence reflects that on 9/18/14 Petitioner was required to push a loaded cart weighing approximately 500 lbs. a distance of approximately 100 feet. The evaluator who performed the Functional Capacity Evaluation of Petitioner found Petitioner to be capable of pushing 80 lbs. and pulling 78 lbs. Clearly it is unreasonable to expect that Petitioner was able to push or pull the 500 lb. cart on 9/18/14.

Regarding Petitioner's fall of 8/9/14, resulting in Petitioner's broken finger, said fall was caused from Petitioner's lower back giving out on him as is evidenced by the Dr. Adesara note of 8/11/14. Notwithstanding, if Petitioner was unable to perform his work duties as a B Operator on 9/18/14 he would have still been unable to perform the B Operator job duties if he had reported to work on 8/14/14.

O. Is Petitioner entitled to vocational rehabilitation?

Respondent shall pay for a vocational rehabilitation evaluation of the employee and maintenance costs.

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

Laurie Rohde,

Petitioner,

vs. NO: 12 WC 17794

Chicago Public Schools,

Respondent,

15IWCC0868

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) of the Act having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical, notice and temporary total disability and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below.

The Commission finds that Petitioner failed to prove that she sustained accidental injuries on September 27, 2011.

The Petitioner testified that she first was employed by the Respondent as a School Clerk I. She started working for Respondent in 1991 and prior to August of 2011, her job duties were attendance, truancy, parent phone calls, and behavior problems and taking care of students when they were sick. She testified that she sat a lot during that time. (Transcript Pgs. 4-11)

When she returned after the summer of 2011, she received job duties including lunch and recess. This was to begin in August of 2011. She testified that she had to do those duties 2 1/4 hours a day. She was to supervise students by circulating in the area. She was to prohibit them from arm wrestling and to supervise them in their soccer and football games. She was also assigned to take the students from lunch to recess in an orderly fashion. She testified that she mostly walked during this period but also did a little bit of standing. (Transcript Pgs. 14-19)

She testified that after the first few days of doing this job her right knee was sore from the extra walking. It got progressively worse day by day and she elevated it and iced it at home. She also took Ibuprofen. (Transcript Pgs. 24-26) On September 27, 2011 she was sitting in her office between 7:30-8 am when she "got up from my chair, and my knee gave out. I grabbed the counter, so thankfully I did not fall down." (Transcript Pgs. 26-27)

The Commission finds that Petitioner's right knee giving out was not an accident arising out of the scope and course of her employment, but was a personal risk.

She testified that she saw Dr. Bresch on October 13, 2011 and told him that she thought the excessive walking and standing were harming her right knee. (Transcript Pgs. 59-62)

A careful reading of the record indicates that the Petitioner was being less then truthful in regards to her complaints and history.

She did testify to a partial knee replacement with Dr. Bresch in 2002 after arthroscopies in 1996. She also had a fall to on her right knee in 2009. (Transcript Pgs.12-14) However, at no time, per Dr. Bresch's notes, did she tell him on October 13, 2011 that she thought the "excessive" standing and walking at work was the cause of her problems. On that date, he received a history of an onset of right knee pain for the past three weeks and has had pain getting out of a chair and states that her right knee gave out. She is concerned with her right knee replacement. Nothing is mentioned regarding her alleged "excessive" walking and standing at work. There was no mention to Dr. Bresch of her pain being caused by excessive walking or standing when he saw her again on November 14, 2011. (Petitioner Exhibit 3)

In his deposition, Dr. Bresch insisted that Petitioner told him that she fell down when her leg gave out although Petitioner definitely testified that she did not fall. (Petitioner Exhibit 5 Pg. 10-11) He also made it clear that Petitioner did not advise him of any excessive walking or standing at work on October 13, 2011, November 14, 2011, or December 15, 2011. (Petitioner Exhibit 5 Pgs. 35-36)

Petitioner was sent to see Dr. Brian Cole, a reputable orthopedic surgeon, for an IME on behalf of the Respondent. Petitioner, at first, "adamantly" denied any previous problem with her right knee prior to August 2011. Dr. Cole found that Petitioner "had pre-existing arthritis that was addressed with a unicompartmental arthroplasty deemed not work related, and now has a repeat manifestation of symptoms also unrelated to an injury in the work place."

Mary T. Weaver, the principal at Scammon Elementary, testified that Petitioner was assigned to watch the kids in the lunchroom for 20 minutes and watch the kids at recess for 20 minutes. These duties required standing for 40 minutes. (Transcript Pgs. 69-70)

The Commission finds that Petitioner's testimony regarding her alleged repetitive trauma due to excessive walking and standing is not credible.

The Commission also finds that, even if one were to believe Petitioner's recitation of the facts, the alleged excessive walking she did for the Respondent did not play any role in the

15IWCC0868

eventual need for surgery. The Commission finds that the amount of walking Petitioner had to do for the Respondent was not in any way excessive and did not aggravate or cause her pre-existing arthritis in her right knee.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Petitioner has failed to prove that she sustained accidental injuries arising out of the scope and within the course of her employment on September 27, 2011.

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: NOV 2 4 2015

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

HSF
O: 10/27/15
049

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

ROHDE, LAURIE
Employee/Petitioner

Case# 12WC017794

15IWCC0868

CHICAGO PUBLIC SCHOOLS
Employer/Respondent

On 9/29/2014, 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 0.04% 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:

2652 LAW OFFICE OF MARTIN L GLINK
MICHAEL ROTHMANN
1655 ARLINGTON HTS RD #100E
ARLINGTON HTS, IL 60004

0559 CHICAGO BOARD OF EDUCATION
EUGENE SMITH ESQ
125 S CLARK ST SUITE 700
CHICAGO, IL 60603

15IWCC0868

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)

Case # 12 WC 17794

Consolidated cases: _____

Laurie Rohde
Employee/Petitioner

v.

Chicago Public Schools
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 **8/13/14**. 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. [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 [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, **9/27/11**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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 $**52,000**; the average weekly wage was $**1,000.00**.

On the date of accident, Petitioner was **54** 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 $ for TTD, $ for TPD, $ for maintenance, and $**5877.08** for other benefits, for a total credit of $**5877.08**.

Respondent is entitled to a credit of $ under Section 8(j) of the Act. ARB EX 1.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $666.67/week for 139 2/7 weeks, commencing 12/13/11 through 8/13/14, as provided in Section 8(b) of the Act. Respondent shall receive credit for amounts paid.

Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred in the care and treatment of her causally related condition pursuant to Sections 8 and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid including credit under Section 8(j) of the Act. Respondent shall hold petitioner harmless from any claims by any providers of the services or insurers for which Respondent is receiving this credit.

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

9/26/14
Date

ICArbDec19(b)

SEP 29 2014

STATEMENT OF FACTS

At trial, Petitioner testified that she began working for Respondent in 1996 at Scammon Elementary School. Between 1996 and the school year beginning 8/25/11, Petitioner worked as a school clerk. As a school clerk, Petitioner's duties were those of an office attendant. Petitioner testified that as a school clerk she was not required to perform excessive walking and that her job was considered sedentary as most of her duties were performed while she was seated. Between 1996 and August 2011, Petitioner was never assigned any lunch or recess duties and was never hired as a teacher's assistant. Prior to August 2011, Petitioner was able to perform her sedentary school clerk duties and her activities of daily living.

Petitioner's medical records reveal that Petitioner underwent a right knee arthroscopy with partial lateral meniscectomy, chondroplasty lateral compartment and open excision of meniscal cyst in 1998 with Dr. Bresch. The pre and post operative diagnosis was degenerative tear of the lateral meniscus, lateral compartment chondromalacia and miniscal cyst. PX 3A. Petitioner continued to have right knee pain thereafter and on 12/18/01, Dr. Bresch, performed a hemiarthroplasty lateral right knee and right knee arthroscopy with excision of the lateral meniscus. PX 3A. Petitioner did very well after the 2001 surgery. She returned to Dr. Bresch with complaints to the anterior and lateral aspects of the right knee in February 2004 after squatting and lifting. Petitioner returned to Dr. Bresch in January 2010 with complaints of knee discomfort after a fall at work in November 2009. No acute injury was noted and Petitioner was advised to continue home exercises for stability and strengthening. PX 3A. Her right knee was stable and she was able to perform her activities of daily living and work, including the regular walking and standing, through August 25, 2011.

Petitioner testified that upon her return to the school year starting on August 25, 2011, her duties were changed. Petitioner was now classified as a teacher's assistant and was assigned to supervision of children during lunch/recess duty. Supervision included: "teachers to be attentive to students, circulate the area, supervise recess activities, prohibit arm wrestling, supervise soccer/football activity and monitor transition of students to the lunchroom/outdoors/gym area... Sitting at tables and leaning against support walls are prohibited as it interferes with effective supervision of students." P.Ex. 8. PX 6A indicates that a teacher's assistant position is considered light work when it "requires walking or standing to a significant degree or when it requires sitting most of the time but entails pushing or pulling of arm controls." Petitioner testified that her lunch/recess duty involved supervising 100 children per period during lunch and recess for 6 periods in a row per day, 30 periods per week, or 11.25 hours per week which is 2.25 hours per day. She further testified that her lunch and recess duty required constant walking standing, and circulating without a break, and walking back and forth from the annex school building to the cafeteria which were on opposite sides of the school a distance of approximately one block. These duties were not included in Petitioner's prior job as an office clerk. Other than the 2.25 hours per day Petitioner was to act as a teacher's assistant performing the foregoing duties, she spent the remainder of her work day on her regular office clerk duties. PX 7.

Petitioner testified that shortly after she began performing her lunch/recess duties her right knee became painful and that her right knee pain worsened subsequent to August 25, 2011. She testified that she elevated her knee and used ice at home for pain control. On September 26, 2011 she performed her lunch/recess duty and had increased right knee pain and swelling. Petitioner testified that on September 27, 2011, her knee was swollen and painful. Petitioner

testified that on 9/27/11 at approximately 7:30 am, she was at the school's main office and as she got up out of a chair her right knee gave out. She was unable to place any weight on her right knee. Petitioner's alleged date of accident in this matter is September 27, 2011. Petitioner alleges that the increased walking required in her newly assigned duties caused increased problems for her right knee.

Petitioner testified that she advised Amanda Lukic, the assistant principal, that her right knee had given out and that the reason it gave out was because of the lunch/recess duties and extra walking she was required to do. That day, Petitioner was excused from lunch/recess duty and left work early. Her right knee was extremely swollen as demonstrated in a photograph. P.Ex. 9. Petitioner did not complete an accident report at work at any time.

Petitioner stayed home the next day because of knee pain and returned on September 29, 2011. She met Principal Weaver in the main office and told her that the lunch/recess duty and extra walking and standing were causing right knee pain. Petitioner testified that she further told Principal Weaver about her knee giving out on 9/27/11. Petitioner asked to be taken off her lunch and recess duties while her knee healed but was told she had to report to her lunch and recess duties on 9/29/11 by Principal Weaver. Petitioner testified that she further complained to assistant principal Angela Burgos on 9/29/11 stating that she had to stop the extra duties due to her increased knee pain. Petitioner testified that she was not assisted by Ms. Burgos.

Petitioner testified that from October 3, 2011 to October 14, 2011, she was off work for Fall break, icing her knee and taking medication while at home. On October 13, 2011 she saw Dr. Bresch for her right knee pain and he recommended home exercise and Naprosyn. Petitioner returned to full duty work on October 14, 2011, but the knee pain worsened. On October 28, 2011, Dr. Bresch provided a note stating she should no longer do lunch/recess duty. P.Ex. 14. Petitioner presented the note to Principal Weaver who required more detailed restrictions. On October 30, 2011 Petitioner obtained another note, backdated to October 13, 2011 from Dr. Bresch, which provided restrictions of no running, squatting, kneeling, stair climbing, prolonged standing or walking until further notice. P.Ex. 15. Petitioner provided this note to Principal Weaver. On October 31, 2011 Principal Weaver wrote Petitioner a note "Re: Doctor's Note Received from Laurie Rhode: As we discussed earlier today, you are to continue to perform lunch and recess duty currently assigned. If you believe that you suffer from a condition that prohibits you from performing these functions you need to contact the Chicago Public School ADA administrator and inform them of your medical condition." P.Ex. 11. Petitioner continued to perform her full duties including lunch/recess duty. In October 2011, Principal Weaver provided Petitioner a chair to assist her in her duties. Petitioner testified that she was unable to use the chair and perform her required lunch/recess duties because Petitioner had to continuously walk, stand and circulate and supervise sports for the 100 children per period.

On November 14, 2011 Dr. Bresch provided her with light duty restrictions of no standing or walking for extended periods of time, no running, jumping, kneeling, squatting, stairs and limited bending. She provided this note to Principal Weaver. Petitioner testified that the restrictions were not accommodated. In fact, Petitioner testified that as of November 16, 2011, her duties were increased to include walking the length of the school building six times per day to bring the kids back and forth between lunch and recess. Petitioner continued to perform her daily duties

and on December 13, 2011 she advised Principal Weaver she was taking one week off prior to Winter Break to give her knee extra time to recover.

Principal Mary Weaver testified for Respondent. Principal Weaver testified that Petitioner was assigned the lunch and recess duties in August 2011. She further agreed that the duties required Petitioner to walk and stand during the lunch and recess periods for a total of 2.25 hours per day.

Principal Weaver testified that she was not told on 9/29/11 that Petitioner had a problem standing at school 2 days earlier and that she never received a written report of accident. Principal Weaver testified that Petitioner told her in October 2011 that her extra duties were causing her knee problems and that she advised Petitioner that she needed a doctor's note indicating that her duties caused her knee problems. She further agreed that she told Petitioner to inform the school ADA Administrator of her condition in order to be placed on disability and that when she advised Petitioner to contact ADA she did not know Petitioner was claiming a work related accident. However, on cross exam, the witness agreed that Petitioner told her that the lunch and recess duties were negatively affecting her right knee. She further agreed that the written job requirements require the employee to walk and stand for extended periods of time in the process of circulating the area to supervise students adequately and that the employee was not to lean or sit. However, she testified that these requirements did not apply to Petitioner and that Petitioner was given a chair to use while supervising.

On December 15, 2011 Dr. Bresch provided Petitioner with a steroid injection. On January 9, 2012 he gave her a note authorizing her to be off work from December 13, 2011 to December 16, 2011, and has continued to keep her off work since that time. On January 13, 2012 he performed a right knee arthroscopy for a partial medial meniscectomy and debridement of adhesions for a medial meniscal tear. On January 30, 2012 he kept her off work with restrictions of no repetitive standing, walking, squatting, lunges or stairs. On February 27, 2012 he performed another steroid injection and kept her off work. Since April 5, 2012 to present his restrictions include no repetitive stairs, standing, sitting or walking. PX 3A. He has not released these restrictions nor has Respondent accommodated them. Petitioner is still employed by Respondent and has been receiving non-occupational disability. ARB EX 1.

Dr. Bresch testified via evidence deposition. PX 5. Dr. Bresch testified that he has been treating Petitioner since 1996 "for an ongoing knee condition. It started with an articular cartilage problem and eventually resulted in arthritic degradation of the lateral compartment. She underwent a hemiarthroplasty in 2002." PX 5, p. 7. He further testified that he began treating Petitioner in 1996 for "an injury that resulted in articular cartilage damage of the lateral femoral condyle. At that point in time, the medical meniscus was pristine. So at that point in time, in '02, all of her issues were isolated to that lateral compartment." PX 5, p. 31. Following the surgery in 2002, Dr. Bresch advised Petitioner to avoid high impact and repetitive activities. He testified "... for instance, they can walk as much as they want, but we would discourage them from anything high impact." PX 5, p. 33. Dr. Bresch saw Petitioner in January 2010 for complaints of pain following a fall at work. Petitioner was diagnosed with a strain and told to take it easy. The instrumentation was found in tact and the examination was normal. PX 5, p. 32.

Dr. Bresch first saw Petitioner for her current complaints on October 13, 2011. On that date, Petitioner stated "she had been doing typically reasonably well following her arthroplasty and approximately three weeks prior to her visit on October 13th, she had abrupt onset of right knee pain for approximately three weeks after she had a misstep and fell getting out of a chair." PX 5, p. 9. He noted that her knee gave out. PX 5, p. 11. Again, her exam was within normal limits with excellent range of motion, some effusion or swelling, no incisional irregularities or tenderness, no ligament instability and no increased warmth or erythema to the knee. X-rays showed no evidence of any derangement of our implants and no change in bone density. PX 5, p. 10. He suggested a knee strain and prescribed home exercises and time to settle the inflammation. PX 5, p. 10. He did not impose any mechanical restrictions but advised Petitioner to do what she could tolerate. PX 5, p. 12. His work status report of 10/13/11 indicates, "no prolonged standing or walking until further notice." PX 5, p. 12. Dr. Bresch authored a subsequent note on 10/28/11 indicating "please excuse Ms. Rohde from lunch and recess duty." He testified that the note was provided because those activities were bothering Petitioner due to the "prolonged standing and walking and getting up and about." PX 5, p. 13.

He next saw Petitioner on 11/14/11. At that time, Petitioner had similar complaints and pain over the medial aspect of her knee. She didn't trust her knee and continued to have pain with prolonged activities. He testified, "at that point in time, a majority of her symptoms were more localized to the medial compartment, which is, obviously, the opposite side of the lateral compartment which had been operated on in the past. It was our feeling that more likely than not, she had degenerative changes or breakdown of her medial meniscus. At that point in time, we tried to unload that medial compartment. We placed her into a playmaker brace to try to give her external support and comfort to the knee... we also suggested that she refrain from – again the standing and prolonged walking for extended periods of time. We also suggested that she refrain from, obviously, running, jumping, kneeling, performing squats and minimizing stairs." PX 5, p. 14. He again provided a light duty restriction including no standing or walking for extended periods. PX 5, p. 14.

On December 15, 2011, he tried a cortisone injection to settle the knee down and avoid surgery. On January 9, 2012, he issued a work excuse slip for the dates of 12/13 to 12/16/11 as right knee arthroscopy was scheduled for 1/13/12. On 1/13/12, Dr. Bresch performed arthroscopy finding irregularity of the medial meniscus and the tissue was debrided back to stable edge. He also found adhesive and fibrotic changes to the lateral compartment and debrided those areas to help mobility. PX 5, p. 16. On 1/30/12, he prescribed PT and her restrictions for light duty remained the same. PX 5, p. 17. Dr. Bresch's PA drafted a letter dated 2/2/12 indicating that Petitioner was status post right knee arthroscopy partial medial meniscectomy debridement. She wrote, "the meniscus damage seen intraoperatively was likely due to a walking injury and was therefore associated with her work activities. She is presently weight bearing as tolerated and is still recovering from her surgery." PX 5, 17-18. Dr. Bresch testified that he was of the same opinion that her current knee condition was related to her walking at work. PX 5, p. 18-21.

Dr. Bresch continued Petitioner under the same restrictions while conservatively treating Petitioner during follow up visits through 2012, including a disability certificate dated 11/2/12 continuing his prior restrictions. PX 5, p. 25. On May 17, 2013, Dr. Bresch noted that the

11/2/12 restrictions were likely going to be permanent due to continued tenderness around the right pes bursa and patellar tendon. PX 5, p. 24-26.

On October 1, 2013, Dr. Bresch completed a Certificate of Health Care Provider for Employee with Serious Health Condition again indicating restrictions of no stairs, no standing, no sitting, no squatting and no walking for extended periods of time. PX 5, p. 27. He testified that those restrictions are permanent. He testified that Petitioner will likely need a total knee arthroplasty in the future and the need for this surgery was caused or contributed to by the September 2011 injury. PX 5, p. 28.

On cross exam, Dr. Bresch testified that Petitioner did not indicate excessive walking as a cause of her injury but did indicate that such activity caused her pain. PX 5, p. 35-36. When asked what caused Petitioner's medial meniscus to tear, Dr. Bresch testified "probably the gradual breakdown of the medial meniscus due to her altered gait, excessive walking, other activities. Unfortunately, what occurs is that the meniscus undergoes this maceration and changes, that just one little event like getting out of the chair as she reports, that unfortunately, causes that abnormal tissue to displace, and then once it's displaced, then we have this downward spiral that we have witnessed." Dr. Bresch was asked "And that could happen without a traumatic onset; that could be as you have indicated, it could be a gradual deterioration or accumulation of the reduction in the meniscus or the increase in the tear?" Dr. Bresch answered, "Yes." PX 5, p. 38-39. Further, when asked if the increased walking indicated as the cause of her problem in the February 2012 report written by his PA could be "walking to the car to drive to work, to walk to the job" he answered, "all walking counts." PX 5, p. 40. On redirect, Dr. Bresch testified that if Petitioner had excessive walking as part of her job duties that was a contributing factor of her right knee meniscal tear, the surgery, and the need for continued restrictions. PX 5, p. 44.

Dr. Cole performed a Section 12 exam of Petitioner on 6/27/13. RX 4. He examined her and reviewed Dr. Bresch's records. Dr. Cole noted that Petitioner advised that on 9/27/11, she was "simply walking up stairs when she began to have pain thereafter. She descries that she may have been sitting too long, or standing when she first noticed the pain as well." Dr. Cole determined that Petitioner sustained no "discrete injury" on 9/27/11. His report contains no mention of prolonged walking or standing in connection with Petitioner's work duties at any time. Dr. Cole opined that Petitioner's knee condition was not work related because she did not suffer any injury at work. He provided no opinion as to whether her constant walking and standing and lunch/recess duties could have aggravated or contributed to her right knee condition. He provided no opinion as to whether her knee could have been aggravated by her being required to continue to perform lunch/recess duty after the knee gave out on September 27, 2011. Despite his objective findings of contractures and tenderness and his belief she will likely need full knee replacement in the future, he opined she could return back to work full duty without restrictions.

CONCLUSIONS OF LAW

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

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (C) DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT, AND (F) WHETHER PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS:

Based on the credible testimony of the Petitioner and on the record in its entirety, the Arbitrator finds that Petitioner suffered an accident in the form of repetitive and cumulative trauma to her right knee arising out of and in the course of Petitioner's employment by Respondent and manifesting on 9/27/11.

The record clearly indicates that the 54 year old Petitioner worked for Respondent in a sedentary capacity as a school clerk from 1996 through August 24, 2011. Petitioner underwent extensive right knee surgeries during this time in 1998 and 2002. She attended minimal follow up care between 2003 and 2011 and testified that she was able to continue working in her clerk position for Respondent without difficulty as well as perform her activities of daily living following each of these surgeries. Her last visit to Dr. Bresch before this accident was in January 2010 where she was examined for minimal complaints and given no treatment.

It is undisputed that with the start of the new school year in 2011, Petitioner was given new duties. Petitioner's job was no longer exclusively sedentary. With the start of the 2011 school year as of August 25, 2011, Petitioner was required to perform lunch and recess duties which included student supervision during these time periods. It is undisputed that these duties were not required of Petitioner in her job as a clerk and that these new duties were in addition to her office work. It is further undisputed that Petitioner's new duties required physical exertion that Petitioner was not previously required of Petitioner. Specifically, Petitioner was required to stand and walk while supervising students during lunch periods and subsequently, in addition to standing and walking, was required to walk back and forth escorting the students to and from the lunch room and playground. Finally, it is undisputed that Petitioner's new physical requirements of prolonged standing and repeated walking culminated in 2.25 hours of this activity per day 5 days per week. The Arbitrator notes that the new duties were not optional but rather mandatory and imposed. Principal Weaver agreed.

The record further indicates that these new duties required Petitioner to constantly circulate, walk, stand, and supervise soccer/football during lunch/recess duty for 6 periods/day (30 period per week) or 11.25 hours per week. The rules prohibited her from sitting or seeking relief by leaning against walls for support. The 2.25 hours per day were consecutive hours without any break. P.Ex. 7a-c. Principal Weaver testified that the lunch/recess duties included repetitive walking and standing, that sitting was not permitted and that the aides were required to constantly circulate. The October 31, 2011 letter from Principal Weaver indicates that lunch and recess duty were essential functions of Petitioner's job.

Petitioner testified that shortly after she began performing her lunch/recess duties her right knee became painful and that her right knee pain worsened subsequent to August 25, 2011. She testified that she elevated her knee and used ice at home for pain control. On September 26,

2011 she performed her lunch/recess duty and had increased right knee pain and swelling. Petitioner testified that on September 27, 2011, her knee was swollen and painful. Petitioner testified that on 9/27/11 at approximately 7:30 am, she was at the school's main office and as she got up out of a chair her right knee gave out. She was unable to place any weight on her right knee. Petitioner's alleged date of accident in this matter is September 27, 2011. Petitioner alleges that the mandated repetitive standing and walking required to perform her newly assigned duties caused increased problems for her right knee manifesting in the breakdown of her knee on 9/27/11 and the corresponding need for treatment. The Arbitrator agrees and further notes that after Petitioner presented restrictions from her treating physician regarding her inability to walk or stand, Respondent reiterated the need for Petitioner to perform the required duties which included the escort of children between the lunchroom and playground 6 times per day over a distance of approximately one block in addition to standing and supervising the lunchroom. Petitioner continued working and attempted to comply with the requirements.

An injury "arises out of" one's employment if, at the time of the occurrence, the employee was performing acts she was instructed to perform by her employer, or acts which the employee might reasonably be expected to perform incident to her assigned duties. A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling her duties. *Sisbro, Inc. v. Industrial Comm'n,* 207 Ill.2d 193, 204, 797 N.E.2d 665 (2003), *citing Caterpillar Tractor Co. v. Industrial Comm'n,* 129 Ill.2d 52, 58, 541 N.E.2d 665 (1989). 'Arising out of' refers to the origin or cause of the accident and presuppose a causal connection between the employment and the accidental injury and in order for an injury to come within the Act it must have had its origin in some risk connected with, or incidental to, the employment, so that there is a causal connection between the employment and the injury. *Chmelik v. Vanna,* 31 Ill.2d 272. 201 N.E.2d 434 (1964). "In the course of the employment,' refers to time, place and circumstances under which the accident occurred, and it is stated generally that an accidental injury is received in the course of the employment when it occurs within the period of employment at a place where the employee may reasonably be in the performance of her duties, and while she is fulfilling those duties or engaged in something incidental thereto. Id.

In finding accident, the Arbitrator is cognizant of the fact that the general public walks. However, under the facts presented in this matter, the Arbitrator notes that the amount of standing, walking, constant circulation, supervision of soccer/baseball and quickly walking back and forth that Petitioner was required to do at work on a daily basis was in excess of what the general public does. While the general public walks and stands on a daily basis, they are not required to do so on a repetitive and continuous basis for 2.25 hours per day, 5 days per week. Under the facts of this case, the Arbitrator finds that Petitioner's job duties, newly imposed after having a sedentary position for a number of years, created a risk to her knee to which the general public is not exposed. The Arbitrator finds that the record supports the plausible conclusion that the physical structure of Petitioner's previously operated knee gave way as of 9/27/11 following Petitioner's compliance with her new mandatory duties.

Based on the foregoing, this Arbitrator finds that Petitioner sustained an accident arising out of and in the course of her employment for Respondent in the form of cumulative trauma to her right knee manifesting on 9/27/11.

With regard to the issue of causal connection, the Arbitrator adopts the foregoing analysis on the issue of accident and further finds that Petitioner's right knee condition and the need for its surgical repair is causally related to her accident of 9/27/11. In so finding, the Arbitrator notes that the newly imposed job duties clearly aggravated Petitioner's pre-existing right knee condition causing the need for the additional treatment rendered by Dr. Bresch. In preexisting condition cases, recovery depends on the employee's ability to show that a work-related injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition. *Sisbro,* 207 Ill.2d at 205; *Caterpillar Tractor,* 92 Ill.2d at 36–37, 440 N.E.2d 861 . The Arbitrator further notes that simply because the aggravation of a preexisting condition could have been caused by normal daily activity; that alone does not bar recovery. *Sisbro,* 207 Ill.2d at 212-13. If an accident which arose out of work aggravated or accelerated the preexisting condition, regardless if it could have been aggravated by normal daily activity, such an injury is compensable. Id. The Arbitrator further notes that Petitioner's increased duties were a causative factor in the acceleration of her condition as opined by Dr. Bresch.

Dr. Bresch testified that her lunch/recess duties were a causative factor of the knee giving out on September 27, 2011, in the worsening of her knee and his surgery that he performed on January 13, 2012. Dr. Bresch also opined that once the knee gave out on September 27, 2011 the lunch/recess duty and continuous walking and standing she was required to do, which was contrary to his restrictions, contributed to the tear and the surgery. Dr. Bresch explained that in 2002 she had isolated arthritis, which is why she only needed a partial replacement and he explained that there was no risk of greater progression of arthritis for the rest of the knee. P.Ex.5 at 34-35. While Dr. Cole, Respondent's IME, did not believe she suffered a work injury, he did not provide an opinion as to whether the lunch/recess duty and continuous/uninterrupted walking and standing 2.25 per day/5 days per week could have aggravated her right knee. Based on the evidence, this Arbitrator placed more weight on Dr. Bresch's opinions than Dr. Cole's.

The evidence indicates that Petitioner's preexisting right knee condition and partial right knee replacement was limited to the lateral femoral condyle while the injury at issue involved the medial meniscus, which Dr. Bresch described as being previously pristine. There is no indication that this was an arthritic condition which was getting worse on its own. Petitioner was able to perform her normal activities of daily living and her job duties prior to August 25, 2011. It was only have she began performing lunch/recess duty on August 25, 2011 up through September 27, 2011 when it finally gave out, that the right knee began to worsen and affect her ability to perform activities of daily living and work. Accordingly, the Arbitrator finds that Petitioner's current condition of her right knee is causally connected to her increased work duties for Respondent.

Finally, the Arbitrator notes that per her treating physician, Petitioner may need continued future treatment for her right knee in the form of a total knee replacement. The Arbitrator notes that no request for that treatment was made at trial and no request for a finding of causal connection for that recommended treatment was requested of the Arbitrator. Accordingly, no such finding was made by the Arbitrator in this Decision.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (E) WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO RESPONDENT, THE ARBITRATOR FINDS:

The Arbitrator finds that proper and timely notice of the accident was given to Respondent. In so finding, the Arbitrator notes that although no written accident report exists, Petitioner credibly testified that she advised several co-workers of her knee complaints due to the new work duties almost immediately after she started the duties. Furthermore, Petitioner credibly testified that she advised Principal Weaver of her complaints and her inability to perform the job functions at the latest by the end of October 2011. Petitioner continued to have increased knee pain thereafter, continued to advise Respondent and ask to be excused from lunch/recess duty based on the notes of Dr. Bresch. This Arbitrator finds Petitioner credible based on the corroborating testimony of Principal Weaver and Petitioner. Respondent's testimony that Petitioner never reported an "accident" is inconsistent with the evidence and Principal Weaver's admission.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (J) REASONABLENESS OR NECESSITY OF MEDICAL, SURGICAL OR HOSPITAL BILLS OR SERVICES, THE ARBITRATOR FINDS:

Based on the Arbitrator's findings on the issues of accident, notice and causal connection, the Arbitrator further finds that Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred in the care and treatment of her causally related injuries pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid, including credit under Section 8(j) of the Act. Respondent shall hold petitioner harmless from any claims by any providers of the services or insurers for which Respondent is receiving this credit.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (K) THE AMOUNT OF COMPENSATION DUE FOR TEMPORARY TOTAL DISABILITY, THE ARBITRATOR FINDS:

The Arbitrator notes that Petitioner proceeded to trial under Section 19(b) of the Act, seeking payment of temporary total disability. No request for a finding of nature and extent was made at trial and no such finding is made by the Arbitrator.

Based on the Arbitrator's findings on the issues of accident, notice and causal connection, the Arbitrator further finds that Petitioner was temporarily and totally disabled per her treating physician Dr. Bresch for the period of 139-2/7 weeks commencing 12/13/11 through 8/13/14. Petitioner was given restrictions against walking and standing and requested to be taken off the lunch and recess duties necessitated by the restrictions. The restrictions were not accommodated by Respondent. Respondent shall receive credit for amounts paid.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Patricia Jackson,

Petitioner,

vs. NO: 04 WC 01771

Illinois State Police,

Respondent.

15IWCC0827

DECISION AND OPINION ON REVIEW UNDER SECTIONS 19(h) AND 8(a)

Timely Petitions for Review under Sections 19(h) and 8(a) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of further permanency and further medical benefits and being advised of the facts and law, denies the section 19(h) petition and grants the 8(a) petition for the reasons set forth below.

On January 21, 2011 the Commission issued a Decision and Opinion on Review in this matter awarding certain chiropractic bills and permanent partial disability benefits corresponding to 35% of the person as a whole.

On May 22, 2013 Petitioner timely filed a 19(h) and 8(a) Petition which fails to specify the relief sought. The matter proceeded to a 19(h)/8(a) hearing on June 15, 2015 before the Honorable Ruth White. Testimony was taken from Petitioner and chiropractic bills were entered into evidence.

At hearing Petitioner testified that she is now retired from the Illinois State Police and is employed part-time as a home health care nurse. Petitioner continues to receive chiropractic care at three to four month intervals. She testified that she has sustained no further accidents or injuries since the arbitration hearing in 2009.

15IWCC0827

Petitioner testified that she gets pain in her lower back and hip which radiates to her right foot for which she receives chiropractic manipulation and home exercise programs. Petitioner has paid some bills out of pocket and the rest have been paid by group health insurance.

Petitioner testified that the complaints she has currently are the same as she had when she testified in 2009. The symptoms are not more severe, they are periodically recurrent. A report submitted by petitioner's treating chiropractor, Dr. Olson, established causal connection and the ongoing need for chiropractic care.

Respondent agrees to the payment of the ongoing chiropractic care pursuant to section 8(a) of the Act. It is clear from the record that there has been no significant change in Petitioner's condition that would warrant any adjustment in her permanent disability pursuant to section 19(h) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Petitioner's Petition pursuant to Section 19(h) of the Act is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the medical bills in Petitioner's Exhibit 2, Petitioner's Exhibit 3 and Petitioner's Exhibit 4 under Sections 8(a) and 8.2 of the Act. Respondent is entitled to a credit under Section 8(j) of the Act for the corresponding payments made by its group insurance carrier, provided that Respondent holds Petitioner harmless from any claims and demands by the carrier.

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

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

Pursuant to Section 19 (f)(1) of the Act there shall be no right of appeal as the State of Illinois is Respondent in this matter.

DATED: NOV 10 2015
o-9/10/15
SM/msb
44

Stephen Mathis

Mario Basurto

David L. Hane

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

- ☐ 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

Keith Embrey,

Petitioner,

vs. No: 04 WC 49334

City of Calumet,

15IWCC0829

Respondent.

DECISION AND OPINION ON REMAND
FROM THE ILLINOIS APPELLATE COURT

This case comes before the Commission on remand from the Illinois Appellate Court in case number 12 L 50504. On April 15, 2011, the Arbitrator issued a decision finding that Petitioner's right arm condition of ill-being was causally related to his September 9, 2003 accident, which was stipulated to. The Arbitrator further found Petitioner entitled to 361-3/7 temporary total disability (TTD), from September 10, 2003 through August 30, 2005 and from January 31, 2006 through January 13, 2011, the date of the Arbitration hearing. Additionally, the Arbitrator awarded Section 19(k) penalties totaling $46,320.68, Section 19(l) penalties totaling $10,000.00, and Section 16 attorney's fees totaling $11,264.13. On Review, the Commission (in case number 12 IWCC 339) modified the Arbitrator's decision, finding that Petitioner was entitled to 280-1/7 weeks of TTD, from September 10, 2003 through August 30, 2005 and from August 21, 2007 through the January 13, 2011 hearing date. The remainder of the decision was affirmed and adopted. The Respondent appealed to the Circuit Court of Cook County, which affirmed the Commission. Respondent then appealed to the Illinois Appellate Court. On March 17, 2014 the Appellate Court affirmed the Commission's decision except for with regard to the Section 19(k) penalty award. The Court noted that Section 19(k) penalties are not available based on an employer's delay in authorizing a medical procedure. In that regard, they have instructed

15IWCC0829

the Commission to recalculate the Section 19(k) award, "deducting whatever portions is [*sic*] attributable to respondent's delay in authorizing the procedure at issue."

Taking the failure to authorize treatment out of the penalties equation, the only award upon which penalties could be based would be TTD. In reviewing the TTD periods awarded by the Commission previously, which were affirmed by the Circuit and Appellate Courts, we calculate the period of time covered to be 280-3/7 weeks. Based on the TTD rate of $230.92, the total amount of TTD awarded was $64,756.66.

Pursuant to Section 19(k), 50% of the award would be $32,378.33. Therefore, the Commission finds that Petitioner is entitled to Section 19(k) penalties totaling $32,378.33.

While we have not been specifically instructed by the Court to modify the Section 16 attorney's fees award, the Commission notes that the amount of Section 16 attorney's fees are contingent upon the amount of Section 19(k) penalties awarded. As such, we also reduce the Section 16 attorney's fees to $6,475.67, which is 20% of the 19(k) award.

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 $230.92 per week for a period of 280-3/7 weeks, that having been 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. Respondent shall have credit for all temporary total disability benefits it paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner additional compensation of $32,378.33 as provided in §19(k) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner additional compensation of $10,000.00 as provided in §19(l) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to the attorney for the Petitioner legal fees in the amount of $6,475.67 as provided in §16 of the Act; the balance of attorneys' fees to be paid by Petitioner to his attorney.

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

15IWCC0829

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 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: NOV 10 2015
TJT: pvc
O 10/7/14
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Elroy Norris,
Petitioner,

vs.

SOI Dept of Corrections,
Respondent.

15IWCC0833

NO: 07 WC 14188

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 15, 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: NOV 12 2015
KWL/vf
O-11/9/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0833

NORRIS, ELROY
Employee/Petitioner

Case# **07WC014188**

12WC004048

SOI DEPT OF CORRECTIONS
Employer/Respondent

On 4/15/2015, 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 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0924 BLOCK KLUKAS & MANZELLA PC
MICHAEL D BLOCK
19 W JEFFERSON ST STE 100
JOLIET, IL 60432

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

APR 15 2015

RONALD A.RASCIA, 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 **15IWCC0833**

Elroy Norris
Employee/Petitioner

v.

State of Illinois, Department of Corrections
Employer/Respondent

Case # **07** WC **14188**

Consolidated cases: **12** WC **4048**

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 **March 6, 2015**. 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 January 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 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 $37,096.00; the average weekly wage was $713.38.

On the date of accident, Petitioner was 35 years of age, *married* with 3 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 $55,915.59 for TTD[1], $0 for TPD, $0 for maintenance, and $0 for other benefits, for a total credit of $55,915.59. *See* AX1.

Respondent is entitled to a credit as agreed by the parties, if any, under Section 8(j) of the Act. *See* AX1.

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner has established a causal connection between his right shoulder and right wrist condition and his accidents at work on January 31, 2006 and February 3, 2009.

Medical Benefits

Respondent shall pay reasonable and necessary medical services reflected in Petitioner's Exhibits 21-26 for treatment from January 31, 2006 through February 2, 2009 incurred by Petitioner that remain unpaid pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall receive a credit as agreed by the parties, 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: Schedule Injury (Right Shoulder)

Respondent shall pay Petitioner permanent partial disability benefits of $428.03/week for 87.5 weeks, because the injuries sustained caused the 17.5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Permanent Partial Disability: Schedule Injury (Right Hand/Wrist)

Respondent shall pay Petitioner permanent partial disability benefits of $428.03/week for 57 weeks, because the injuries sustained caused the 30% loss of the hand, as provided in Section 8(e) of the Act.

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[1] As agreed by the parties, no claim is made for unpaid or overpaid temporary total disability. *See* AX1.

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

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

Signature of Arbitrator

April 13, 2015
Date

APR 15 2015

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Elroy Norris
Employee/Petitioner

v.

State of Illinois, Department of Corrections
Employer/Respondent

Case # **07** WC **14188**

Consolidated cases: **12** WC **4048**

FINDINGS OF FACT

A consolidated hearing was held in both of Petitioner's above-captioned cases. Arbitrator's Exhibit[2] ("AX") 1; AX2. The issues in dispute in this case include causal connection, Respondent's liability for certain unpaid medical bills, and the nature and extent of Petitioner's injury. AX1. The issues in dispute related to Petitioner's claimed accident on February 3, 2009 are addressed in the concurrent decision issued in Case No. 12 WC 4048. The parties have stipulated to all other issues. AX1.

Background

Petitioner testified that he began working for Respondent in November of 2003 as a correctional officer. His duties since that time have remained the same and include ensuring the safety, security and restraint of inmates, if necessary. Petitioner testified that he worked segregation with the "worst of the worst" of the inmates. Previously, Petitioner sustained a right shoulder injury, which healed after some physical therapy. Otherwise, before January 31, 2006, Petitioner testified that he had no problems in his neck, hands or wrists.

Respondent submitted a Workers' Compensation Employee's Notice of Injury dated January 30, 2006. RX1. The report indicates that Petitioner was escorting an inmate in the Cook County Courthouse and the inmate "twisted (R) hand of officer with box in chain. Numbness, pain to wrist[.]" *Id.* Two witnesses to the incident, A. Johnson and N. Brown, were listed. *Id.* Petitioner indicated that "Inmate kept trying to run at officer, kept pulling away from me twisting + turning[.]" *Id.*

At trial, Petitioner testified that he was involved in an inmate altercation. He was escorting an inmate to court. The inmate was cuffed around the belt to a lead chain as well as a hoop with a chain so that Petitioner could gain control of the inmate. The inmate got into a verbal altercation with another officer. As Petitioner was walking the inmate up the stairs, the inmate started running back down the stairs. Petitioner testified that he fell with his hand outstretched and landed on his right shoulder with the inmate on top of him. He explained that the lead chain was still wrapped around his wrist.

Medical Treatment

The medical records reflect that Petitioner went to the Provena St. Joseph Emergency Room the same day on January 30, 2006 where he was given a sling, ice and a wrist brace. PX1 at 1-20. Petitioner's wrist x-rays were negative for fracture. *Id.* He was diagnosed with a right hand wrist strain, given an ace bandage and Ibuprofen,

[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.

15IWCC0833

restricted from lifting over five lbs. for two days, and discharged home with instructions to follow up with his primary care physician. *Id.*

Petitioner followed up with his primary care physician at Sanitas Medical Group on February 2, 2006. PX2 at 1. Dr. Gurfinchel ordered right wrist x-rays for Petitioner's right wrist pain. PX3 at 6-7. The x-rays showed no fracture, maintained radial carpal joints, and unremarkable carpal bones. *Id.* On March 10, 2006 at which time he was referred to a specialist, Dr. Richa Vohra. PX2 at 1-3.

On May 9, 2006 Dr. Vohra diagnosed Petitioner with right shoulder pain, impingement syndrome with possible tendonitis, right hand pain, right extensor synovitis, and possible nerve traction injury causing numbness in hand. PX4 at 2-5. He ordered physical therapy, an MRI or the right hand and shoulder, and placed Petitioner on light duty with no lifting over 10 lbs. and no forceful pushing or pulling. *Id.* Petitioner underwent physical therapy at Richart Sports & Spinal Rehabilitation on May 15, 2006 through October 17, 2006. PX5. The physical therapy addressed Petitioner's right shoulder, right hand, and later his neck. *Id.*

In the interim, Petitioner continued to see Dr. Vohra. PX4. On May 23, 2006, Petitioner underwent a right shoulder MRI which the interpreting radiologist noted to show the following: (1) acute subacromial/subdeltoid bursitis; (2) acromioclavicular degenerative change with tendinosis of the rotator cuff tendons without focal tear and no suggestion of a full thickness tear; and (3) glenohumeral degenerative change without abnormality of the labrum. PX4 at 9-10; PX6. The following day, on May 24, 2006, Petitioner underwent an EMG/NCV with Dr. Vohra. PX4 at 12-14. The results were normal with no evidence of carpal tunnel syndrome, peripheral neuropathy or any other entrapment neuropathy. *Id.* On June 27, 2006, Petitioner underwent a right hand MRI, which the interpreting radiologist noted showed evidence of extensor tenosynovitis of the index and middle fingers and no tendon tears or subluxations. PX4 at 17; PX6A.

On July 6, 2006, Petitioner present at Provena St. Joseph Medical Center with a laceration to the right hand that occurred approximately two hours before while remodeling his home when he caught his hand on an exposed screw in the wall. PX1 at 68-69. Petitioner had a 3 cm laceration that was repaired. *Id.* He was discharged home and instructed to follow up with his primary care physician. *Id.* Petitioner followed up with Dr. Vohra on July 8, 2006. PX4 at 19-20. Petitioner reported that he was doing better with the shoulder, but his hand was still very painful. *Id.* Dr. Vohra diagnosed Petitioner with right shoulder pain, subacromial bursitis and rotator cuff syndrome, and right hand pain and tenosynovitis. *Id.* He kept Petitioner restricted to light duty work. *Id.*

On August 19, 2006, Dr. Vohra injected Petitioner's right hand to address the tenosynovitis. PX4 at 25-26. Petitioner also reported an onset of occasional neck pain radiating into the shoulder. *Id.* Dr. Vohra added a diagnosis of neck pain radiating to the shoulder. *Id.* He ordered ongoing physical therapy and kept Petitioner restricted to light duty work. *Id.* On September 14, 2006, Dr. Vohra ordered an MRI of the cervical spine and maintained Petitioner's work restrictions. PX4 at 28-29. Petitioner underwent the recommended MRI on September 23, 2006 for neck pain radiating into both shoulders and down both arms, right side worse than left. PX4 at 30; PX6B. The interpreting radiologist found that the cervical spine MRI was unremarkable. *Id.*

Dr. Vohra noted on September 27, 2006 that Petitioner may need a second opinion with an orthopedist. PX4 at 32-33. On October 14, 2006, he released Petitioner to full duty work effective October 16, 2006. PX4 at 34-35. Petitioner testified that he underwent treatment for neck, right shoulder and hand through October 17, 2006.

On October 19, 2006, Dr. Vohra ordered a functional capacity evaluation and referred Petitioner out for an orthopedic consultation. PX4 at 36-37. He restricted Petitioner to light duty work from October 19, 2006 to

October 26, 2006. *Id.* At a follow up visit on October 26, 2006, Dr. Vohra reiterated his recommendation for a functional capacity evaluation and referral for an orthopedic consultation. PX4 at 38-39. He kept Petitioner restricted to light duty work through November 9, 2006. *Id.* On November 30, 2006, Dr. Vohra referred Petitioner to Dr. Durkin and maintained Petitioner's light duty work restrictions. PX4 at 41.

On December 5, 2006, Petitioner saw Dr. Michael Durkin at Hinsdale Orthopaedics. PX7 at 1-2. He reported his injury at work involving an inmate "who he had in restraints with his restraints wrapped around his arm leading him up some stairs, pulled his arm sharply. He reports having a forced external rotations injury and then he fell down the stairs." *Id.* Petitioner also reported pain in the right wrist, pain in the shoulder down the front, and some neck pain." *Id.* After an examination, Dr. Durkin referred Petitioner to his colleague, Dr. Urbanosky, for the wrist and ordered a cervical spine MRI to rule out disc herniations and right shoulder MRI to look at the subscap and labrum. *Id.*

On December 15, 2006, Petitioner underwent the recommended cervical spine MRI. PX7 at 2-3. The interpreting radiologist noted the following: (1) mild degenerative disc disease at C5-6 with small disk bulging and endplate degenerative changes with slight asymmetric narrowing right of midline; (2) minimal degenerative changes at C4-5 along the vertebral endplates; (3) straightening of the normal lordotic curve; and (4) no intrinsic spinal cord lesions. *Id.* Petitioner also underwent the recommended right shoulder MRI. PX7 at 3-4. The interpreting radiologist noted the following: (1) mild supraspinitus tendinosis without discrete full thickness rotator cuff tear and with mild subacromial bursitis; (2) degenerative change at the level of the AC joint mildly effacing the adjacent myotendinous junction; and (3) mild tendonopathy of the long head of the biceps tendon. *Id.*

On January 10, 2007, Dr. Durkin noted that Petitioner was waiting to see Dr. Urbanosky and would return to see him after that visit and an EMG. PX7 at 4. Dr. Durkin placed Petitioner off work. *Id.* On January 19, 2007, Petitioner underwent the recommended right upper extremity EMG, which showed no mono polyneuropathy, obvious radiculopathy, or plexopathy. *Id.* The evaluating physician, Dr. Marie Kirincic, noted that the EMG was normal. *Id.*

Petitioner then saw Dr. Leah Urbanosky on January 29, 2007. PX7 at 6-7. After an examination, Dr. Urbanosky recommended a bone scan to determine if he had any distal radius or ulna pathology, given Petitioner's persistent symptoms despite normal x-rays. *Id.* Dr. Urbanosky also recommended an MR arthrogram to assess any interarticular pathology. *Id.* She suspected that Petitioner may have a scapholunate ligament tear and/or TFCC tear or possible occult scaphoid fracture for which thumb spica casting would be recommended. *Id.* Dr. Urbanosky maintained Petitioner's work restrictions per Dr. Durkin's orders. *Id.*

Petitioner testified that from May 15, 2006 he began receiving extended benefits through January 31, 2007.

On February 21, 2007, Dr. Durkin noted Petitioner's report of continued shoulder pain with popping. PX7 at 8. He ordered one month of physical therapy to focus on postural training and rotator cuff strengthening to be followed by an MR arthrogram if Petitioner showed no real improvement. *Id.*

On March 28, 2007, Dr. Durkin administered an injection into the biceps tendon and subacromial space around the AC joint. PX7 at 9. After noting a lack of improvement and minimal relief from the injection, on April 25, 2007 Dr. Durkin recommended a shoulder arthroscopy surgery with probable subacromial decompression and repair of the subscap tendon. *Id.*

On June 7, 2007, Petitioner underwent right shoulder surgery at Provena St. Joseph's Medical Center. PX1 at 39-40; PX9. Pre-operatively, Dr. Durkin diagnosed Petitioner with right shoulder subscapularis tear, biceps tendonitis and impingement, and acromioclavicular joint impingement. *Id.* Dr. Durkin performed a right shoulder arthroscopy, debridement of the biceps tenodesis, repair of the subscapularis tendon, supraspinitus tendon, and an arthroscopic subacromial decompression and distal clavicle excision. *Id.* Post-operatively, Petitioner was diagnosed with right shoulder subscapularis tear, biceps tendonitis and impingement, acromioclavicular joint impingement, a tear of the supraspinitus and acromioclavicular joint impingement. *Id.*

Petitioner returned to Dr. Durkin on June 20, 2007, at which time he ordered post-operative physical therapy. PX7 at 10. Petitioner then began physical therapy at ATI. PX15. At a follow up visit on September 12, 2007, Dr. Durkin noted that Petitioner would be transitioning from physical therapy to work conditioning. PX7 at 11. Petitioner then returned to Dr. Durkin on October 17, 2007 at which time he administered an injection to decrease tightness and swelling in the front of the shoulder. PX7 at 14.

The prior day, on October 16, 2007, Petitioner underwent a right wrist arthrogram to evaluate for scapholunate or TFCC tear. PX3 at 28-29. The interpreting radiologist noted findings consistent with disruption of the triangular fibrocartilage likely at the level of the radial portion with no evidence of scapholunate or lunotriquetral ligament injury. *Id.* Petitioner then saw Dr. Urbanosky on October 29, 2007. PX7 at 15-16. He reported that his symptoms had not changed. *Id.* She recommended an injection versus surgery, but wished to review Petitioner's prior treatment records first. *Id.*

As of November 14, 2007, Dr. Durkin continued to keep Petitioner off work and in work conditioning. PX7 at 18. On December 19, 2007, he released Petitioner back to work with no use of firearms, 35 pound restrictions, and no overhead work. PX7 at 20.

On December 31, 2007, Dr. Urbanosky noted that Petitioner continued to have a positive Finkelstein's test on evaluation of the wrist and complaints of numbness and tingling that he reported were distinctly different than what he experienced at the time of his last EMG. PX7 at 21-22. Dr. Urbanosky ordered an updated EMG/NCV and recommended an open right-sided de Quervain release and right wrist arthroscopy with debridement as needed of the TFCC. *Id.* Petitioner underwent the recommended EMG with Dr. Kirincic on January 9, 2008. PX7 at 23. She noted no evidence of neuromuscular disease, no mononeuropathy, peripheral neuropathy, cervical radiculopathy, or plexopathy on the right upper extremity. *Id.*

On January 16, 2008, Dr. Durkin put Petitioner's continued work conditioning on hold while he addressed his right wrist condition with Dr. Urbanosky. PX7 at 24. On February 26, 2008, Dr. Urbanosky noted her review of Petitioner's normal EMG, but noted continued numbness and tingling in the index, long, ring and small fingers consistent with subclinical carpal tunnel syndrome. PX7 at 26-27. She again recommended surgery. *Id.*

Petitioner underwent surgery to the right wrist on February 28, 2008. PX10; PX11 at 22-23. Pre- and post-operatively, Dr. Urbanosky diagnosed Petitioner with right wrist de Quervain's tenosynovitis, slight carpal tunnel syndrome and transjugular fibrocartilage complex tear. *Id.* She performed a right-sided de Quervain's release, a right-sided dexamethasone injection, right wrist arthroscopy with repair of the transjugular fibrocartilage complex, and debridement of synovitis. *Id.*

Petitioner returned to Dr. Urbanosky for follow up on March 17, 2008. PX7 at 28. He reported no change in numbness and tingling after the injection, but definite relief of thumb pain and soreness in the appropriate surgical sites. *Id.* Dr. Urbanosky placed Petitioner off work and ordered physical therapy. *Id.* Several days

later, Petitioner saw Dr. Durkin and reported that after a strain-type injury in work conditioning he has had continued deep pain in the shoulder. PX7 at 29. Dr. Durkin recommended a second opinion. *Id.*

Petitioner then saw Dr. Durkin's colleague, Dr. Giridhar Burra, on April 11, 2008 and ordered an MR arthrogram and CT scan. PX7 at 30-31. After reviewing Petitioner's MR arthrogram and CT scan, Dr. Burra recommended another shoulder surgery involving a release of adhesions. PX7 at 34. Petitioner returned to Dr. Durkin on May 9, 2008 at which time he released Petitioner to light duty work with a 35 pound lifting restriction, minimal overhead work, and no use of firearms. PX7 at 35.

On May 12, 2008, Dr. Urbanosky recommended a second surgery for the right wrist. PX7 at 36. She noted Petitioner's report that his paresthesias returned. *Id.* She recommended a carpal tunnel release surgery to be performed at the time of his shoulder surgery. *Id.* As of June 23, 2008, Dr. Urbanosky noted that Petitioner was hesitant to have further surgery, but that he was unable to work at that time. PX7 at 38. As of August 4, 2008, Dr. Urbanosky placed Petitioner at maximum medical improvement and released Petitioner back to full duty work with regard to the wrist effective August 5, 2008. PX7 at 39.

Four days later, Petitioner returned to Dr. Durkin at which time he was released to light duty work with a 30 pound lifting restriction, no climbing ladders, and no overhead activity. PX7 at 40. Petitioner was instructed to follow up when he was ready to pursue the second adhesion removal surgery in the shoulder. *Id.*

Petitioner testified that he returned to work on August 18, 2008.

On September 29, 2008, Petitioner returned to Dr. Urbanosky reporting wrist popping while handcuffing prisoners. PX7 at 43. She prescribed a custom splint and continued Dr. Durkin's work restrictions. *Id.* As of January 13, 2009, Petitioner continued to report popping in the wrist. PX7 at 45. Dr. Urbanosky recommended a repeat MR arthrogram of the right wrist to check for possible extensor carpi ulnaris subsheath tear, inflammation, instability, or possible recurrent TFCC tear. *Id.*

February 3, 2009

On February 3, 2009, Petitioner testified that he was working with inmates in the showers in a cell house. He explained that two inmates began fighting. He was slammed against the shower and hurt his neck and right shoulder. Petitioner completed an incident reported the incident to Lieutenant Knalls.

The medical records reflect Petitioner returned to Dr. Durkin one week later on February 10, 2009. PX7 at 46. Dr. Durkin noted Petitioner's report that he was in an altercation at "with an inmate in which he was slammed against the shower, and he is now having pain in the top of his right shoulder. He has shooting pain down the right side when he turns his neck. This is a new symptom. He is still having the pain in the lateral aspect of the shoulder with decreased range of motion that he has been doing home exercises on, and he is coming in today to discuss surgical options at this point." *Id.* Dr. Durkin again prescribed right shoulder surgery. *Id.*

As of March 25, 2009, Dr. Durkin restricted Petitioner from lifting over 35 pounds and he again recommended surgery including an arthroscopy, debridement, release of adhesions, and rotator interval debridement. PX7 at 47-48. While waiting for approval for the recommended surgery, Dr. Durkin ordered some physical therapy on May 20, 2009. PX7 at 49. Petitioner saw Dr. Durkin from June 19, 2009 through August 26, 2009 for a knee and ankle condition that is not at issue in the above-captioned cases. PX7 at 50-55.

Petitioner returned to Dr. Urbanosky on August 28, 2009. PX7 at 56. Dr. Urbanosky noted that the MRI arthrogram of the right wrist had finally been approved. *Id.* She noted that he had ruptured his repair and had a recurrent TFCC tear. *Id.* Dr. Urbanosky prescribed medications and a repeat TFCC repair surgery with ulnar shortening osteotomy. *Id.* She reiterated her recommendation for surgery on December 11, 2009. PX7 at 62-63. At a visit on January 4, 2010, Dr. Urbanosky noted that Petitioner was trying to obtain a second opinion. PX7 at 64. From February 5, 2010 through August 31, 2010 Petitioner continued to receive treatment to the right knee and ankle with Dr. Durkin. PX7 at 65-66.

On September 7, 2010, Petitioner returned to Dr. Durkin to address his shoulder. PX7 at 67. He reported that he could likely not tolerate being off work for the amount of time required after a repeat surgery and he indicated that he would consider surgery. *Id.* Dr. Durkin noted that Petitioner would continue with home exercises. *Id.* Petitioner testified that this is the last time he saw Dr. Durkin for the shoulder.

Petitioner returned to Dr. Urbanosky on November 10, 2010. PX7 at 68-70. Petitioner reported that he was unable to get a second opinion, the same complaints in the right wrist, and difficulty fishing. *Id.* Petitioner also reported that he had to re-certify on the shooting range the prior day. *Id.* Dr. Urbanosky placed Petitioner off work for two days and released him to full duty effective November 12, 2010. *Id.*

Petitioner testified that he declined to have the recommended second surgeries. He understood from the doctors that the surgeries could make him worse, and he was in fear of being put out of work permanently.

Petitioner's Independent Medical Evaluation & Deposition Testimony – Dr. Coe

On March 5, 2013, Petitioner saw Dr. Jeffrey Coe at his attorney's request. PX19. After reviewing various medical records, taking a history from Petitioner, and examining him, Dr. Coe rendered various opinions. *Id.* Specifically, he opined that there was a causal relationship between Petitioner's first injury at work on January 31, 2006 and his right shoulder, arm and wrist condition. *Id.* He also opined that there was a causal relationship between Petitioner's second injury at work and his right shoulder and neck condition. *Id.* Dr. Coe also agreed with the recommended surgeries prescribed by Dr. Durkin and Dr. Urbanosky. *Id.*

Petitioner called Dr. Coe as a witness at an evidence deposition taken on November 25, 2013. PX27. Dr. Coe testified consistent with the opinions and conclusions that he rendered in his March 5, 2013 report and specifically explained how Petitioner's structural problems in the right shoulder, right wrist, and neck—as well as the need for additional medical treatment including surgeries which he indicated Petitioner reasonably declined to undergo given the risks and chronic nature of the conditions at that point—were directly caused or aggravated by both injuries at work. *Id.*

Additional Information

Regarding his current right shoulder condition, Petitioner testified that it has not gotten any better. He explained that his symptoms seem to be worsening. Petitioner testified that he still does not have the range of motion he should have and he continues to have aches. In the morning, Petitioner testified that he has to wind up his shoulder and stretch it out. He also experiences numbness and explained that he has about 10-20% strength in his right shoulder.

Petitioner also explained a reference to him "just barely hanging on." He explained that this means that he has sleepless nights, feels he is not able to perform his job as required, and he takes a lot of over-the-counter pain medications.

When he is performing his duties, Petitioner testified that he now leads with the left side of his body when engaging in activities such as opening a door, which could weigh over 100 pounds, or restraining an inmate. On a daily basis, Petitioner testified that he "keys out" about 80 inmates using a Keystone key for lunch and healthcare appointments. He has to slide the doors open and back. Petitioner described the pain after these activities as excruciating. Petitioner also testified that he experiences a lot of sharp shooting pains and aches in his shoulder during bad weather.

With regard to his neck, Petitioner testified that he wakes up with crooks and cranks in it. He also testified that he has trouble sleeping.

With regard to his right wrist, Petitioner testified that his wrist seems to be worsening. He has a lot of numbness and tingling in the wrist and he experiences popping with any movement in the wrist. Petitioner estimated that he has no strength in the right wrist. He explained that he is unable to open cell doors with his right hand without feeling excruciating pain, so he now uses his left hand to turn the keys.

Petitioner also testified that he felt depressed. He explained that he is not able to throw a football very far. He also described problems starting his car every day, opening doors, and performing his job duties. Petitioner testified that it also hurts to fish and wind the rod up. He testified that he used to weight-lift, but he no longer does that. He also testified that he does not run anymore because it jars the shoulder and makes the wrist act up. Petitioner testified that he takes Advil over-the-counter on a daily basis and takes hot baths.

15IWCC0833

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 hearing as follows:

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:

The Arbitrator finds that Petitioner's claimed current condition of ill-being in the right shoulder and right wrist are causally related to the injury sustained at work on January 31, 2006. In so concluding, the Arbitrator relies on the credible testimony of Petitioner which is corroborated by contemporaneous medical records as well as the opinions of his treating physicians, Dr. Durkin, Dr. Burra, and Dr. Urbanosky, as well as the opinion of Petitioner's independent medical examiner, Dr. Coe, which are uncontroverted.

There is no evidence in this record that Petitioner had any prior condition in the right shoulder or right wrist that prevented him from working for years before his first injury on January 31, 2006. The medical records reflect a consistent and plausible chain of events resulting in Petitioner's reported symptoms correlating to his accident at work. Petitioner immediately reported symptoms in the right shoulder and right wrist when he sought medical attention shortly after his accident. He continued to report such symptoms to the medical staff at the Provena St. Joseph Emergency Room, Dr. Gurfinchel (his primary care physician), Dr. Vohra (the specialist to whom Dr. Gurfinchel initially referred Petitioner), as well as Dr. Durkin and Dr. Burra (his primary shoulder specialist and second opinion), Dr. Urbanosky (his wrist specialist) and Dr. Coe (his independent medical evaluator).

Petitioner's testimony at the hearing was also consistent with the medical records of these treating physicians as well as the report of Dr. Coe. Notably, no contrary opinion was offered by Respondent to refute any of the findings of Petitioner's treating physicians or Dr. Coe.

Petitioner then suffered a second injury on February 3, 2009. He continued to receive medical treatment with Dr. Durkin and Dr. Urbanosky. Petitioner's testimony about the symptoms in his right shoulder and right wrist is consistent with his reports to his treating physicians as reflected in the medical records after this second injury. There is no evidence that Petitioner's right shoulder or right wrist condition improved after this injury. To the contrary, Petitioner's right shoulder condition was aggravated by the second accident and the substance of Petitioner's claim that he sustained a compensable accident on this date affected both the right shoulder and the neck are addressed in the concurrent decision issued in Case No. 12 WC 4048. Petitioner's treating physicians continued to recommend surgeries to both body parts, with adjustments made to the types of surgeries given Petitioner's additional symptoms after his second accident.

Given the chain of events, plausible explanation by these physicians as to Petitioner's conditions and the relation to the accidents at work, and lack of contrary opinion, the Arbitrator adopts the opinions of Dr. Durkin, Dr. Burra, Dr. Urbanosky, and Dr. Coe.

Based on all of the foregoing, the Arbitrator finds that Petitioner's condition of ill-being with respect to his right shoulder and right wrist is causally related the work accident he sustained on January 31, 2006 and that his right shoulder condition is also causally related to the work accident he sustained on February 3, 2009 as explained in the concurrent decision issued in Case No. 12 WC 4048.

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 right shoulder and right wrist conditions are causally related to his accidents at work relying on Petitioner's credible testimony as well as the opinions of his treating physicians and his own independent medical examiner, Dr. Coe. The medical bills submitted into evidence are for the reasonable and necessary medical treatment rendered to Petitioner to address these conditions.

Accordingly, the Arbitrator finds that the medical bills from January 31, 2006 through February 2, 2009 incurred by Petitioner that remain unpaid (as reflected in Petitioner's Exhibits 23 and 24, which is a bill total for the amounts listed in Petitioner's Exhibits 21 thru 26) are to be paid by Respondent as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive a credit, if any, as agreed by the parties.

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 sustained a right shoulder injury requiring conservative care followed by surgery to address a right shoulder subscapularis tear, biceps tendonitis and impingement, acromioclavicular joint impingement, a tear of the supraspinitus and acromioclavicular joint impingement with an additional diagnosis of adhesive capsulitis and recurrence and worsening in symptoms after the second work accident for which a second surgery was again recommended (an arthroscopy, debridement, release of adhesions, and rotator interval debridement), but declined, and with some continued symptoms after a release to work and lifestyle changes—the Arbitrator finds that Petitioner has established permanent partial disability to the extent of 17.5% loss of use of the man as a whole pursuant to Section 8(d)2 for his right shoulder injury[3].

[3] The Arbitrator notes that the evidence presented at the consolidated hearing in these matters was insufficient to "delineate and apportion the nature and extent of permanency attributable to each accident." *See City of Chicago v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 258, 265 (1st Dist. 2011). As such, the permanency award in this case encompasses and compensates Petitioner for his injuries alleged in both of the above-captioned claims and no separate award is made in Case No. 12 WC 4048. *See Baumgardner v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 274, 279-80 (1st Dist. 2011) ("From a procedural and practical standpoint, where a claimant has sustained to separate and distinct injuries to the same body part in the claims are consolidated for hearing and decision, it is proper for the commission to consider all of the evidence presented to determine the nature and extent of his permanent disability as of the date of the hearing.").

Based on the record as a whole—which reflects that Petitioner sustained a right wrist injury requiring conservative care followed by surgery to address right wrist de Quervain's tenosynovitis, slight carpal tunnel syndrome and transjugular fibrocartilage complex tear with a recurrence and worsening in symptoms for which a second surgery was again recommended (a repeat TFCC repair with ulnar shortening osteotomy), but declined, and with some continued symptoms after a release to work and lifestyle changes—the Arbitrator finds that Petitioner has established permanent partial disability to the extent of 30% loss of use of the right hand pursuant to Section 8(e) for his right wrist injury[4].

[4] *See* FN 3.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TED KUCZAK,

Petitioner,

vs. NO: 07 WC 31004

SCE UNLIMITED, INC.,

Respondent,

15IWCC0837

DECISION AND OPINION ON REMAND

This matter returns to the Commission on remand from the Circuit Court of Will County. The Commission had found in its Corrected Order, dated August 28, 2013, that it did not have jurisdiction to hear Respondent's Motion to Vacate Settlement because Respondent failed to file a Petition for Review within 20 days, per the Supreme Court decision of Alvarado v. Indus. Comm'n, 216 Ill.2d 547 (2005). On May 28, 2014, Judge Thodore J. Jarz found that Alvarado "should not be interpreted to eliminate the requirement for Commission review or shorten the time requirement for this step to 20 days." (Court Order at 3). The court ordered that since Respondent had filed its Petition for Review 28 days after receipt of the approved settlement contracts, "the Commission should properly have taken jurisdiction with authority to make a ruling on the petition concerning abatement." (Id. at 3-4).

As background, the parties agreed to settle Petitioner's claim for $175,000.00. The timeline of events is as follows:

8/5/11	Respondent's attorney signed the contract
8/17/11	Petitioner signed the contract
[undated]	Petitioner's attorney signed the contract
9/17/11	Petitioner died of causes unrelated to his claim
9/29/11	Arbitrator Falcioni approved the contract
10/11/11	Respondent received the approved contract
10/28/11	Respondent filed a Petition for Judicial Review in the Circuit Court
11/8/11	Respondent filed a Petition for Review and Motion to Vacate Settlement with the Commission

Respondent argues that the settlement agreement should be found null and void since Petitioner had died prior to the approval of the contract by the Arbitrator. Respondent cites two Commission decisions for the proposition that Petitioner's claim abated at the time of his death. However, both of these decisions are distinguishable from the case at bar.

In Merchant v. State of Illinois, the Department of Children & Family Services, 04 IIC 580 (2004), the Commission found that the petitioner's claim had abated since he died without any dependents and that the settlement agreement was null and void. The facts in Merchant are that the claimant died on June 5, 2002. Claimant's attorney signed the contract almost 16 months later on October 3, 2003. Claimant's signature was on the contracts but no date was listed. Without having knowledge of claimant's death, Respondent's attorney signed the contract on October 28, 2003 and it was approved by the arbitrator on November 6, 2003. The decision isn't entirely clear but it seems likely that claimant's attorney was aware that his client had passed away prior to submitting the contract to respondent's attorney to be signed. Exactly how claimant was able to sign that contract when he had died in 2002 is also not fully addressed in the decision. Regardless, it would appear that no "meeting of the minds" occurred regarding the settlement because the reasonable inference was that the claimant had died prior to the settlement negotiations and the signing of the contract. Unlike Merchant, the settlement contract in the case at bar indicates that Respondent's attorney signed it on August 5, 2011, and Petitioner signed it on August 17th, one month before he passed away. It is clear that there was a "meeting of the minds" between Petitioner and Respondent regarding the settlement and the only step that remained was formal approval by the Arbitrator.

Respondent also cites Cook v. Dollar General Corporation, 02 IIC 900 (2002) for the proposition that a worker's claim abates when the worker dies from unrelated causes while the case is pending and there are no dependents. Respondent also quotes from that decision that "proposed settlements are subject to the Commission's approval and are not binding on the parties until actually approved by the Commission." (Id. at 5). However, Cook is also distinguishable from the case at bar. In Cook, the claimant died on June 19, 1999. Almost a month later, on July 16, 1999, claimant's attorney sent a letter to respondent's attorney outlining the alleged settlement terms that had been discussed that same day. No formal contract was ever entered into, let alone approved by an arbitrator, and the claimant's attorney was attempting to rely on an "oral contract" with respondent's attorney. At a hearing on the motion, the claimant's attorney claimed that her client had authorized her to settle his claim before his death and that she had no duty to inform respondent's attorney that her client had died. The Commission affirmed the arbitrator's denial of claimant's motion to enforce a settlement contract and found, among other things, that claimant's attorney did not negotiate in good faith, that there was no "meeting of the minds," and that "since the Petitioner was already deceased at the time of the settlement negotiations Petitioner could not sign or enter into a settlement contract." (Id. at 6). The Commission also referred Petitioner's attorney to the Illinois Attorney Registration and Disciplinary Commission.

In the case at bar, however, Petitioner was alive throughout the settlement negotiations and at the time he agreed to the settlement, as evidenced by his signing of the contract on August 17, 2011, one month before he died. The parties had clearly reached a "meeting of the minds" and were simply awaiting the approval of the Arbitrator. There is no allegation of fraud or bad-faith negotiations or that Petitioner's attorney was aware that his client had died prior to the approval of the settlement contract. To the contrary, at the hearing on Respondent's motion, Petitioner's attorney affirmatively represented that he was unaware that Petitioner had died prior to the contract being approved by the Arbitrator:

"Everything was in the Commission's lap before this gentleman died and within days of that submission, he died. Before we learned of it, the approval of the lump sum contract was made."

(T.12).

Despite Respondent's reliance on Merchant and Cook, it acknowledges that the appellate court decisions of Nationwide Bank & Office Management v. IC, 361 Ill.App.3d 207 (1st Dist. 2005) and, recently, Janet K. Bell, Administrator of the Estate of Mary J. Nash v. IWCC, 2015 Ill.App.4th (140028 WC; filed May 2015), clearly state that a petitioner's claim does not abate if the petitioner dies while his claim is pending even if he has no dependents.

The Commission finds that there was a "meeting of the minds" regarding the settlement of Petitioner's claim and the evidence shows that neither attorney was aware of Petitioner's death prior to the approval of the contract by the Arbitrator. Therefore, we find that the settlement contract is enforceable and deny Respondent's Motion to Vacate Settlement.

The Commission also notes that Petitioner has a Petition for Penalties and Fees on file. However, we deny this Petition and find that Respondent had a good faith legal defense regarding the enforceability of the contract and the question of abatement.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent's Motion to Vacate Settlement is hereby denied.

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: NOV 13 2015

Charles J DeVriendt

Ruth W. White

Joshua D. Luskin

SE/
O: 10/20/15
49

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Thomas M. Bugg,
Petitioner,

vs.

NO: 09 WC 25518

Cerro Flow Products,
Respondent.

15IWCC0825

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, permanent 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 January 7, 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 $16,100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 10 2015
o10/20/15
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0825

BUGG, THOMAS M
Employee/Petitioner

Case# **09WC025518**

CERRO FLOW PRODUCTS
Employer/Respondent

On 1/7/2015, 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:

0384 NELSON & NELSON
NATHAN LANTER
420 N HIGH ST PO BOX Y
BELLEVILLE, IL 62220

0507 RUSIN & MACIOROWSKI LTD
THEODORE J POWERS
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

15IWCC0825

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

THOMAS M. BUGG
Employee/Petitioner

Case # 09 WC 25518

v.

Consolidated cases: N/A

CERRO FLOW PRODUCTS
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 **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **November 6, 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 Petitioner's injuries?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other:

FINDINGS

On the date of accident, **07/15/08** 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 accident that arose out of and in the course of employment.

Timely notice of the 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 **$29,707.82**; the average weekly wage was **$571.30.**

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

Petitioner was temporarily totally disabled from December 11, 2008 through December 29, 2008, a period of 2 4/7 weeks.

Respondent has paid $1,182.13 in TTD, $0 in TPD, $0 in maintenance, $0 in non-occupational disability benefits and $0 in other benefits for which credit may be allowed under Section 8(j) of the Act.

Necessary medical services have been provided by Respondent.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **$342.78** per week for a total of **50** weeks because the injury sustained caused **a 10% 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 between **July 15, 2008** and **November 6, 2014** and shall pay the remainder of the award, if any, in weekly installments.

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 4, 2015** Date

ICArbDec

JAN 7 - 2015

Thomas M. Bugg v. Cerro Flow Products, 09 WC 25518

FINDINGS OF FACT AND CONCLUSIONS OF LAW

This is one of three claims tried before this Arbitrator on November 6, 2014. The other two claims allege left elbow injuries (more specifically, bilateral cubital tunnel syndrome) due to repetitive trauma (09 WC 25519 and 13 WC 16330). The parties agreed that all three cases would be consolidated for purposes of hearing; however, separate issues for the elbow claims and the instant shoulder claim were to issue.

Petitioner's claim herein involves a left shoulder injury as a result of an accident occuring on July 16, 2008. However, upon conclusion of the trial of this matter, Petitioner's attorney orally moved to amend the date of accident to July 15, 2008, based upon Petitioner's testimony and the evidence presented at trial. This motion was granted. The only issues in dispute are Petitioner's average weekly wage and the nature and extent of his injury.

The Arbitrator finds:

Petitioner acknowledged, and the evidence in the record reflects, that Petitioner had a prior workers' compensation claim against Respondent stemming from repetitive trauma injuries to his upper extremities. This claim dated back to 2002. Petitioner underwent multiple surgeries for his hands and elbows bilaterally. He received no shoulder treatment. Petitioner's case went to arbitration in 2005 and he was awarded 25% loss of use of the left hand, 25% loss of use of the left arm, 27.5% loss of use of the right hand and 27.5% loss of use of the right arm. The Arbitrator's Decision was affirmed by the Commission on review. Of note, Petitioner testified at his hearing that as a result of his elbow and hand surgeries he had less strength in his hands and arms and loss of motion in his right elbow. As of October 31, 2005 he was unable to bow hunt,

work on his cars or perform household chores such as caring for his grandmother or repairing his fence.

At the time of his accident on July 15, 2008, Petitioner was 47 years old. He had been employed by Respondent for approximately 29 years. Petitioner was working as a #4 Vaughn Block Operator on July 15, 2008 when he was involved in an accident. Petitioner was operating the block and swinging the jaw head with his left arm; however, the jaw head was not level and had to be raised by Petitioner. While reaching out with his left arm in front, Petitioner experienced pain and a burning sensation in his left shoulder while lifting the jaw head.

Petitioner reported the injury to his supervisor, Bob Eichelmann. Respondent's dispensary records confirm Petitioner reporting the injury to his left shoulder on July 15, 2008. (RX 2) Petitioner also completed an employee statement of accident and injury regarding the left shoulder injury on July 16, 2008. (RX 3) A report of the accident investigation was completed by Respondent regarding the left shoulder injury on July 17, 2008. (RX 1)

Petitioner initially received treatment at Midwest Occupational Medicine on July 16, 2008. He was initially diagnosed with left shoulder pain. (PX 4) Petitioner was also placed on restricted work activities and prescribed anti-inflammatories. (PX 4)

Petitioner continued with treatment at Midwest Occupational Medicine on July 25, 2008. He was also undergoing physical therapy. Petitioner continued to have symptoms and complaints involving his left shoulder on August 14, 2008 although still undergoing therapy. (PX 4) Petitioner was also working light duty. (PX 4) Petitioner worked as a sweeper/operator. He would drive the sweeper.

Petitioner subsequently underwent an MRI of his left shoulder in September, 2008. (PX 4) Petitioner was also referred to an orthopedist, Dr. Paletta for further treatment. (PX 4; PX 2)

Dr. Paletta first saw Petitioner on October 6, 2008. Dr. Paletta reviewed the MRI film which showed evidence of tendinopathy and a partial thickness rotator cuff tear along with impingement. (PX 2) Dr. Paletta initially prescribed conservative treatment including a Corti steroid injection and a Medrol Dosepak. He further ordered additional physical therapy. Dr. Paletta further continued with work restrictions. (PX 2)

As Petitioner's symptoms and complaints did not improve with conservative treatment, Dr. Paletta recommended arthroscopic surgery which was performed on December 11, 2008. (PX 2) Dr. Paletta debrided the partial thickness rotator cuff tear. He further performed a subacromial decompression, bursectomy and acromioplasty. The tear of the anterior aspect of the supraspinatus involved approximately 25% of the thickness of the cuff. (PX 2)

Dr. Paletta initially restricted Petitioner from working after the surgery from December 11, 2008 to December 29, 2008. (PX 2; PX 11) Dr. Paletta thereafter released Petitioner to restricted duty work which was accommodated by the Respondent between December 30, 2008 and April 20, 2009. (PX 2; PX 11)

While on restricted work or light duty, Dr. Paletta continued to treat Petitioner post-operatively. Petitioner underwent physical therapy at Pro-Rehab. Petitioner also underwent a course of work hardening specifically aimed near the end at mimicking Petitioner's job duties as much as possible. As of April 8, 2009 Petitioner was having some concerns about his shoulder with certain activities; however, he also reported having problems with the inside of his elbows bilaterally. (PX 2)

Dr. Paletta released Petitioner to return to full duty work on April 20, 2009. He released Petitioner from treatment on May 20, 2009. (PX 2)

In June of 2009 Petitioner's medical care began to focus on his elbow complaints, the subject of his two companion claims. In January of 2010 Petitioner underwent surgery for his elbows. (PX 3) Thereafter, he returned to work on #4 Block but noticed additional bilateral elbow pain for which he returned to see Dr. Beatty in November of 2010. Additional elbow surgeries followed in early 2011. (PX 3) Petitioner has since returned to work on #4 Block. He has had no further treatment for his left shoulder since being released by Dr. Paletta in May of 2009.

Petitioner did not immediately return to work on #4 block. Initially, he returned to work as a sweeper/operator. While Petitioner was uncertain as to the exact length of time he performed that job he believed it was about two months. He then returned to #4 block. Petitioner was paid temporary total disability benefits while off work for the surgery and Petitioner acknowledged that Respondent accommodated his restrictions until he was released to full duty work in April of 2009.

Petitioner testified that Dr. Paletta did not restrict Petitioner as to overhead work. Dr. Paletta did not place any restrictions as to lifting. Although Petitioner said that he had good improvement with his left shoulder after the surgery and currently had no difficulty performing his job as a #4 block operator, he testified to some ongoing tightness, soreness and stiffness. Generally speaking, he experiences some shoulder discomfort when he works with his left arm out in front of his body. He described his shoulder pain as a "3/10" at the end of his shift. Petitioner testified to experiencing trouble trimming trees and performing raking and shoveling activities at home. He takes over-the-counter Ibuprofen or Aleve for any pain complaints.

Despite his complaints, Petitioner said that he has not been reprimanded by the Respondent for poor work performance due to his shoulder condition. In discussing his

difficulties with tree trimming, raking and shoveling, Petitioner confirmed that Dr. Paletta placed no restrictions regarding these activities. Petitioner also said that because he is right hand dominant, he relies on his right arm to engage in activities.

Petitioner denied any significant left shoulder pain or difficulty raising his left shoulder before July of 2008. He also denied receiving any medical treatment or chiropractic care for his left shoulder before July of 2008. He was not under any work restrictions for his left shoulder before July of 2008.

Evidence was also presented regarding Petitioner's average weekly wage due to the wage dispute. Petitioner is alleging an average weekly wage of $689.58 based upon annual earnings of $35,858.16. (AX 4) Respondent is alleging an average weekly wage of $571.30 based upon annual earnings of $29,707.82. (AX 4; RX 14)

Evidence presented at arbitration regarding Petitioner's wage included Petitioner's testimony of working 8-10 hours, 5-6 days a week. Petitioner also testified he worked mandatory overtime after returning to work in May of 2010. Petitioner also produced the "contract book" regarding the hourly rate for union members at Respondent's employment. (PX 10) Petitioner testified that a year prior to the accident his hourly rate was $17.49 per hour. (PX 10) Petitioner's TTD check stubs were also admitted into evidence. (PX 11)

Respondent produced Petitioner's wage statement for the year prior to the accident. Petitioner's earnings for regular time and shift differential amounted to $29,707.82. (RX 14)

The Arbitrator concludes:

1. Issue (G) - What were Petitioner's earnings?

Petitioner failed to prove an average weekly wage of $689.58. Even though Petitioner testified that he worked mandatory overtime, he only testified to doing so after returning to work

in May of 2010 and, furthermore, he provided no evidence that such overtime was regularly scheduled. (See, *Edward Hines Limber Company v. Industrial Commission*, 215 Ill. App.3d 659, 575 N.E.2d 1234 (1990)) Petitioner failed to prove that the overtime was part of his regular employment or regular hours. The Arbitrator relies upon Respondent's wage exhibit (RX 14) as the best evidence of Petitioner's earnings for the year preceding his accident. Consequently, the Arbitrator concludes that Petitioner's average weekly wage is $571.30. This results in a TTD rate of $380.87 and a PPD rate of $342.78.

2. Issue (L) What is the nature and extent of the injury:

Petitioner has sustained permanent partial disability to his left shoulder as a result of his work injury on July 15, 2008 to the extent of 10% loss of the man as a whole under Section 8(d)2. Petitioner sustained a partial rotator cuff tear to his non-dominant arm. He underwent one operative procedure. He was medically released to full duty work with no restrictions as to his physical activities, including any activities or use of the left arm and shoulder above shoulder level, or activities involving lifting. He has not returned for any further care since being released by Dr. Paletta in May of 2009. Petitioner's testimony regarding his ongoing symptoms and complaints was credible.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Thomas M. Bugg,
Petitioner,

vs.

NO: 09 WC 25519
13 WC 16330

Cerro Flow Products,
Respondent.

15IWCC0826

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, permanent 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 January 7, 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.

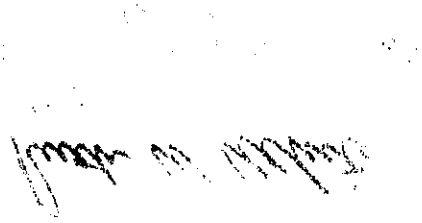
Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $36,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 10 2015
o10/20/15
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin



ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0826

BUGG, THOMAS M
Employee/Petitioner

Case# **09WC025519**

13WC016930

CERRO FLOW PRODUCTS
Employer/Respondent

On 1/7/2015, 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:

0384 NELSON & NELSON
NATHAN LANTER
420 N HIGH ST PO BOX Y
BELLEVILLE, IL 62220

0507 RUSIN & MACIOROWSKI LTD
THEODORE J POWERS
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

15IWCC0826

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

THOMAS M. BUGG
Employee/Petitioner

Case # **09** WC **25519**

v.

Consolidated cases: **13 WC 16330**

CERRO FLOW PRODUCTS
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 **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Mt. Vernon,** on **November 6, 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 Petitioner's injuries?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other:

FINDINGS

On the dates of accident, **07/15/08** and **11/01/10** 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 the date of July 15, 2008, Petitioner ***did*** sustain an accident that arose out of and in the course of employment. On the date of November 1, 2010 Petitioner ***did not*** sustain an accident that arose out of and in the course of his employment.

Timely notice of the July 15, 2008 accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident of July 15, 2008.

In the year preceding the injury on 07/15/08, Petitioner earned **$29,707.82** and his average weekly wage was **$571.30.**

On the 07/15/08 date of accident, Petitioner was **47** years of age, ***single*** with **0** dependent children. On the 11/01/10 date of accident, Petitioner was **50** years of age, ***single*** with **0** dependent children.

Necessary medical services have been provided by Respondent.

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

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

Respondent is entitled to a general credit for any amounts paid in non-occupational disability indemnity benefits for which credit may be allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay TTD benefits from **01/06/10** to **05/17/10** and from **02/15/11** to **09/19/11**, which totals **49 5/7 weeks**, at a rate of **$380.83/week**. Respondent shall receive a general credit for non-occupational indemnity benefits that were paid to Petitioner during these periods of time.

Respondent shall pay Petitioner permanent partial disability benefits of **$342.78 per week** for a total of **50.6** weeks because the injury sustained caused **10% loss of each arm**, as provided by Section 8(e) of the Act. This permanent partial disability award is in excess of the credit Respondent receives for the prior award of 27.5% of Petitioner's right arm and 25% of Petitioner left arm.

Respondent is to pay the medical bills related to treatment to Petitioner's bilateral elbows identified in Petitioner's Exhibit 8 as provided in Sections 8(a) and 8.2 of the Act subject to the fee schedule. Respondent shall be given a general credit of amounts paid for medical benefits that have been paid under Section 8(j) of the Act for any bill paid through its group medical plan.

Respondent shall pay Petitioner compensation that has accrued between July 15, 2008 and November 6, 2014 and shall pay the remainder of the award, if any, in weekly installments.

15IWCC0826

Petitioner's claim for compensation in case number 13 WC 16330 is denied. Petitioner failed to prove he sustained an accident on November 1, 2010 that arose out of and in the course of his employment. All other issues regarding that case are moot 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

January 4, 2015
Date

ICArbDec

JAN 7 - 2015

THOMAS M. BUGG v. CERRO FLOW PRODUCTS, 09 WC 25519; 13 WC 16330

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner alleges that he developed bilateral cubital tunnel syndrome as a result of his employment duties with Respondent which were repetitive in nature. At the beginning of the hearing, for claim number 09 WC 25519, Petitioner was alleging an accident date/manifestation date of July 16, 2008. (See, AX 5) For claim number 13 WC 16330, Petitioner was alleging an accident date/manifestation date of November 1, 2010. (See, AX 6) At the conclusion of the hearing, Petitioner amended his accident date/manifestation date for the first claim (09 WC 25519) to July 15, 2008. The Arbitrator also granted Petitioner's motion during the hearing to amend Petitioner's age from 47 years of age to 50 years of age on the request for hearing form in the 13 WC 16330 claim. (AX 3)

The Arbitrator finds:

Petitioner previously filed a claim against Respondent for elbow injuries, as well as hand injuries, based upon a theory of repetitive trauma. (PX13; RX 13) Petitioner alleged an accident date of May 24, 2002. (PX13; RX 13) At that time, Petitioner was in a "no-bid" job for Respondent working as a furnace packer, pointer operator, forklift driver, power sweeper operator, crane hooker, saw operator, die handler and saw crew. (PX13; RX 13)

As a result of this prior accident, Petitioner was diagnosed with bilateral carpal tunnel syndrome, bilateral epicondylitis, and possible bilateral radial tunnel syndrome. (RX 13; PX13) Petitioner underwent surgical releases for right carpal tunnel syndrome, a right open ulnar tunnel release, right open radial tunnel release and a right lateral epicondylar release and partial epicondylectomy. Petitioner also underwent surgical releases for the left hand and arm. He

underwent a left open carpal tunnel release, a left open ulnar tunnel release, a left open radial tunnel release, and a left lateral epicondylar release with partial epicondylectomy and anconeus muscle flap transposition. (PX13; RX 13) Petitioner subsequently underwent additional surgery on the right elbow. This included a revision of the lateral epicondylar release, a right elbow arthrotomy and synovectomy, as well as an anconeus muscle flap transposition. (PX13; RX 13)

Petitioner's case proceeded to trial on October 31, 2005. At that time, Petitioner testified that he had less strength in his hands and arms. He also complained that he had a loss of motion in his right elbow. He claimed he was unable to bow hunt, work on his cars and perform household chores including caring for his grandmother and repairing his fence. Petitioner also complained of having difficulties using a phone because of the pain associated with bending his arm to raise the phone to his face. (PX13; RX 13)

Petitioner was awarded a 27.5% loss of use of his right hand and right arm (each) and a 25% loss of use of his left hand and left arm (each) stemming from his work injuries on May 24, 2002. (PX13; RX 13) The Arbitrator's award was thereafter confirmed by the Commission on March 23, 2007. (PX13; RX 13)

On July 7, 2008 Petitioner reported to Respondent's dispensary for swelling in his right pinky finger. On July 15, 2008 Petitioner returned there with complaints of shoulder popping and stabbing burning pain in his left shoulder along with an observable knot. Ice was applied. He also complained of pain in both elbows.[1] On July 16, 2008 Petitioner completed an accident report regarding his left shoulder indicating he had reported it to Bob Eichelmann.[2] (RX 3)

[1] While the actual document is not entirely clear the parties stipulated to this interpretation during the hearing.
[2] Petitioner's left shoulder claim is the subject of case # 09- WC -25518.

On July 16, 2008 Petitioner was seen by Dr. Ruiz at Midwest Occupational Medicine for his left shoulder. No elbow complaints were noted. With regard to his left shoulder, Petitioner was placed on restricted duty of no forceful activity with the left arm. (PX6)

An accident investigation report followed on July 17, 2008. (RX 4) Neither RX 3 nor RX 4 mentions an elbow injury.

Petitioner was re-examined at Midwest Occupational on July 18, 2008. No elbow complaints were noted. Physical therapy and medications were prescribed for Petitioner's shoulder. (PX6)

On July 25, 2008 Petitioner again returned to Midwest Occupational. He was examined by Dr. Byler. Additional therapy was prescribed and his left arm restrictions were continued. (PX6)

Dr. Byler re-examined Petitioner on August 14, 2008. No elbow complaints were noted. Petitioner was told to finish his therapy and they'd see how he had progressed. (PX6)

Petitioner underwent another exam at Midwest Occupational on September 4, 2008. An MRI was ordered for his left shoulder. No elbow complaints were noted. On September 26, 2008 Petitioner was again seen at Midwest Occupational and he was referred to an orthopedist for his shoulder. No elbow complaints were noted. (PX6)

Petitioner treated with Dr. George Paletta from September 11, 2008 through May 20, 2009 for his left shoulder problems. Prior to surgery, treatment included an injection and physical therapy. Petitioner voiced no elbow complaints during this time. Still symptomatic, Dr. Paletta recommended surgery which followed. Petitioner was taken off work as of December 11, 2008, the date of surgery. (PX 2)

Post-surgery, Petitioner began physical therapy.

At Respondent's request, Petitioner underwent an independent medical evaluation with Dr. Strecker on March 31, 2009. According to his written report, this exam was being conducted in connection with Petitioner's 2002 injury. (RX 9) Dr. Strecker took a history from Petitioner regarding his elbow symptoms and complaints. Petitioner gave Dr. Strecker a history of having problems with his arms and elbows several years earlier, consisting of elbow pain with numbness and tingling in the hands. (RX 9) He added "He states that although this involved both elbows it now involves the left nondominant more than the right. He feels that the left is more involved because he had to pull the product from the left side." Dr. Strecker also noted that Petitioner stated that he was currently experiencing some aching discomfort in his elbows and numbness and tingling primarily in the ring, small finger, and thumb that began in July of 2008. Dr. Strecker examined the medical records from Dr. Sudekum, Pro-Rehab, Dr. Gragnani and Dr. Khattake for Petitioner's treatment from 2002 to 2004. This included Petitioner's surgical treatment in 2003 and 2004. (RX 9)

Based upon this evaluation, Dr. Strecker believed Petitioner had symptoms compatible with cubital tunnel syndrome. He recommended electrical studies. Dr. Strecker went on to opine that if Petitioner's job required that his elbows be in a fully flexed position for prolonged periods of time his job would be a contributing factor to his cubital tunnel syndrome. (RX 9)

After the exam, Petitioner continued with his shoulder therapy.

On April 3, 2009, Petitioner returned to Dr. Paletta's office for an exam. At that time, Dr. Paletta anticipated Petitioner returning to full duty on April 20, 2009.

On April 7, 2009 Petitioner saw Dr. Yaganti. There was no mention of any elbow complaints. (PX4)

On April 8, 2009 Petitioner attended one of his physical therapy appointments for his shoulder. At this point in time physical therapy was aimed at trying to mimic the job duties it was believed Petitioner would be engaged in when returning to work. Petitioner reported having some shoulder concerns with certain activities but he also reported having problems with the inside of his elbows and "had already seen a doctor for them." Petitioner was not certain what his job would be when he returned to work. He did indicate that his previous job was as a "crane hooker, "which was easy." While Petitioner didn't feel he would have any problems with that job, it had been given to someone else. Petitioner anticipated going back to work on the block performing various jobs which required a great deal of pulling. When Petitioner returned for his April 16, 2009 office visit it was noted that Petitioner was waiting to see what the doctor had said about his elbows. (PX 2)

Petitioner returned to work for Respondent on April 20, 2009.

Petitioner then returned to Dr. Paletta's office on May 20, 2009. Dr. Paletta felt Petitioner could continue working without any restrictions and released Petitioner from his care. There was no mention of any elbow complaints or concerns. (PX 2)

On May 12, 2009 Petitioner filed his Application for Adjustment of Claim in case number 09-WC-22519 alleging repetitive trauma injuries to his elbows with an accident date of July 16, 2008. (AX 5)

Petitioner returned to work as a sweeper/operator for approximately two months. He then went to work on 4 Block.

Petitioner presented to Dr. Yaganti on June 9, 2009. Petitioner gave a history of rotator cuff surgery and bilateral carpal tunnel surgery and epicondyle surgery. Petitioner expressed "complaints of pain." Petitioner mentioned he had seen the "w/c doctor." Dr. Yaganti explained

to him he didn't treat work-related injuries. Petitioner had "complaints of bilateral medial epicondylitis, elbow pain for longtime. He feels numbness, including numbness and tingling in left small ring finger. He does lots of constant pulling on things into roller." Petitioner reported intermittent paresthesia of the hands. Dr. Yaganti noted bilateral elbow tenderness in the medial epicondylar region. Dr. Yaganti advised Petitioner to get an EMG but explained he would need to go to a different doctor for treatment of his elbows. (PX4)

Petitioner underwent x-rays of his elbows on June 24, 2009. (RX 8) The x-rays revealed evidence of degenerative arthritis in both elbows. (RX 8) Electrical studies performed on June 24, 2009 for the ulnar nerve were within normal limits across the wrist, forearm and elbow. (RX 7)

On July 27, 2009 Petitioner, through his attorneys, filed a Section 19(h) Petition in the 2002 claim (03 WC 50065).

Petitioner then sought treatment from Dr. Beatty on July 30, 2009. (PX3) Petitioner completed a questionnaire giving an onset date of "7-16-09" and providing job summaries for both a Block Line Pointer and a Block Line Operator. He also indicated he used a hammer, power saw, and hack saw. Petitioner gave a history of epicondyle pain in his elbows with numbness in the ring and fifth fingers for one to two years. Dr. Beatty noted that Petitioner had seen Dr. Strucker in March of this year at Respondent's request and the doctor confirmed the problem was work-related "as told to the patient." Respondent, however, told Petitioner it was not work-related and to do it on his own. Dr. Beatty's physical examination reflected a positive Phalen's sign bilaterally in all fingers. He diagnosed Petitioner with ulnar neuropathy by history and recommended Petitioner undergo nerve conduction studies. (PX3)

At the request of Respondent Dr. Strecker prepared a supplemental IME report on August 9, 2009, after examining Petitioner's updated treatment records following his shoulder injury. This included the medical records from Dr. Paletta, Dr. Byler, and physical therapy notes from Pro-Rehab. Dr. Strecker also examined the task analysis report for block operator. (See RX 4) (RX 10) Based upon his examination of these updated records he did not believe that Petitioner's cubital tunnel symptoms were a result of his prior work injury from 2002. (RX 10) Dr. Strecker also opined that there was no casual relationship between Petitioner's job duties as a #4 block operator and his cubital tunnel symptoms. (PX10) In reaching this opinion, Dr. Strecker noted that Petitioner did not have any complaints of cubital tunnel symptoms in the medical treatment records until April 16, 2009 while on light duty. He further based his opinion on the job analysis which failed to demonstrate Petitioner's elbows being at a fully flexed position for prolonged periods of time. (RX 10)

Petitioner then returned to Dr. Yaganti on August 20, 2009. Dr. Yaganti reviewed the electrical studies as well as the x-rays. Based upon the electrical studies and the x-rays, Dr. Yaganti diagnosed Petitioner with medial epicondylitis and ulnar nerve associated degenerative arthritis in the left elbow and less severe degenerative arthritis in the right elbow.

Petitioner underwent electrical studies with Dr. Yadava on November 2, 2009. According to the history, Petitioner had been experiencing persistent discomfort in his hands that began in July of 2008. Petitioner explained that he worked as a block operator, a job that involved a considerable amount of "load handling." Petitioner explained that he previously underwent surgery for lateral epicondylitis and carpal tunnel syndrome with excellent results and "got back to all of his chosen activities in an uncomplicated way." Petitioner further told the doctor that he then began a new position with Respondent and his arm started bothering him. Due to increasing

pain he went to Dr. Beatty. (PX5) Dr. Yadava noted considerable irritation of the ulnar nerve and hypertrophy at the cubital tunnel with a markedly positive Tinel's sign bilaterally. The results were consistent with entrapment neuropathy consistent with cubital tunnel syndrome, moderate to severe on the left and moderate on the right. (PX5) Petitioner then returned to Dr. Beatty on November 23, 2009. Based upon the electrical studies of Dr. Yadava, Dr. Beatty recommended surgery. He noted, "I concur with previous doctors that this would be work related." Petitioner was given work restrictions of limited lifting, repetitive motion, and pushing and pulling. (PX3)

In a letter to Petitioner's attorney dated November 30, 2009 Dr. Beatty advised that he would be taking steps to get Petitioner's surgery authorized by the workers' compensation carrier but if there was no response, he recommended a 19(b) Petitioner be pursued in light of the moderate severity of Petitioner's problem. (PX 3)

Petitioner underwent a left ulnar nerve release on January 6, 2010 followed by a right ulnar nerve release on January 26, 2010. (PX3) Dr. Beatty took Petitioner off of work effective January 6, 2010. (PX3)

The deposition of Dr. Beatty was taken on February 9, 2010. Dr. Beatty opined that Petitioner's elbow condition was work-related based on the work activity Petitioner had related his complaints to. (PX 9, p. 15)

Dr. Beatty said that Petitioner's cubital tunnel syndrome was a progressive condition because it was due to cumulative or repetitive trauma. (PX9, p. 47) Dr. Beatty also acknowledged that the electrodiagnostic study performed by Dr. Ravi in June of 2009 failed to reveal an ulnar neuropathy at the elbows and that Dr. Yadava's electrical studies 4 ½ months later revealed moderately severe on the left and moderate on the right cubital tunnel syndrome. (PX9, pp. 47-48)

Dr. Beatty admitted that cubital tunnel syndrome can develop outside of work. (PX9, p.52) Dr. Beatty also testified that arthritis in the elbows can lead to the development of cubital tunnel symptoms. (PX9, p.54) He said that after viewing the x-ray reports ordered by Dr. Yadava of Petitioner's elbows, degenerative arthritis might play a role. (PX9, pp.55-57)

Throughout the deposition Dr. Beatty repeatedly testified that he relied on Petitioner's description of his job duties at his initial appointment as a basis for his causation opinion. Dr. Beatty was also given the task analysis to review and said that the activities listed on the task analysis could cause cubital tunnel syndrome. (PX9, p. 31) When questioned about the job task analysis' conclusion that Petitioner's job did not contain significant elements of repetition, Dr. Beatty stated that an ergonomic analysis is strictly "what you pay for." (PX4, p.59) Dr. Beatty acknowledged that he had not reviewed any of Petitioner's medical records pre-dating 2008. (PX 9, p. 36)

Dr. Strecker gave his evidence deposition on March 24, 2010. (RX 11, p. 28) Based upon his examination, Dr. Strecker did not believe there was a causal relationship between Petitioner's cubital tunnel condition and his job duties for Respondent. In so opining, he relied on Petitioner's description of his job as given on March 31, 2009. (RX 11, p. 14) In explaining the basis of his opinion, Dr. Strecker stated that cubital tunnel syndrome can develop in the work environment when someone has to rest on the elbows to perform any activity for prolonged periods of time or when an employee has to maintain her elbows in a fix flexed position for prolonged periods of time, thereby putting tension on the nerve. Dr. Strecker noted that Petitioner said he did not do that. (RX 11, p. 14-16)

Dr. Strecker was also asked questions about his second report from August of 2009, issued after he had reviewed additional records, including an ergonomic job analysis. Dr.

Strecker testified that the first mention of any medial-sided elbow pain he found in the medical records was dated April 16, 2009. Dr. Strecker then discussed how Petitioner's earlier medical records regarding his elbow (2002 - 2004) never mentioned medial elbow problems and a normal EMG and nerve conduction study in 2004. Therefore, Dr. Strecker did not feel Petitioner's elbow condition in 2009 was related to his earlier 2002 accident, noting Petitioner had undergone normal examinations of his elbow between then and now. (RX 11, pp. 20, 21,27) As for whether Petitioner's elbow condition related to his job as a Block Operator, Dr. Strecker, relying on the job description given by Petitioner, did not have to maintain his elbows in a fixed flexed position for prolonged periods of time nor was he required to put constant pressure on the medial aspect of his elbow so he didn't feel it was "directly" related to his job. He also noted that Petitioner was on light duty between July of 2008 and May of 2009 (when his symptoms were first noted) and he wasn't doing anything during that time that would have contused his ulnar nerve. (RX 11, pp. 20-21)

Dr. Strecker examined the task analysis report as part of his evaluation of Petitioner. He examined the report to determine the actual job duties and to determine if the job activities required force flexion of the elbows. (RX 11, pp. 23, 28-29) Based upon the task analysis, Dr. Strecker stated that Petitioner was not required to engage in forced flexion of the elbow. (RX 11, p. 23) When asked if he relies upon job analyses and ergonomic reports in looking at the causation issue Dr. Strecker testified that there is "variable reliability sometimes with ergonomic evaluation[s], but it's an opinion, so when I'm forming mine I take a look at it." (RX 11, p. 23)

On cross-examination Dr. Strecker acknowledged that Petitioner told him he lifted and pulled on coils. Petitioner told him he had to lift, he had to push, and he had to pull. the major activity was pulling, especially with his left arm and that's what he felt was the repetitive nature

of his problem. (RX 11, p. 30) He acknowledged that he did not ask Petitioner specifically how much time he spent during his 8-10 hour shifts performing the various activities. (RX 11, p. 32) He had no opinion as to the cause of Petitioner's cubital tunnel syndrome noting he had no symptoms until 2008 but said nothing until 2009 and had undergone numerous nerve conduction studies that were normal. If nothing else, he attributed it to age. (RX 11, pp. 33-34) At the end of cross-examination the doctor was asked if the information he was given regarding Petitioner's job duties was different, might his opinions change. Dr. Strecker replied, "Yes, sir." (RX 11, p. 34)

Thereafter Petitioner continued treating with Dr. Beatty who released Petitioner from treatment on May 13, 2010 with a full duty release effective May 17, 2010. Petitioner was thereafter cleared to return to work for Respondent by Midwest Occupational Medicine on May 17, 2010. At that time, Petitioner stated that he was doing much better and his arms were doing very well. (RX 15)

Petitioner returned to work on #4 Block.

Petitioner returned to see Dr. Beatty on November 1, 2010 reporting bilateral elbow pain at the area of the surgical sites and, on the left at times, into the fifth finger. The right side was not as sensitive. Petitioner's left elbow was noted to have a tendency to sublux. "He was left with appropriate sling to prevent that, but that area had been treated with Cortisone injections in the past to my recollection. Options were surgery or a sling. they agreed to proceed with surgery and Petitioner was given an elbow pad in the interim. (PX 3)

Dr. Beatty performed a left elbow medial epicondylectomy and ulnar neurolysis on February 15, 2011. (PX4) Dr. Beatty performed the same surgery on the right elbow on June 7, 2011. (PX3) Petitioner was taken off work as of February 15, 2011.

Petitioner received follow-up treatment from Dr. Beatty thereafter. (PX3) Dr. Beatty released Petitioner from treatment, with no restrictions, on September 1, 2011. At that point, Dr. Beatty noted Petitioner was doing well with his grip strength improving. (PX3) Petitioner returned to work on September 19, 2011. (PX 3)

A second deposition of Dr. Beatty was taken on June 26, 2012. Dr. Beatty testified that the second surgeries were a result of subluxation of the ulnar nerve in the medial elbow. (PX9, Dep. 2, p.15) He returned to see the doctor in November of 2010 due to pain at the surgical sites. (PX 9, Dep. 2, p. 27) He acknowledged that the sling type of repair he did in 2010 had not worked out and Petitioner began having problems when he returned back to work. . (PX 9, Dep. 2, pp. 29-31, 36)

Dr. Beatty agreed that when Petitioner returned for treatment on November 1, 2010 he did not give a history of developing symptoms as a result of his job duties. (PX9, Dep. 2, p.27) Dr. Beatty testified that although he did a sling of repair to prevent subluxation during the first surgeries in January, 2010, the procedures did not work. (PX9, Dep. 2, p. 29) When Dr. Beatty saw Petitioner on November 1, 2010 he only found evidence of subluxation of the ulnar nerve on the left. Petitioner later developed subluxation of the ulnar nerve on the right. The subluxation on the right occurred when he was off of work. (PX9, Dep. 2, p. 29-30)

At the arbitration hearing, multiple witnesses testified.

Testimony of Petitioner

Petitioner testified regarding his work status and condition of his elbows prior to the alleged accident of July 15, 2008. Petitioner acknowledged prior bilateral upper extremity surgeries and testified that he had been released by his treating surgeon, Dr. Sudekum, without restrictions on April 5, 2004. Petitioner also testified that when he returned to work in 2004, he

worked as a crane hooker for a year or so. According to Petitioner this job required that he hooked loads with slings on an overhead crane.

Petitioner testified that he could not recall that Dr. Sudekum believed he would continue to have problems with his elbows. However, Petitioner admitted that he couldn't straighten his elbows out after the surgeries for the claim in 2002. Petitioner said it was a lifetime problem. Petitioner also said that after his accident in 2002, his elbows would cramp if he flexed them and that the cramping was still a problem. Petitioner also said that his elbows would freeze due to the 2002 accident. Petitioner also said that he had difficulties sleeping if his elbows are flexed due to the accident in 2002. Petitioner also complained of his elbows popping all of the time. He confirmed he could no longer bow hunt. Petitioner also testified that he could not care for his grandmother due to his elbow problems because he could not lift her. Petitioner also stated that due to the accident in 2002, he couldn't refurbish his 1967 Camaro as he couldn't use a ratchet wrench due to elbow pain. Petitioner also said that he couldn't use a post hole digger due to elbow pain to complete building his fence.

Petitioner also testified that when he returned to work after the surgeries related to the 2002 claim, he continued to have elbow pain. Petitioner said that he was having ongoing elbow problems since the arbitration hearing in 2005 for the 2002 claim. Petitioner said that the pain was not due to one type of job, but based on either the activity involved or positioning of his arms.

Petitioner testified he returned to work for the Respondent as a "crane hooker" until 2006. He described it as a moderately physically demanding. The job involved an overhead crane lowering a boom with a hook and Petitioner having to use his arms out in front of his body to put the ends of a sling around the hook so the crane could raise the load. Petitioner testified

this required him to lift only a couple of pounds. Petitioner performed this job 8 to 10 hours per day and five, sometimes six, days per week. Petitioner testified he did not experience any elbow pain while performing "crane hooking". Sometime in 2006 Petitioner was moved to the #4 block line. Since 2006, working the #4 block line has been Petitioner's main job for Respondent.

According to Petitioner the #4 block operator job required him to pull two inch coil tubing through a dye box. Petitioner claimed that he would reach out with both hands in front to grab the coil. He claimed he did this 300 times per shift. Petitioner had assistance from the point operator to move the coil to the die box. Petitioner would place copper tubing in the die box. He said this was a pretty quick process. Petitioner would then take the jaw head and clamp onto the copper and make the run. Petitioner also said that the jaw head was on a pivot that it would move so he did not lift it. Petitioner testified that moving the jaw head was neither easy nor hard. Once the copper was clamped, Petitioner would push a button to start and watch the run. He said that the run would take approximately a 1 to 1 ½ minutes. Petitioner said that most of the time he was standing and watching while holding the button.

Petitioner further explained that his job duties included standing and grabbing with both hands the end of a coil of copper tubing, 2 inches in diameter, from his left side and pulling the end of the tubing, at chest height towards and across his body, into a dye box located on Petitioner's right side. The pulling of the copper tubing towards his chest required Petitioner to flex his elbows. He would use his body weight to pull the tubing across his body. Petitioner testified it was a strenuous activity. Petitioner testified the resistance each copper tube is different and depends on how much each tube stretches and the amount of tension of each tube. Petitioner testified each copper tube provides at least 25 to 40 pounds of resistance. Petitioner testified that sometimes the amount of resistance is more when the copper tube gets hung in the

rollers so he has to jerk the tube to get it free. After the tubing was successfully placed in the dye box, he would grab a "jaw head" by unlatching the jaw arm with his left arm and with his right hand push a button on a control panel to allow the jaw head to go into reverse. Sometime the jaw head would move freely, other times it provided quite a bit of resistance. Petitioner would guide the jaw head, sometimes with use of both arms, back towards himself to complete the process. Petitioner worked 8 to 10 hours per day, five, occasionally six, days per week. Petitioner testified he would repeat this entire process an average of 300 times per shift.

Petitioner testified that his elbow symptoms started a few months before he hurt his shoulder. Petitioner further claimed that in 2007 when pulling on the copper he would experience symptoms with his elbows, including his fingers going numb. Petitioner testified these symptoms began a few months before July 2008. Petitioner testified that during the months before July 2008, the more hours he worked consecutively performing his job on the #4 line his elbow symptoms would increase. The more intensely he worked his elbow symptoms would increase. When Petitioner worked less, after a weekend or vacation, his elbows and hands felt better. Petitioner testified these symptoms of numbness were different than those he experienced previously involving his elbows and hands in the prior workers' compensation claim.

Petitioner claimed that he periodically mentioned his elbows to Bob Eichelmann who gave him Ibuprofen. In addition to reporting his left shoulder injury on July 15, 2008, Petitioner also claimed that he reported his elbow injury as well. Petitioner said that when he informed Bob Eichelmann of a shoulder injury, he also told him about pain in his elbows.

Petitioner testified that he also told Mr. Mike Staublan, Respondent's safety director, about his shoulder and elbows at the dispensary when he was there on July 16, 2008. According

to Petitioner, Mr. Staublan advised him that they would take care of the shoulder first and elbows next.

Petitioner also testified that about a conversation/meeting with Dave Coppola, the "Two mill manager" on July 17. Petitioner testified that he explained to him how everything happened on the job that night that he got hurt. He testified that he told him about his shoulder and his elbows and that they had been bothering him for a long period of time before then. Mr. Coppola is no longer with the company.

Petitioner also testified that he told Dr. Paletta about his elbows during his last treatment in May, 2009. Petitioner testified that Mike Staublan told him to have Dr. Paletta examine his elbows.

Petitioner testified that when he returned to work in May of 2010 his elbows felt great. He testified that he returned to work in #4 Block. Petitioner testified that he worked in #4 Block 8 - 10 hours a day and five days per week. During this time overtime was mandatory.

Petitioner claimed that in October, 2010 his elbows began bothering him again. He had numbness and tingling in his little and ring fingers similar to before. Petitioner initially stated that he did not recall telling anyone at Respondent of his elbow problems when he saw Dr. Beatty on November 1, 2010. He further testified that he may have told Mary Bohlen in the human resources department that he had to take a day off. Petitioner later testified he reported the injury to supervisor Dave Shields. (AX 6) Petitioner claims he told Dave Shield that his elbows were bothering him again; however, he never said that they were work-related. Petitioner also testified that he may have only told Ms. Bohlen that he had a doctor's appointment.

Petitioner was asked about the job description he provided to Dr. Beatty during trial. Although Petitioner said that he was not doing the point operator job, he listed these job duties in his written description to Dr. Beatty.

Petitioner denied filing a Petition under Section 19(h) seeking additional monies due to his 2002 claim. He was not aware that a claim was pending. Petitioner's attorney did admit that a 19(h) Petition was pending.

In addition to reporting his left shoulder injury on July 15, 2008, Petitioner also claimed that he reported his elbow injury as well. Petitioner said that when he informed Bob Eichelmann of a shoulder injury, he also told him about pain in his elbows.

Petitioner stated that even though he had elbow problems in the past, the symptom of numbness he was experiencing in 2008 was different. Petitioner acknowledged, however, that he did not mention any numbness to Mr. Eichelmann. Petitioner further did not recall telling Mr. Staublan of having numbness and tingling when he complained of elbow pain on July 16, 2008. Petitioner said that when he told Mr. Eichelmann of his injury on the evening of July 15, 2008 he told him of elbow pain, not numbness. This was despite Petitioner confirming that the numbness into the fingers was a new symptom. Petitioner also testified that even though he was doing the sweeper job on light duty while undergoing treatment for his shoulder, the light duty job caused elbow symptoms. Petitioner testified there was no improvement of his elbow symptoms while on light duty.

Petitioner also testified that while he was receiving treatment for his shoulder injury in 2008 and 2009 he was also seeing his family physician, Dr. Yaganti. Petitioner received treatment from Dr. Yaganti in April, 2009, around the time that he was released to work by Dr. Paletta for his shoulder. Petitioner's first complaints regarding his elbows to Dr. Yaganti

occurred on June 9, 2009. At that time, Petitioner was still doing the sweeper job. Petitioner testified that the entire time he was on light duty he was working as a sweeper and that his elbows continued to bother him during that time. It may have gotten a little better while on light duty but it never went away.

Petitioner testified he has slight difficulty performing his job duties since his last surgeries. He said that pulling tubes causes discomfort. He takes ibuprofen to combat discomfort. Petitioner said that he had no problems doing activities at home. Petitioner has worked as a #4 block operator for the last three years.

Testimony of Bob Eichelmann

Bob Eichelmann is a production supervisor for Respondent. He is a 37 year old employee. He was the supervisor of the #4 block operator job in 2008. Mr. Eichelmann was aware of a work injury on July 15, 2008; he made a note of Petitioner reporting accident. Petitioner requested some Ibuprofen at 2:00 in the morning. Petitioner also paged him at 7:30 that morning asking for a pass to go to the dispensary and Mr. Eichelmann told him he would be right over with it. When he got there Petitioner had already gone to the dispensary. Mr. Eichelmann didn't know if Petitioner went to the dispensary or not. Mr. Eichelmann wasn't completely sure what the issue was but he recalled Petitioner saying something about lifting the block or the jaw head. He didn't write down exactly what the issue was. He didn't recall Petitioner exactly stating there was an injury. Mr. Eichelmann did not recall if Petitioner made any complaints to him regarding his elbows. However, when asked what Petitioner did complain about, Mr. Eichelmann testified that as the shift was getting started he was going to assign Petitioner to the "#3 block pointing" but Petitioner made the comment that his arms couldn't take that and that if he was put there Mr. Eichelmann might as well write him a pass for the

dispensary. Mr. Eichelmann then proceeded to work things out and Petitioner worked on 4 block, rather than 3 block that night. Mr. Eichelmann also could not recall specific times when he might have given Petitioner Ibuprofen; however, he might have done so on occasion. He really couldn't recall if it was a regular basis or anything of that nature. On cross-examination Mr. Eichelmann acknowledged that he might have given Petitioner Ibuprofen from his desk drawer in the months before July 15, 2008. Mr. Eichelmann also testified that Petitioner made no complaints regarding his elbows leading up to July 15, 2008; however, he really didn't recall. He just didn't remember.

Testimony of Michael Staublan

Michael Staublan has worked for Respondent seven years as its safety manager. Part of his duties includes being responsible for the dispensary logs/records "if he's there." The purpose of the log is to keep track of any injuries that are reported. Mr. Staublan testified that Petitioner came to him the morning of July 16, 2008 complaining about his left shoulder and elbows. Mr. Staublan did not recall telling Petitioner they would wait until later to take care of his elbows. He further denied giving him any direction concerning treatment for his elbows with Dr. Paletta.

Mr. Staublan acknowledged that he gave Petitioner RX 3 to complete but that he provided him with no direction as to what to state. He denied giving Petitioner any information regarding not mentioning in his elbows in that report/statement. Mr. Staublan denied that Petitioner ever came in wanting to fill something out because his elbow hurt. On cross-examination he acknowledged that employees are encouraged to speak to their supervisors before coming to him regarding complaints. If an employee didn't think it was job related, he or she wouldn't ordinarily present to Mr. Staublan.

Testimony of Brian Stemlor

Brian Stemlor, union president for employees of respondent also testified. Mr. Stemlor stated that he was aware that Petitioner was experiencing elbow pain at the time of his shoulder injury in 2008 based on the dispensary log. However, although he was union president since 2002, he was not aware Petitioner had any prior problems with his elbows. Mr. Stemlor said that he was sure he knew Petitioner had prior elbow surgery. But, he did not know if Petitioner was having elbow problems prior to July, 2008. Mr. Stemlor also looked at the accident report describing only a shoulder injury. He acknowledged there was nothing on the accident report regarding the elbows. He further stated that Petitioner's statement also only mentioned an injury to his shoulder. Petitioner never filled out an accident statement for his elbows.

A job analysis for the #4 block operator job was also performed on January 18, 2005 to assess essential functions of the job. The job analysis was performed by Timothy Knox at Occupational Consulting and Rehabilitation. (RX 5) It is noted that job required operating a console that controls the work station rollers, block jaw, drum and stripper. The job also required guiding points of coils into block jaws, monitoring and making adjustment during draws, removing plugs, throwing scrap pieces down a chute and moving and operating the pointer. (RX 5)

A task analysis report and job analysis was also tendered into evidence at trial of this matter. (RX 4; RX 5) The task analysis report was performed through the ergonomics department at the BJC Corporate Health Services in St. Louis, Missouri on November 8, 2004. The purpose of the task analysis was to determine the physical demands of a job and whether the job is likely to result in musculoskeletal disorder. (RX 4) Based upon the analysis for the #4 Vaughn block operator job, the task analysis report reflects the risk factors were within acceptable limits for arms, hands, and wrists under the various measuring tools utilized in the

analysis. The Strain Index score suggested a "very low risk" for work related musculoskeletal disorders in the distal upper extremities. The Recovery Time score negated any long-term musculoskeletal affect on the tissues and made the task "unlikely" to produce a repetitive motion disorder or cumulative trauma strain. The Snook Tables for the "Push/Pull the pointer machine toward/from the clamped tube end" indicated the job was "likely" safe for at least 100% of the male population. OSHA's ergonomic standard indicated the job did not contain "significant" elements of repetition, awkward posture, force or vibration. (RX 4)

Evidence presented at arbitration regarding Petitioner's wage included Petitioner's testimony of working 8-10 hours, 5-6 days a week. Petitioner also testified he worked mandatory overtime when he returned to work in May of 2010. Petitioner also produced the "contract book" regarding the hourly rate for union members at respondent's employment. (PX10) Petitioner testified that a year prior to the alleged accident on July 15, 2008, his hourly rate was $17.49 per hour. (PX10) For the alleged accident on November 1, 2010 Petitioner testified he was earning $18.49 per hour for the year prior. (PX10)

Respondent produced Petitioner's wage statement for the year prior to Petitioner's alleged accident on July 15, 2008. (RX 14)

The Arbitrator concludes:

1. Issues (C), (E), and (F) --Accident, Notice, and Causal Connection. (Both claims)

Petitioner sustained an accident on July 15, 2008 that arose out of and in the course of his employment with Respondent. Petitioner's current condition of ill-being in the medial side of his elbows is causally connected to his injury of July 15, 2008 and his work duties for Respondent. Petitioner provided notice of his injury.

Petitioner reported both shoulder and elbow complaints on July 15, 2008. While Mr. Eichelmann was not sure regarding the injury Petitioner reported, he did not go with Petitioner to the dispensary. Indeed, Mr. Eichelmann was not sure about a great many things. Mr. Staublan acknowledged that Petitioner reported something about his elbows. He also testified that employees go the dispensary for work-related problems. Petitioner's testimony regarding his conversation with Dave Coppola was unrebutted.

While Respondent may contend that Petitioner failed to give adequate notice of an elbow injury, this Arbitrator, under these circumstances, disagrees. Notice was provided. It may have been somewhat defective; however, there has been no prejudice to Respondent. Something happened to trigger the examination with Dr. Strecker on March 31, 2009. It did not come out of the blue. Petitioner's testimony that he mentioned both his shoulder and elbow to Mr. Staublan but that Mr. Staublan told him they would address the more serious of the two first, makes sense and is plausible. Mr. Staublan could not recall if he said that or not. As Petitioner was progressing to a return to work for his shoulder and undergoing physical therapy mimicking his job duties, he began experiencing elbow problems. The therapist noted that Petitioner associated his left-sided complaints with his job duties of pulling. Petitioner explained this to Dr. Strecker at the time of the examination. Thus, Respondent was aware of the nature of Petitioner's complaints and how he associated them with his job duties. There was also the past conversation with Mr. Coppola in which Petitioner remarked his elbows had been bothering him for awhile. Petitioner's statements to Mr. Coppola could understandably have led to Respondent's scheduling of an examination to determine if there was any relationship between Petitioner's old injury and his ongoing complaints. Thus, Respondent had ample opportunity to investigate Petitioner's elbow complaints (and, indeed, was doing so by virtue of the examination itself). Alternatively, the

Arbitrator could amend the accident date to March 31, 2009, the date of the exam with Dr. Strecker. Certainly Petitioner's elbow condition and its relationship to his work manifested itself at that time. The central issue is the relationship, if any, between Petitioner's work duties and his elbow condition.

The Arbitrator begins by noting that Petitioner was a very credible, strong, direct, and forthright witness. He was upfront regarding his 2002 injury and its resulting limitations. He was very clear and direct in his description and demonstration of his job duties as a Block Operator. No one really disputed his description. Rather, Respondent relies on the ergonomic report and job description to negate any conclusion that the job was repetitive in nature. Petitioner's testimony regarding his conversations with supervisors and managers regarding his elbow symptoms was strong and persuasive. He recalled the details whereas those with whom he had conversations did not necessarily do so. Petitioner was very clear in describing the difference in his symptoms beginning in 2008 as compared to his earlier ones stemming from his 2002 injury.

The evidence is strong that Petitioner had a significant problem with his upper extremities beginning with his 2002 claim. He underwent multiple surgeries to both extremities and received significant awards. However, he was returned to full duty work without any permanent restrictions. The treatment he received at that time did not involve the medial side of his elbows. The Arbitrator also acknowledges Petitioner's testimony regarding the limitations Petitioner had in his upper extremities when he tried his cases in 2005. Petitioner acknowledged ongoing problems from those surgeries at the time of this hearing.

The problems Petitioner was treated for by Dr. Beatty stemmed from a new injury

and not the 2002 injury. First, they involved a different part of the elbows -- the medial side. Second, the job Petitioner associated with his new complaints in his elbow was different than that performed in 2002. Petitioner's testimony, Dr. Beatty's testimony, and the medical records support a repetitive injury or aggravation of the condition of Petitioner's medial elbows. Dr. Strecker made a big concession on cross-examination when he acknowledged that if he had additional information pertaining to Petitioner's job his opinion might change. His opinions otherwise were based upon incorrect information and an incomplete and thorough understanding of Petitioner's job. Dr. Strecker's causal opinion is based on an inaccurate understanding that Petitioner's medial complaints developed after July 2008. Petitioner testified his bilateral medial elbow symptoms began in the months before July 15, 2008 and did not dissipate while he was either off work or on light duty following treatment he was receiving for his left shoulder and continued through his initial appointment with Dr. Beatty on July 30, 2009. Respondent's ergonomic analysis and job description were, as Dr. Strecker acknowledged, just one piece of the puzzle or part of the information to be considered. Having thoroughly reviewed and read both documents, this Arbitrator has concluded that the ergonomic study (which never once mentioned the elbow specifically) does not rule out a situation such as Petitioner's. The Strain Index discusses a "very low risk", the Recovery Time was felt "unlikely" to produce a repetitive motion disorder, and the OSHA standards did not contain "significant" elements of repetition, awkward posture, force or vibration. (RX 4, p. 2) Petitioner herein was not your ordinary worker. He had significant problems with his elbows before he went to work as a Block Operator. Thus, he began that job with pre-existing problems in his elbows altogether. Neither the Task Analysis, job description, nor Dr. Strecker considered how the job might impact Petitioner given his prior problems/ pre-existing condition of his elbows. While arguably on a different side of the elbow,

Petitioner nevertheless did not have a normal elbow. Petitioner's job duties for Respondent on the #4 block line in the months before July 15, 2008 were significant enough to be a cause of Petitioner's bilateral medial elbow symptoms which did not dissipate while he was either off work or on light duty following treatment he was receiving for his left shoulder. Indeed, the timeline makes complete sense. Petitioner was having some problems with his elbows which he reported in July of 2008. His shoulder, however, was the primary problem at the time, and, therefore, medical attention focused on it. During this time he was given light duty. Petitioner testified that his elbow problems were better during that time but they didn't completely resolve. Petitioner had shoulder surgery and was given physical therapy. As the therapy began to mirror his job duties on the Block, he mentioned elbow problems. As he returned to #4 Block, the elbow complaints persisted and Petitioner reached a point he needed treatment.

With regard to Petitioner's alleged accident on November 1, 2010 (13 WC 16330), the Arbitrator finds that Petitioner failed to establish an accident arising out of and in the course of the employment on that date. Petitioner's complaints were a continuation of his July 15, 2008 accident and the additional surgeries and treatment with Dr. Beatty thereafter were causally related to that accident. Dr. Beatty diagnosed Petitioner with subluxation of the ulnar nerves after his cubital tunnel surgeries in January, 2010. Dr. Beatty admitted that the sling procedure he used to prevent subluxation of the nerves did not work. The surgeries in 2011 were therefore necessary to prevent a subluxation. Petitioner's symptoms and complaints in 2010 which developed in October or November, 2010 resulted from a complication of the prior surgeries.

It should be further noted that Petitioner's right ulnar nerve was not subluxing when initially treated by Dr. Beatty on November 1, 2010. The subluxation of the right ulnar nerve did

not start until April, 2011 and while Petitioner was not even working. This evidence reflects a failure of the prior surgical procedures to hold the ulnar nerves in place.

2. **Issue (G): What were Petitioner's earnings?**

Petitioner's earnings for the year preceding the accident of July 15, 2008 were $29,707.82 and his average weekly wage was $571.30. Petitioner relies on the TTD checks to support his average weekly wage claim. However, that will not suffice. Petitioner provided no testimony regarding his wages except for identifying his hourly wage per the contract book and some testimony regarding the number of hours he worked per day and the number of days per week. The only testimony regarding overtime was given within the context of his working mandatory overtime after returning to work in May of 2010. Even then Petitioner did not provide any evidence that overtime was regularly scheduled.

Respondent, on the other hand, produced a wage statement. It shows earnings of $29,707.82 based upon regular earnings and shift differentials. That would equate to an average weekly wage of $571.30.

3. **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 all the medical treatment provided to Petitioner for his bilateral elbows was reasonable and necessary and Respondent is responsible for the medical bills incurred as a result thereof. Consistent with her liability determination, the Arbitrator awards Petitioner any medical bills in PX 8 related to treatment for Petitioner's bilateral elbow condition. Respondent is to pay the medical bills indentified in Petitioner Exhibit 8 as provided in Sections 8(a) and 8.2 of the Act subject to the fee schedule including reimbursement to Petitioner for any

out-of-pocket expenses he incurred. Respondent shall be given a credit for any amounts 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.

4. **Issue (K): What TTD benefits are owed?**

The Arbitrator concludes that Petitioner is entitled to payment of temporary total disability benefits as a result of the July 15, 2008 date of accident from 01/06/10 to 05/17/10 (18 5/7 weeks) at a rate of $380.83 per week. Dr. Beatty kept Petitioner completely off work for this period of time. The Arbitrator concludes that Petitioner is further entitled to payment of temporary total disability benefits from 02/15/11 through 09/19/11 (30 6/7 weeks) at a rate of $380.83 per week. Dr. Beatty kept Petitioner completely off work for this period to time. Respondent's dispute over temporary total disability benefits was based upon liability and that has been determined in Petitioner's favor.

5. **Issue (L): What is the nature and extent of Petitioner's injuries?**

With regard to Petitioner bilateral medial elbows, Petitioner has sustained permanent partial disability to the extent of 10% disability of each arm. This conclusion is based upon Petitioner's testimony, the relevant medical records, and the prior workers' compensation decision. Petitioner sustained injuries to both elbows, which required two surgeries to the medial aspect of each elbow. Petitioner has been able to return to his job without restrictions and his ongoing complaints and symptoms are minimal. He has sought no further treatment since being released by Dr. Beatty. Petitioner testified he has slight elbow pain when performing his job duties. He experiences discomfort pulling on copper tubing and running the #4 block. He takes Ibuprofen and Aleve to combat the discomfort. He continues to work 8 to 10 hours per day. This

permanent partial disability award is in excess of the credit Respondent receives for prior award of 27.5% of Petitioner's right arm and 25% of Petitioner left arm.

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

Linda Hilton,

Petitioner,

15IWCC0834

vs.

NO: 09 WC 30491

Garik, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, notice, 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 March 16, 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 $9,400.00. 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: NOV 12 2015
KWL/vf
O-11/9/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

NOTICE OF 19(b) ARBITRATOR DECISION

15IWCC0834

HILTON, LINDA
Employee/Petitioner

Case# **09WC030491**

GARIK INC
Employer/Respondent

On 3/16/2015, 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 0.09% 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:

2738 McCARRON LAW FIRM PC
JOSEPH A McCARRON
624 N MAIN
BLOOMINGTON, IL 61701

2593 GANAN & SHAPIRO PC
JESSICA BELL
411 HAMILTOPN BLVD SUITE 1006
PEORIA, IL 61602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 19 (B)

15IWCC0834

Linda Hilton
Employee/Petitioner

v.

Garik, Inc.
Employer/Respondent

Case # **09** WC **30491**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Peoria**, on **January 26, 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. [x] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
   [ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **Prospective Medical**

FINDINGS

On **November 24, 2008**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**13,264.80**; the average weekly wage was $**255.09**.

On the date of accident, Petitioner was **46** years of age, ***single*** with **0** dependent children.

Petitioner has not received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $**5,000** for TTD, $**0.0** for TPD, $**0.0** for maintenance, and $**30,857.00** for other benefits, for a total credit of $**35,857.00**.

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

ORDER

PETITIONER DID SUSTAIN ACCIDENTAL INJURIES WHILE WORKING FOR THE RESPONDENT ON NOVEMBER 24, 2008.

PETITIONER GAVE PROPER NOTICE UNDER THE ACT.

PETITIONER'S CURRENT CONDITION OF ILL BEING INVOLVING THE LUMBAR SPINE IS CAUSALLY RELATED TO THE PETITIONER'S ACCIDENT.

RESPONDENT IS ORDER TO PAY THE PAST MEDICAL CONSISTENT WITH THE FINDINGS OF FACT AND CONCLUSIONS OF LAW ATTACHED.

RESPONDENT IS ORDERED TO PAY FOR THE TREATMENT PRESCRIBED BY DR. MULCONREY PURSUANT TO SECTION'S 8 AND 8.2 OF THE ACT.

IN NO INSTANCE SHALL THIS AWARD BE A BAR TO SUBSEQUENT HEARING AND DETERMINATION OF AN ADDITIONAL AMOUNT OF MEDICAL BENEFITS OR COMPENSATION FOR 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

March 11, 2015
Date

MAR 16 2015

Findings of Fact

The Petitioner testified that on November 24th, 2008 she was working for the Respondent stocking cases of liquor. She testified she remembered it was the Monday before Thanksgiving which was a busy time for the store. She testified that as she was lifting a case of liquor which contained approximately twenty four one pint bottles. The box slipped out of her grasp and she caught it using her right leg. She noticed the onset of pain in her lower back and right hip area. She was working alone and did not immediately tell anyone what had happened. Her pain continued and at the end of her shift, she said that she told a co-worker who came to relieve her about her accident. The co-worker was John Holt, the brother of her supervisor.She was off work due to her schedule or Tuesday, Wednesday, and Thursday and was scheduled to return to work on Friday. She testified that she attempted to address the pain in her low back by alternating ice and heat as well as using over the counter medication. She testified that the pain did not resolve and in fact continued to get worse resulting in muscle spasms so she went to the emergency room on Friday November 28th, 2008.

Petitioners exhibit E contains is a medical record from November 28th, 2008 which would be the following Friday. It states "The PT stated that the pain started on Monday after she was lifting boxes at work." (See exhibit E bate stamped p. 00563) Also from November 28th, 2008 record in exhibit E states:

> "History of the present illness: Ms. Hilton is a forty six year old female who reports increasing back pain with radiation into the right leg diffusely since Monday. This has worsened and has not been alleviated with several medications including Aleve, Ibuprofen, and Flexural. She has also tried heat and ice with no relief... This pain has been consistent and persistent and worsening since Monday." (Exhibit E bate stamped p. 000577)

Also the emergency room record in Petitioners exhibit E indicates the chief complaint as an injury and pain to back and context is lifting at work. (Exhibit E bate stamped p. 00556, 608) Her examination revealed acute low back pain. (Id at 609) The triage screening form from the emergency room states that the Petitioner complained of right sided low back pain radiating down the right leg since Monday and that the problem was work related. (Id at 611) The ambulance notes of November 28, 2008 state that the Petitioner's pain began on Monday after she was lifting boxes at work. (Id at 615)

The following Monday December 1st, 2008 is the second earliest medical record that we have regarding the injury and is contained in Petitioners exhibit C. The medical record states with blanks filled in by the Petitioner:

"Date, time of accident: 11/24/08 PM Was your accident directly related to your work? Yes. Briefly describe the events that occurred just before and during your accident: putting cases of inventory on shelves and stock room/left one of thirty cases as I couldn't lift anymore...Did you report your accident to your employer? Yes. What recommendations did your employer make just after your accident? Contacted him by phone on Friday 28th as going to Hospital." (Petitioners exhibit C bate stamped pgs. 00143-00147)

Petitioner testified that she let her supervisor Rick Holt know of the injury on November 28th, 2008, as she was scheduled to go back to work that day. Although the Petitioner did not remember the exact conversation that she had with Mr. Holt on November 28th, 2008, this should not be surprising as the trial was taking place over six years after she would have made that phone call. However the Petitioner testified that she received her full TTD benefits for the time that she was off work from November 24th, 2008 until she was released back to work by Dr. Mulconrey in May of 2009. No witnesses from the Respondent testified suggesting that she did not adequately indicate the mechanism of her injury or to otherwise dispute that the accident happened as she indicated. The above mentioned entries from the emergency room, the ambulance service and the chiropractor sufficiently corroborate the Petitioner's testimony concerning her accident and notice. Accordingly Petitioner met her burden of proof regarding accident, its date and notice.

The Petitioner testified that Respondents workers compensation carrier asked her to see Dr. Daniel Mulconrey. However once Dr. Mulconrey indicated that Petitioner would need a surgery in October 2009, Respondent decided to hire Dr. Delheimer Pursuant to Section 12, in December 2009. Unfortunately Dr. Delheimer passed away prior to his deposition, so the Respondent then hired Dr. Lawrence Li pursuant to Section 12 to examine the Petitioner. The Petitioner hired Dr. Skaletsky who also gave an Independent Medical Examination on her behalf. These four where the only medical experts who gave opinion testimony regarding causation and Ms. Hilton's need for surgery.

The Petitioner testified that she saw Dr. Mulconrey because her worker's compensation administrator asked her to see Dr. Mulconrey. The Petitioner resided in McLean County and Dr. Mulconrey's office is in Peoria Illinois. The Petitioner testified that she did not know who Dr. Mulconrey was until the workers compensation carrier recommended that she see him. In Dr. Mulconrey's deposition he indicated that he was not sure how Ms. Hilton was referred as he normally would dictate the primary care physician or the referring physicians name at the top of the note and he did not do that, he admitted that it was possible that the workers compensation carrier referred Ms. Hilton to him. He testified that he sent a copy of his initial treatment note who he understood to be the case management worker for Petitioners workers compensation claim. (Bate stamped p. 001304)

Dr. Mulconrey testified that he is solely a treating physician and does not give independent medical examinations for Petitioners or Respondents. (See deposition of Dr. Mulconrey bate stamped p. 001305) Dr. Mulconrey treated Petitioner from February 2nd, 2009 through February of 2013. Dr. Mulconrey reviewed a CT report from the CT scan taken on November 28th, 2008. He also reviewed a CT mylograms which he had taken in September of 2009, and April of 2013. The doctor specifically found that she had bilateral foraminal narrowing at L5 S1. This bilateral foraminal narrowing was present not only in 2009 but from the November 28th, 2008 CT scan. (See Dr. Mulconrey's Deposition page 17 to 18 bate stamped pgs. 001316 through 001317) Dr. Mulconrey testified that this narrowing could account for the radiation down her right leg. (See deposition Dr. Mulconrey page 18 bate stamped p. 001317)

Dr. Mulconrey thought that the CT scan on November 28th, 2008 as well as the CT mylogram taken in September of 2009, as well as the third CT scan which he took and reviewed in April of 2013 were all consistent. (See deposition of Dr. Mulconrey's Deposition pages 17-20 bate stamped pgs. 001316 through 001319) The doctor indicated that he discussed surgical fusion with her on October 19th, 2009. (See deposition of Dr. Mulconrey page 19 bate stamped p. 001318) Shortly after this the respondent sent Petitioner to an IME and denied subsequent treatment.

Petitioner again saw Dr. Mulconrey on February 4th, 2013 and Dr. Mulconrey with respect to that visit he said "the symptoms are very similar to what she reported to me in 2009. In the interim since our last appointment it did not appear there had been significant change in her over all condition." (See deposition of Dr. Mulconrey page 20 bate stamped p. 01319)

> He again indicated "based on her symptoms, failure of conservative treatment, and radiographic findings she would still be a candidate for spinal fusion surgery at L5-S1, very likely possibly to include L4-5, but I would need to reevaluate the patient and reevaluate the CT scan as well as perhaps even a new Ct mylogram." (See deposition page 21 of Dr. Mulconrey bate stamped p. 001320)

The doctor clearly indicated that he believe her work injury on November 24th, 2008 caused her need for the treatment that he had given her in the past as well as the surgery that he was recommending. (See deposition of Dr. Mulconrey pages 24 and 25 bate stamped pgs. 001323 and 001324) he indicated that he was basing that opinion on her history as well as the objective tests including her CTs and mylograms. (Deposition of Dr. Mulconrey page 27 bate stamped p. 001326)

Dr. Mulconrey testified that he did return her to work in May but denied that he found her to be at MMI at that time. He indicated that he wanted to return her and let her try going back to work full duty for a short period of time to see how she did. (See deposition of Dr. Mulconrey page 30 & 31 bate stamped pgs. 001329 through 001330) Since she returned back to him shortly after that in July of 2009 he did not think she was at MMI. After the Respondent's cross examination of Dr. Mulconrey he confirmed that

the issues raised did not change any of the opinions that he gave on direct examination. (See deposition of Dr. Mulconrey page 42 bate stamped p. 001341)

Dr. Skaletsky agreed with Dr. Mulconrey on all points. He agreed that the objective scan of November 28, 2008 showed bilateral lateral recess stenosis which could cause problems down either of her legs. (See deposition of Dr. Skaletsky pages 12 and 13 bate stamped pgs. 001258 and 001259) He also indicated that her possible need for surgery and future mylogram were casually related to her work injury. (See deposition of Dr. Skaletsky page 13 bate stamped p. 001259)

The Respondent offers Dr. Lawrence Li's deposition as evidence that the Petitioners condition of ill being is not related to her accident and that the Petitioner reached MMI in May of 2014. Essentially Dr. Lawrence Li disagreed with Dr. Mulconrey, and Dr. Skaletsky, regarding how he interpreted the reports of the CT scans. Specifically he thought these reports would only indicate left sided narrowing not right sided or bilateral narrowing as found by Dr. Mulconrey. (See Respondents exhibit 9 page 21 and 22 deposition of Dr. Li) Dr. Li did agree that the CT scan showed a disc protrusion and herniation (see Respondents exhibit 9 page 24 deposition of Dr. Li) Dr. Li agreed that someone could aggravate a pre-existing back injury by lifting cases if liquor and had that aggravation lead to the need for surgical intervention. (See deposition of Dr. Li page 24) Dr. Li stated that in his review of the medical records Linda Hilton did not have any significant back complaints until we go back to March of 2000 before her date of accident of November 24th, 2008. (See deposition of Dr. Li 25 and 26)

When asked about his experience regarding lumbar treatment Dr. Li indicated that he does not currently do lumbar surgeries. (Respondents exhibit 9 page 31) When he was asked if he had /ever/ done a lumbar surgery he answered "essentially no I think I've done like one when I first started practice, so, essentially, no." (id.)

Accordingly Dr. Li's experience dealing with lumbar problems is in sharp contrast with both Dr. Mulconrey and Dr. Skaletsky's. Dr. Skaletsky indicated that from 1981 until 2001 he performed about 300 to 350 neurosurgical procedures per year as a primary surgeon and assisting on at least that many for some of his partners. He indicated that he stopped doing spinal surgeries in 2001. He indicated that since that time his primary focus has remained on the spine. (See deposition of Dr. Skaletsky page 6) Dr. Skaletsky testified that he would have performed surgeries on people with similar conditions of Linda Hilton's approximately three thousand times. (See deposition of Dr. Skaletsky page 6 and 7)

Similarly Dr. Mulconrey has an obvious emphasis on spinal surgery and lumbar spine issues. His CV which is attached as Exhibit A to his deposition shows that he has given national or international papers presentations or posters twenty four times related to the spines. He has also published eight articles relating to spinal treatment including several dealing with fusions. These listings do not include an additional twenty four regional presentations that Dr. Mulconrey has given most of which are relating to the spine. (See CV of Dr. Mulconrey deposition exhibit A) Accordingly to the extent there is

some disagreement on how the CT scan reports should be interpreted Dr. Mulconrey and Dr. Skaletsky both clearly have much more experience in this regard.

Finally the Respondent relies on Dr. Delheimer's report, Dr. Delheimer not only disagrees with Dr. Mulconrey and Dr. Skaletsky but he also disagrees with Dr. Li, regarding the interpretation of the CT scans. Whereas Dr. Skaletsky and Dr. Mulconrey both believe the CT scans show bilateral issues, and Dr. Li believes that it would show only left sided issues, Dr. Delheimer states:

> "Diagnostic review: I reviewed the mylogram/lumbar CT scan that showed evidence of degenerative disc disease at L4-5 and L5-SI. There was no evidence of a herniated disc or significant impact on any nerve root. She does have significant narrowing of the L5-S1 disc."

Accordingly Dr. Delheimer disagrees with all three of the doctors who testified as well as the radiologist who performed the CT scans. These differences on how he interpreted the diagnostic studies no doubt lead to his conclusion that

> "After obtaining a narrative history, performing neurological exam and reviewing medical records and diagnostic studies, is my opinion Ms. Hilton at most suffered a soft tissue injury to the lumbar region during the course of her work activities on November 24th, 2008. There is no evidence of a herniated disc or impact on any nerve root seen on her diagnostic study and her examination today was not consistent with lumbar radiculopathy. In the absence in any objective findings on her examination today I would not recommend any restrictions for her work activities..." (Page 6 of Dr. Delheimer's report)

He continuously denies seeing "any evidence of a herniated disc or impact on any nerve root." (See page 7 of Dr. Delheimer's report) (See also) "There is no evidence of a herniated disc or impact on any nerve root seen on her diagnostic study and her examination today was not consistent with lumbar radiculopathy." (Page 6 of Dr. Delheimer's report) Accordingly Dr. Delheimer is at odds with all of the other physicians who have testified.

Finally Dr. Delheimer wrote "She denied any specific work related incident associated with the onset of pain, but stated that the pain simply began during the course of her work activities of November of 2008." (See Dr. Delheimer report page 2) The Respondent did not submit the intake sheet filled out by the Petitioner when she saw Dr. Delheimer. However that record is contained in Dr. Mulconrey's medical records which were submitted as Petitioners exhibit D. In exhibit D bate stamped p. 00330 we see a document at the top that says "Steven C. Delheimer, MD" and then below that an intake sheet that states: "Was this condition a result of accident?" She indicated "Just lifting cases at work" Dr. Mulconrey agreed that that was not his record and would have been a record that the patient filled out for Dr. Delheimer. (See deposition of Dr. Mulconrey page 43 to 44)

Finally during the cross examination of the Petitioner she was asked questions regarding some sporadic treatment in 2003 and 2004 from Dr. Leese. The Petitioner did indicate she would see Dr. Leese occasionally for various issues including sinus headaches. Both the Respondent and then Petitioner have these records in their exhibits. It is at times difficult to determine whether the hand written notes are indicting a "CS" which would presumably mean cervical spine or possibly even C5 versus a "LS" which may be lumbar spine or even L5. At any rate none of the doctors who gave an opinion in this matter thought that this treatment or the problems that she would have had in 2004 were somehow the cause of her current problems.

Accordingly I find that the medical treatment following the Petitioners accident of November 24th, 2008 was casually related to her accident of November 24th, 2008. The Respondent is ordered to pay those past medical bills which include an unpaid medical bill from OSF St. Joseph Medical Center in the amount of $9,044.25, pursuant to the Fee Schedule. It should also reimburse the Petitioner for the self-payment for her visit with Dr. Mulconrey in February of 2013 for $229.35.

I also find that the Respondent shall authorize the subsequent CT scan and surgical procedure recommended by Dr. Mulconrey.

D. D. McCarthy
Signature of Arbitrator

March 11, 2015
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 McHENRY	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Carrie S. McCabe,
Petitioner,

vs.

NO: 09WC 43026

Huntley Fire Protection District,
Respondent,

15IWCC0820

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, causal connection, medical, employee/employer relationship, penalties, fees, permanent partial disability, temporary 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 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: NOV - 6 2015
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DLG/mw
045

David S. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CARRIE S McCABE
Employee/Petitioner

Case# **09WC043026**

HUNTLEY FIRE PROTECTION DISTRICT
Employer/Respondent

15IWCC0820

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:

0491 SOSTRIN & SOSTRIN PC
ELLIS M SOSTRIN
33 W MONROE ST SUITE 1510
CHICAGO, IL 60603

0507 RUSIN & MACIOROWSKI LTD
DANIEL R EGAN
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

STATE OF ILLINOIS)
)
COUNTY OF McHenry)

15IWCC0820

☐ 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

Carrie S. McCabe
Employee/Petitioner

Case # 09 WC 43026

v.

Consolidated cases: _____

Huntley Fire Protection District
Employer/Respondent

15IWCC0820

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 Industrial Commission, in the city of Woodstock, on 12/4/2014. 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 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? 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 the respondent?
N. ☐ Is the respondent due any credit?
O. Other _____

15IWCC0820

FINDINGS

- On 6/30/2009, the respondent Huntley Fire Protection District *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.
- Petitioner's current condition of ill-being ***is*** causally related to the accident.
- In the year preceding the injury, Petitioner earned $**19,665.88**; the average weekly wage was $**378.19**.
- On the date of accident, Petitioner was **31** years of age, ***married*** 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 $ for TTD, $ for TPD, $ for maintenance, , an $ 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 reasonable and necessary medical services of $29,947.05, as provided in Sections 8(a) and 8.2 of the Act.

- If any medical provider seeks reimbursement for which Respondent has previously received or sought a credit for write offs or adjustments, Respondent shall hold Petitioner harmless from any such claim.

- Respondent shall pay Petitioner temporary partial disability benefits of $68.47/week for 133 2/7 weeks, commencing 7/1/2009 through 1/6/2010 and 1/15/2010 through 1/26/2012, as provided in Section 8(a) of the Act.

- Respondent shall pay Petitioner temporary total disability benefits of $268.67/week for 4/7 weeks, commencing 1/7/2010 through 1/14/2010, as provided in Section 8(b) of the Act.

- Respondent shall pay Petitioner permanent partial disability benefits of $268.67/week for 75.25 weeks, because the injuries sustained caused the 35% loss of the left leg, as provided in Section 8(e) of the Act.

- Respondent shall pay to Petitioner penalties of $3,922.66, as provided in Section 16 of the Act; $19,613.33, as provided in Section 19(k) of the Act; and $10,000.00, as provided in Section 19(l) of the Act.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest of 0.13 % 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.

Mark E Mc
arbitrator

JAN 5 - 2015

December 19, 2014
date

Carrie S. McCabe vs.
Huntley Fire Protection District
09 WC 43026
D/A 6/30/2009

15IWCC0820

MEMORANDUM OF DECISIONOF ARBITRATOR

FINDINGS OF FACT

Petitioner testified on December 4, 2014. After carefully reviewing the record, the Arbitrator finds that Petitioner's testimony was credible and consistent with the medical records and documentation that were offered into evidence at the time of hearing. Petitioner testified that she previously worked for the Sugar Grove Fire Department and was certified through the state Fire Marshall as a Firefighter. She also received certification under hazmat, paramedic and critical care training in 2001-2003. Petitioner also worked as a part time paramedic for the Sandwich Fire District. She was first certified as a fire fighter in late 2001, early 2002.

She first became involved with the Huntley Fire Protection District in fall 2008. Petitioner filled out the Huntley Fire Protection District Application for Employment on October 10, 2008. (Pet Ex 1) She had an interview with Deputy Chief Mallegni in late fall 2008, . Her interview took place at the main station on Coral Street. During the interview, Deputy Chief Mallegni asked her about her past experience as a fire fighter and paramedic. Deputy Chief Mallegni offered to pay her $18 per hour for the job and Petitioner accepted his offer of pay. She was offered and accepted the job as a part time position of fire fighter and filled out various documentation including but not limited to: the Huntley Fire Protection District Part Time Employment Agreement (Pet Ex 3), an IL W-4 Employee's Illinois Withholding Allowance Certificate (Pet Ex 5), an Employment Eligibility Verification Form (Pet Ex 6), an Electronic Communication System Member Acknowledgment Form (Pet Ex 7), and a Firefighter Code of Ethics (Pet Ex 8). Petitioner testified that she got the job but needed orientation training for the job so she began the fire training at Huntley on January 23, 2009.

Petitioner testified that the training program was at the Huntley location, directed by Scott Ravagnie who was the training officer at Huntley. Huntley directed her training activities on the duties of a firefighter, how it was to be accomplished and graded her on her activities. She was provided an orientation schedule and training reports to demonstrate her grades on her performance. (Pet Ex 2) Petitioner began the training period and then Scott Ravagnie asked Petitioner to build up her upper body strength and she took a leave of absence from Huntley to improve her upper body strength. She returned to undergo the second training period at Huntley on or about June 25, 2009 and she repeated the training she performed in the first session. This training entailed going into the training tower and performing search and rescue in full rescue gear, as well as performing ladder carries and hose pulls. Her full turnout gear included a helmet, gloves, and boots. All the equipment was provided from Huntley; she could not provide her own equipment and the name "Huntley Fire Protection District" was labeled on the helmet and the gear. Huntley directed her training exercises and she was graded by

Huntley Lieutenant James Brown on accomplishing her training. She testified that her training related to the general business of the Huntley Fire Department by learning to utilize the equipment faster and learn to maneuver around things during a fire.

Petitioner testified that when she was performing her duties for the Huntley Fire Department, she was paid by pay check and taxes were withheld from her pay checks. Petitioner also testified that pursuant to the employment agreement she signed with Huntley, in exchange for receiving paramedic training, if she quit working on her own for 2 years she would have to pay the costs of the training back to Huntley. Huntley did have the right to discharge Petitioner. (Pet Ex 3)

Petitioner testified that while she was working for Huntley, and making $102.70 per week at Huntley, she was concurrently working for Fox Valley Associates and making $275.49 per week. This was also stipulated to by the parties in Arb Ex 1.

Petitioner testified that on June 30, 2009, Petitioner was working for Huntley Fire Protection District and was undergoing a training exercise in the training tower. (Pet Ex 10) She was required to raise a ladder in the training tower that was filled with smoke to perform an individual search and rescue. She climbed a ladder to the second story window, repelled through a window and when she hit the ground, her left knee twisted and popped and she landed on her left leg. She heard a pop and felt severe pain in her left leg and knee. Petitioner was wearing full turnout gear: her coat, fire rescue hood, gloves, boots, self-contained breathing apparatus, breathing mask and air tube, and was carrying an axe or crowbar. Her equipment weighed approximately 60 lbs. The ladder she was climbing belonged to Huntley. Lieutenant James Brown was in the window and witnessed the accident.

Huntley Fire Protection stabilized her left leg, called an ambulance and removed her gear. She was rushed to St. Joseph Hospital Emergency Room on June 30, 2009. (Pet Ex 25) The Emergency room records document that she twisted her knee during a training exercise today at the firehouse. (Pet Ex 25) Her patella was tender, her left knee was swollen and she was unable to bear weight. They performed an x-ray to her left knee and prescribed ice, elevation, knee immobilizer, crutches, Motrin for pain and Vicoprofen. The records indicate "there may be a very tiny medial peripatellar avulsion fracture." (Pet Ex 25)

Petitioner next followed up with Dr. Grosskopf at Fox Valley Orthopedics on July 1, 2009. (Pet Ex 26) The history in the Fox Valley records documents that Petitioner "injured her left knee during her final days of preliminary firefighter training; specifically she repelled through a window as part of her fire training drills and when she hit the ground her left knee twisted and popped. Absolutely no problems or injury to left knee before this accident. She had immediate pain, some swelling, a sense of weakness and instability." (Pet Ex 26) Dr. Grosskopf examined her and reviewed her x-rays; he diagnosed her with an acute left knee injury and indicated that she may have an MCL/ACL injury but she could have had a lateral patellar subluxation or dislocation with spontaneous reduction as well. (Pet Ex 26) He ordered an MRI, fitted Petitioner for a DonJoy brace, prescribed physical therapy, Vicoprofen, and prescribed light duty work.

Petitioner testified that she notified Deputy Chief Mallegni and gave him the light duty note, but he told her that they have no light duty for the position of a firefighter. She was released to light duty at Fox Valley Orthopedics and only performed sitting down work with the phone or with triage.

On July 20, 2009, Petitioner underwent the MRI of her left knee which demonstrated a tear injury of the medial patellar retinaculum with associate edema of the soft tissues adjacent to the retinaculum. There is also bone marrow edema signal identified involving the medial most aspect of the medial patellar facet. Along with a tear injury of the medial patellar retinaculum, these findings are consistent with a patellar dislocation injury, which has relocated. (Pet Ex 26)

Petitioner followed up with Dr. Grosskopf on July 27, 2009 and he reviewed the MRI and diagnosed Petitioner with a lateral patellar dislocation. He prescribed additional physical therapy, sit down work, and prescribed Vicoprofen. On August 26, 2009, Dr. Grosskopf again examined the Petitioner and prescribed physical therapy, a Palumbo type brace, and sit down work. (Pet Ex 26) Petitioner underwent the physical therapy at Athletico and underwent heat, electrical stimulation, stretching, riding a bike and squatting. On September 30, 2009, Petitioner followed up with Dr. Grosskopf and Petitioner testified that her left knee was unstable, and the patella felt like it could slip out. Dr. Grosskopf examined her and prescribed one more month of therapy and then re-evaluate possible surgery, but continue her rehab and prescription medicine, and continue sitting work. (Pet Ex 26) On October 28, 2009, Dr. Grosskopf examined Petitioner and performed an intra-articular steroid injection to help with inflammation and swelling, prescribed continued therapy, light duty work in the form of sit down work and the possibility of surgery. (Pet Ex 26) Petitioner testified that she noticed a temporary improvement from the injection, but then the steroid was wearing off and she developed more significant knee pain, knee swelling and patellar instability. On December 7, 2009, Dr. Grosskopf examined her, prescribed surgery, and continued her light duty.

On January 7, 2010, Petitioner underwent an arthroscopic condral debridement of the patella, arthroscopic electrosurgical lateral release and arthroscopic medial patellofemoral ligament imbrication at the Fox Valley Orthopedic Surgery Center. (Pet Ex 26) After the surgery, Petitioner was taken off work for one week and could not perform any duties at Huntley or Fox Valley Associates, then after one week, Petitioner returned to sedentary sit down work at Fox Valley Associates only. She could not return to Huntley because they did not have any light duty. Subsequent to the surgery, Petitioner underwent physical therapy at Athletico two to three times per week. (Pet Ex 27) She also wore a Palumbo brace and took Vicoprofen. In March 2010, Dr. Grosskopf stopped her brace and increased her therapy. (Pet Ex 26) In May 2010, Dr. Grosskopf prescribed more therapy and light duty, but no carrying anything due to leg weakness. (Pet Ex 26) In June 2010, Petitioner was getting some strength back and Dr. Grosskopf recommended more formal therapy. In July 2010, Petitioner still had decreased range of motion and some swelling and discomfort. Dr. Grosskopf prescribed additional therapy, light duty with no squatting, kneeling or ladders. (Pet Ex 26) In October 2010, Petitioner still noted problems with flexing and would get a deep subpatellar pain. She noted that ladders, squatting, kneeling, lunges and squatting down with her child or picking up toys all still hurt. (Pet Ex 26) The doctor at Fox Valley Orthopedics recommended glucosamine and chondroitin sulfate as vitamins for the joint and she was working a good therapy program. (Pet Ex 26)

On March 16, 2011, Petitioner followed up with Fox Valley Orthopedics; she noticed some improvements but was still struggling with getting full flexion, with squatting down, and kneeling. The physician kept her same work restrictions and prescribed additional physical therapy which she underwent at Athletico. (Pet Ex 26, 27) On April 26, 2011, Petitioner noted continued problems with deep squats and bending, but was making significant gains in therapy. Her doctor continued her restrictions and continued her therapy for one month. (Pet Ex 26) On May 24, 2011, Petitioner was gaining range of motion in her knee but still had some weakness, tightness and pain. Her doctor examined, continued her 2-3 times per week for another month of physical therapy and prescribed the same work restrictions of no squatting, kneeling, or climbing ladders. (Pet Ex 26) On November 29, 2011, Petitioner still had instability, swelling, and discomfort in her left knee. She also was experiencing clicking and crepitus in the knee. Her doctor discussed the use of visco supplementation, additional therapy to work on a patellofemoral program with focus on her IT band, and determined she was not yet at maximum medical improvement.

On January 26, 2012, Petitioner still complained of instability of the left knee with swelling, pain, clicking, tightness, and stiffness. (Pet Ex 26) Dr. Grosskopf examined Petitioner and prescribed left knee surgery consisting of a reconstruction with allograft. (Pet Ex 26) Petitioner testified that as of the present time, she has opted not to have the surgery since her husband's group insurance would not pay for it, she did not have the money to cover it, and she has two young children and could not be laid up with two young children who need care. Dr. Grosskopf never released Petitioner's restrictions of limited squatting, kneeling, no ladder climbing and no heavy lifting. Petitioner testified that in her experience in firefighting, these restrictions would not allow her to return to that occupation.

Petitioner testified that she has suffered no prior injuries to her left knee. She testified to one prior workers compensation injury in 2001/2002 when she injured her left wrist. She testified that on the date of her accident, her condition of health was excellent. She has suffered no subsequent injuries since June 30, 2009.

Petitioner testified that she was off work subsequent to her left knee surgery on January 7, 2010, from January 7, 2010 through January 14, 2010 and received no pay for that period of time. Petitioner testified that subsequent to January 14, 2010, she was only working sedentary and then light duty at Fox Valley Associates, but Huntley Fire Protection could not accommodate her light duty and she did not return to work for Respondent; further, she was not paid any Temporary Partial Disability Benefits.

Petitioner testified that she still has pain and problems with her left knee. She still has difficulty climbing up and down the stairs, her left leg gets tired and fatigued, and she can feel her knee cap slipping. She feels pain when she attempts to sit Indian style or squat. She has decreased range of motion in her left knee. She still does a home exercise program to prevent slipping of the patella. If she is playing with her two kids, the next day, her leg is hurting. She often takes anti-inflammatories or ices her leg. She quit marching in the band as she used to march and carry the drum. She has difficulty taking long walks or short jogs. She still feels pain and discomfort in her left knee and her knee cap remains unstable so she wears a knee brace.

15IWCC0820

Petitioner was examined at the request of the workers' compensation insurance carrier by Dr. Kevin Walsh on January 10, 2013. Dr. Kevin Walsh testified through an evidence deposition. Dr. Walsh took a history and examined the Petitioner and opined that it is not at all likely the patient's subjective complaints at the time are causally related to the accident described in June 2009; he opined if the patient had suffered an acute patellar dislocation as a result of the injury described, more likely than not, the patient would have had significant swelling at the time of the MRI scan and the records indicate a mild edema. (Walsh Dep Ex 2) He opined that the MRI of July 20, 2009 indicated only a trace joint effusion and if the patient suffered an acute patellar dislocation, more likely than not, she would have had a large effusion at the time of her evaluation in the ER and large effusion on her MRI scan taken 3 weeks later after the event. (Walsh Dep Ex 2) More likely than not, the patient would have been diagnosed with a patellar dislocation when seen in the emergency room or initially by Dr. Grosskopf. (Walsh Dep Ex 2) More likely than not, the patient is at MMI with regards to arthroscopic intervention by Dr. Grosskopf. (Walsh Dep Ex 2) Patient can return to work without formal restrictions. (Walsh Dep Ex 2) Patient requires no additional treatment or restrictions as a result of the injury described. Care and treatment received by the patient appears to be reasonable. Initial evaluation in the ER and initial visits by Dr. Grosskopf are reasonable and necessary and related to her work injury. (Walsh Dep Ex 2)

CONCLUSIONS OF LAW

In support of the Arbitrator's decision relating to "B," Was there an employee-employer relationship, the Arbitrator makes the following conclusion:

The Arbitrator finds that Petitioner was an employee working for the Respondent employer pursuant to Illinois case law. Under Ware v. Industrial Commission, 318 Ill. App. 3d 1117, 1122, 743 N.E. 2d 579, 252 Ill. Dec. 711 (2000):

> No rigid rule of law exists regarding whether a worker is an employee or an independent contractor. Rather, courts have articulated a number of factors to consider in making this determination. The single most important factor is whether the purported employer has a right to control the actions of the employee. Also of great significance is the nature of the work performed by the alleged employee in relation to the general business of the employer. Additional factors to consider are the method of payment, the right to discharge, the skill the work requires, which party provides the needed instrumentalities, and whether income tax has been withheld. Finally, a factor of lesser weight is the label the parties place upon their relationship. The term employee, for purposes of the Workers' Compensation Act, should be broadly construed.

The actual exercise of control is strong evidence of the employer's right to control. Ware, 318 Ill. App. 3d at 1123. In this claim, the evidence is clear that Respondent, Huntley Fire Protection had the right to control the actions of the Petitioner. Petitioner testified that she was undergoing the training program at the Huntley location, directed by Scott Ravagnie who was the training officer at Huntley. Huntley directed her training activities on the duties of a firefighter, how and when it was to be accomplished and graded her on her training activities. She was provided an orientation schedule and training reports to demonstrate her grades on her performance. (Pet Ex 2) This training entailed going into the training

tower and performing search and rescue in full rescue gear, as well as performing ladder carries and hose pulls. She was performing the fire fighter training program in the manner as directed by Huntley and in the time frame as directed by Huntley (Pet Ex 2) and was being graded on all her tasks by Huntley. Huntley had the right to control Petitioner's actions and in fact did control the manner and timing in which Petitioner performed the work.

Petitioner was working for the Huntley Fire Protection District and the nature of the work that she was performing was firefighting. Petitioner's testimony and documentation demonstrates that the method of payment supports that Petitioner was also an employee. Pet Ex 4 is a payroll record showing Petitioner as an employee with deduction. (Pet Ex 4) Pet Ex 5 is an Illinois withholding allowance certificate. (Pet Ex 5) Pet Ex 9 was a Huntley W2 form. (Pet Ex 9) The documentation offered into evidence supports that Petitioner was paid an hourly salary, Respondent took out money for taxes, and Respondent paid her as an employee.

The testimony was unrebutted that Respondent had the right to discharge Petitioner and pursuant to the employment agreement she signed with Huntley, in exchange for receiving paramedic training, if she quit working on her own for 2 years she would have to pay the costs of the training back to Huntley. (Pet Ex 3) Petitioner testified that Respondent provided the needed instrumentalities. Respondent provided Petitioner with her equipment and full turnout gear, which included a helmet, gloves, and boots. All the equipment was provided from Huntley; Petitioner could not provide her own equipment and the name "Huntley Fire Protection District" was labeled on the helmet and the gear.

Huntley directed Petitioner's training exercises and she was graded by Huntley Lieutenant James Brown on accomplishing her training. She testified that her training related to the general business of the Huntley Fire Department by learning to utilize the equipment faster and learn to maneuver around things during a fire. Petitioner has demonstrated the requisite elements under Ware to demonstrate that Petitioner was an employee for Respondent.

Even if Respondent alleges that Petitioner was not yet an employee, but a trainee, Petitioner would still be considered an employee under Illinois law. In Dodaro, claimant began training at the Chicago Police Academy as a "trainee," "recruit," or "probationary police office" and that claimant who sustained injuries was not a "duly appointed member" of the Chicago police department to fall within the exclusion of the Act, but none-the-less, qualified as an employee whose injuries are compensable under the Illinois Workers' Compensation Act. Dodaro v. IWCC, 403 Ill. App. 3d 538 (2010).

In Locasto, claimant was not a "duly appointed member" of the city fire department, but rather a candidate fire paramedic in training and had not been "formally admitted to the responsibilities and privileges" of the fire department at the time of his injuries. City of Chicago v. IWCC, 2013 IL. App (1st) 121507WC, 4 N.E. 3d 158, 378 Ill. Dec. 559 (2014) In Locasto, the Court cited Dodaro and found claimant not a "duly appointed member" of the fire department to be governed by the city of Chicago statutory exclusion, but rather an employee under the Act with its attendant benefits which in this case also included temporary partial disability benefits.

The facts in this case are clearer than either Dodaro or Locasto in that no statutory exclusion would ever apply in the case of the Respondent Huntley Fire Protection District and the only issue which has been clearly demonstrated through all the evidence is that the Petitioner here, as a trainee, is clearly an employee under the Act. Even if Respondent argues that Petitioner was an applicant, the evidence shows that she was a paid trainee performing the actions as requested by the Huntley Fire Protection. She was offered a job, accepted and was being paid to perform rigorous training exercises while being graded by Respondent. Petitioner was not injured while filling out a job application. She was practicing the duties of a firefighter while being paid, under Respondent's direction, when she was injured. The Arbitrator concludes that under Illinois law, Petitioner was Respondent's employee.

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 makes the following conclusion:

The Arbitrator finds in favor of Petitioner on the issue of accident. Petitioner testified that on June 30, 2009, she was working for Huntley Fire Protection District and was undergoing a training exercise in the training tower. She was required to raise a ladder in the training tower that was filled with smoke to perform an individual search and rescue. She climbed a ladder to the second story window, repelled through a window and when she hit the ground, her left knee twisted and popped and she landed on her left leg. She heard a pop and felt severe pain in her left leg and knee. Petitioner was wearing full turnout gear: her coat, fire rescue hood, gloves, boots, self-contained breathing apparatus, breathing mask and air tube, and was carrying an axe or crowbar. Her equipment weighed approximately 60 lbs. The ladder she was climbing belonged to Huntley. Lieutenant James Brown from the Huntley Fire Protection District was in the window and witnessed the accident. This history is consistent with all the medical documentation that was offered into evidence at the time of trial. (Pet Ex 25-27) The unrebutted testimony and exhibits support a finding that Petitioner suffered accidental injuries, arising out of and in the course of her employment by Respondent.

In support of the Arbitrator's decision relating to "F," Is Petitioner's current condition of ill-being casually related to the injury, the Arbitrator makes the following conclusion:

The Arbitrator concludes that there is a causal relationship between Petitioner's accident of June 30, 2009 and the present condition of ill-being of Petitioner's left knee. Illinois law states, "[p]roof of the state of the health of the employee prior to and down to the time of the injury, and the change immediately following the injury and continuing thereafter, is competent as tending to establish that the impaired condition was due to the injury. Where an injury has a characteristic result the result is an objective symptom." Spector Freight System v. Industrial Comm., 93 Ill. 2d 507, 513, 445 N.E.2d 280, 67 Ill. Dec. 800 (1983) (citing Union Starch & Refining Co. v. Industrial Com., (1967) 37 Ill. 2d 139, 143)

The medical documentation and Petitioner's testimony establish that Petitioner has no history of left knee problems. Petitioner testified that she has suffered no prior injuries to her left knee. She testified to one prior workers compensation injury in 2001/2002 when she injured her left wrist. She testified that on the date of her accident, her condition of health was excellent. She has suffered no subsequent injuries since June 30, 2009. This evidence is unrebutted and also supported by the medical testimony.

The day after her accident, Petitioner sought treatment with Dr. Grosskopf at Fox Valley Orthopedics on July 1, 2009. (Pet Ex 26) The history in the Fox Valley records documents that Petitioner "injured her left knee during her final days of preliminary firefighter training; specifically she repelled through a window as part of her fire training drills and when she hit the ground her left knee twisted and popped. Absolutely no problems or injury to left knee before this accident. She had immediate pain, some swelling, a sense of weakness and instability." (Pet Ex 26) The evidence demonstrates that Petitioner had no prior problems with her left knee prior to and down to the time of the injury, a change immediately following the injury, and continuing thereafter as documented in the medical records. (Pet Ex 26)

The treating medical records also support a causal connection between Petitioner's left knee condition and her June 30, 2009 accident. All of Petitioner's treating medical records contain consistent descriptions of Petitioner's work injury and support a finding that Petitioner's left knee was injured in her work injury of June 30, 2009. (Pet Ex 25,26) Additionally, the January 7, 2010 operative report states that Petitioner's postoperative diagnosis is persistent symptomatic patellofemoral pain with lateral patellar instability that is traumatic in origin, left knee, with Grade III condromalacia central patellar ridge. (Pet Ex 26) Dr. Grosskopf's operative report also notes that Petitioner's patellofemoral joint had a distinct lateral tilt and at least 5 to 6 mm of lateral subluxation or incomplete or partial dislocation. (Pet Ex 26) The operative findings confirmed the patellar dislocation as noted in the MRI, the earlier doctor's notes, and was determined to be traumatic in origin.

Respondent's Section Twelve Examiner, Dr. Kevin Walsh, testified though an evidence deposition. The Arbitrator finds that Dr. Walsh's opinions lack credibility and are not consistent with the medical records which have been offered into evidence. Dr. Walsh first asserts that it is not at all likely the patient's subjective complaints at the time are causally related to the accident described in June 2009; he opined if the patient had suffered an acute patellar dislocation as a result of the injury described, more likely than not, the patient would have had significant swelling at the time of the MRI scan and the records indicate a mild edema. (Resp Ex 3 - Walsh Dep Ex 2) He opined that the MRI of July 20, 2009 indicated only a trace joint effusion and if the patient suffered an acute patellar dislocation, more likely than not, she would have had a large effusion at the time of her evaluation in the ER and large effusion on her MRI scan taken 3 weeks later after the event. (Resp Ex 3 - Walsh Dep Ex 2)

The medical records and treatment plan contradict Dr. Walsh's opinions regarding the issue of the swelling; the Emergency Room notes from the date of accident state that Petitioner fell and hurt her left knee: "Swelling noted." (Resp Ex 3 - T. 66, Pet Ex 25) In the Emergency Room, Petitioner's doctors prescribed protection, rest, ice, compression, and elevation and they were recommended to "decrease swelling, to immobilize, ... and Motrin to decrease inflammation." (Resp Ex 3 - T. 69-70) The treatment records from the day after the accident, July 1, 2009, demonstrate that Dr. Grosskopft found that Petitioner's leg was visibly swollen and with effusion and she had quadriceps inhibition or inability to contract the quad muscle because of pain or swelling (Resp Ex 3 - T. 14-15 & Pet Ex 26). Left knee swelling is replete in the medical records and Petitioner did follow her treatment plan and used various treatments to help relieve swelling. Dr. Walsh admitted that the MRI was 3 weeks after the accident and if she had been taking Ibuprofen and Vicoprofen and iced and elevated her knee, in 3 weeks, her

swelling could become less than what it was when she was seen in the ER on 6/30/09 or 7/1/09. (Resp Ex 3 - T. 72)

Dr. Walsh next opines that there is no causal connection because more likely than not, the patient would have been diagnosed with a patellar dislocation when seen in the emergency room or initially by Dr. Grosskopf. (Resp Ex 3 - Walsh Dep Ex 2) Dr. Walsh later at his same deposition admits that during Dr. Grosskopf's initial visit, the day after the accident, Dr. Grosskopf considered that she could have a lateral patellar subluxation or dislocation with reduction. (Resp Ex 3 - T. 71)

Dr. Walsh disagreed with the radiologist and testified that the radiologist felt that the MRI findings were consistent with a patellar dislocation injury that had relocated and Dr. Walsh opined that that was a possibility, but Dr. Walsh thought that it was more likely a contusion to her knee. (Resp Ex 3 - T. 18) Further the Arbitrator notes the MRI finding that "there is prominent bone marrow edema signal identified along the lateral aspect of the lateral trochlea and extending posteriorly into the lateral femoral condyle. There is also bone marrow edema signal identified involving the medial most aspect of the medial patellar facet." (Resp Ex 3 - T. 74) Dr. Walsh testified that this possibly indicates that this would be of an acute nature rather than a chronic nature. (Resp Ex 3 - T. 74) Dr. Sidney Jane who performed the MRI and wrote the report stated, "Along with the tear injury of the medial patellar retinaculum these findings are consistent with a patellar dislocation injury which has relocated." (Resp Ex 3 - T. 74-75) Dr. Walsh disagreed with Dr. Jane's use of the word "injury," because in an MRI report, injury implies causation. (Resp Ex 3 - T. 75) Also Dr. Jane noted "prominent bone marrow edema." (T. 76) which he believes is significant (Resp Ex 3 - T. 76) Dr. Grosskopf's operative report of 1/7/10 states "persistent symptomatic patellofemoral pain with lateral patella instability that is traumatic in origin, left knee." (Resp Ex 3 - T. 76) Dr. Walsh would not use the word prominent, but would say that the bone marrow edema is present. (Resp Ex 3 - T. 78) The medical records themselves demonstrate swelling, diagnosis the day after the accident, and findings supportive of the diagnosis. These findings contradict Dr. Walsh's opinion that Petitioner merely suffered a strain. The Arbitrator gives greater weight to the treating medical records and finds a causal connection between Petitioner's June 30, 2009 injury and the current condition of ill-being of her left leg.

In support of the Arbitrator's decision relating to "J," Were the medical services that were provided to Petitioner reasonable and necessary, the Arbitrator makes the following conclusion:

Having found in favor of Petitioner on the issue of "F," the Arbitrator finds in favor of Petitioner regarding the issue of medical treatment. All treating medical records (Pet. Ex. 25-27) support a finding as to the reasonableness and necessity of medical care rendered as well as liability therefore. Accordingly, the Arbitrator finds that the medical treatment that Petitioner received constituted reasonable and necessary care.

The Arbitrator awards the bills as listed in Pet Ex 11-13 and Pet Ex 15-24 to be paid pursuant to the Illinois Workers' Compensation Medical Fee Schedule. Payment of the bills shall be paid as part of this

award to the Petitioner. Respondent shall be entitled to a credit for any amounts previously paid from the medical bills awarded.

In support of the Arbitrator's decision relating to "K," What temporary benefits are in dispute, the Arbitrator makes the following conclusion:

The Arbitrator finds that Petitioner is entitled to 4/7 weeks of Temporary Total Disability. In order to demonstrate that Petitioner is entitled to Temporary Total Disability benefits, the "claimant must prove not only that he did not work, but that he was unable to work; and the dispositive test is whether the claimant's condition has stabilized." Anders v. Industrial Commission, 332 Ill. App.3d 501, 507, 773 N.E.2d 746, 266 Ill.Dec.11 (4th Dist. 2002). Petitioner underwent surgery on January 7, 2010 and was taken completely off work for one week. She was off work from January 7, 2010 through January 14, 2010 and then was released to light duty.

Petitioner is entitled to 133 2/7 weeks of Temporary Partial Disability Benefits. Petitioner's treating doctors have prescribed light duty restrictions since Petitioner's accident of June 30, 2009. Petitioner's treating doctors have prescribed light duty since July 1, 2009 until she was completely off work after her surgery, on January 7, 2010. Then, her doctors continued to prescribe light duty restrictions since January 15, 2010. Petitioner testified that she notified Deputy Chief Mallegni and gave him the light duty note, but he told her that they have no light duty for the position of a firefighter. She was released to light duty at Fox Valley Orthopedics and only performed sitting down work with the phone or with triage. Therefore, Temporary Partial Disability is awarded during the period when Petitioner was on light duty restrictions, she was working for Fox Valley Orthopedics but these restrictions were not being accommodated by Respondent; Petitioner was released by Dr. Grosskopf on January 26, 2012. Therefore, TPD is awarded for 133 2/7 weeks, from 7/1/09 through 1/6/10, and 1/15/10 through 1/26/12.

In support of the Arbitrator's decision relating to "L," What is the nature and extent of the injury, the Arbitrator makes the following conclusion:

Petitioner suffered a lateral patellar dislocation as a result of her accident of June 30, 2009. Petitioner's MRI of her left knee demonstrated that there is a tear injury of the medial patellar retinaculum with associate edema of the soft tissues adjacent to the retinaculum. There is also bone marrow edema signal identified involving the medial most aspect of the medial patellar facet. Along with a tear injury of the medial patellar retinaculum, these findings are consistent with a patellar dislocation injury, which has relocated. (Pet Ex 26) On January 7, 2010, Petitioner underwent an arthroscopic condral debridement of the patella, arthroscopic electrosurgical lateral release and arthroscopic medial patellofemoral ligament imbrication with Dr. Grosskopf. (Pet Ex 26) As of Petitioner's last visit with Dr. Grosskopf on January 26, 2012, Petitioner still complained of instability of the left knee with swelling, pain, clicking, tightness, and stiffness. (Pet Ex 26) Dr. Grosskopf examined Petitioner and prescribed left

knee surgery consisting of a reconstruction with allograft. (Pet Ex 26) Petitioner testified that as of the present time, she has opted not to have the surgery since her husband's group insurance would not pay for it, she did not have the money to cover it, and she has two young children and could not be laid up with two young children who need care. Dr. Grosskopf never released Petitioner's restrictions of limited squatting, kneeling, no ladder climbing and no heavy lifting. Petitioner testified that in her experience in firefighting, these restrictions would not ever allow her to return to that occupation.

Petitioner testified at the time of trial, that she still has pain and problems with her left knee. She still has difficulty climbing up and down the stairs, her left leg gets tired and fatigued, and she can feel her knee cap slipping. She feels pain when she attempts to sit Indian style or squat. She has decreased range of motion in her left knee. She still does a home exercise program to prevent slipping of the patella. If she is playing with her two kids, the next day, her leg is hurting. She often takes anti-inflammatories or ices her leg. She quit marching in the band as she used to march and carry the drum. She has difficulty taking long walks or short jogs. She still feels pain and discomfort in her left knee and her knee cap remains unstable so she wears a knee brace. Petitioner still has residual pain and problems and was not released to return to her occupation as a firefighter. Although it could be determined that Petitioner suffered a loss of vocation as she is unable to return to her previous job as a firefighter, the Arbitrator awards permanency in the amount of 35% loss use of Petitioner's left leg.

In support of the Arbitrator's decision relating to "M," Should penalties and fees be imposed upon Respondent, the Arbitrator makes the following conclusion:

Respondent disputes this case under two theories: 1. Petitioner is not an employee as she was working as a trainee for Respondent. 2. Respondent has relied upon the opinions of Dr. Walsh in denying treatment and benefits. Illinois case law is clear that Petitioner is an employee of Huntley Fire Protection as stated in the above findings. Respondent's assertion of no employer-employee relationship, especially when presenting no rebutting evidence, was frivolous, baseless, and presented no true controversy. Additionally, under causal connection the Arbitrator found the opinions of Dr. Walsh inconsistent with the medical records that were offered into evidence. The Arbitrator finds that non-payment of benefits on this claim is unreasonable and vexatious and awards penalties and attorney's fees under Section 19(k), 19(l) and Section 16. Pursuant to Section 19(l),

> 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.

The Arbitrator awards $10,000.00 in penalties under Section 19(l).

Pursuant to Section 19(K),
50% x (TTD + TPD + medical awarded)

50% x ($153.53 + $9,126.07 +$29,947.05)
50% x ($39,226.65) = $19,613.33

The Arbitrator awards $19,613.33 in penalties under Section 19(k).

Pursuant to Section 16,
20% x (penalties awarded)
20% x ($19,613.33) = $3,922.67

The Arbitrator awards $3,992.67 in penalties under Section 16.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DENISE RAMIREZ,

Petitioner,

vs. NO: 10 WC 27212

VALLEY VIEW PUBLIC S.D. 365U,

15IWCC0823

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition 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, causation, temporary total disability, medical expenses, and nature and extent, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Arbitrator awarded 31-6/7 weeks of temporary total disability (TTD) for the periods of April 27, 2010 through September 27, 2010 and from June 15, 2011 through August 22, 2011. Regarding this first period, Petitioner testified that she was released to work on September 20, 2010 and this is supported by Dr. Welch's record of that date. Therefore, we hereby modify this first period of TTD to end on September 20, 2010, which results in 21 weeks.

For the second period, we note that the in the "Conclusions of Law" section, the Arbitrator awarded TTD from May 15, 2011 through August 22, 2011 (14-2/7 weeks) but in the "Order" section, it was only awarded from June 15th through August 22nd (9-6/7 weeks). The Commission clarifies this discrepancy and finds that the award in the Order section is accurate because the start of that TTD period was when Petitioner underwent surgery on June 15, 2011.

Therefore, we hereby modify the award for temporary total disability to 30-6/7 weeks (4/27/10 – 9/20/10 and 6/15/11 – 8/22/11).

All else is affirmed and adopted.

15IWCC0823

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $691.21 per week for a period of 30-6/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act, with Respondent receiving credit for $15,206.62 in benefits already paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $622.09 per week for a period of 25.625 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of use of 12.5% of the right hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $14,678.80 for medical expenses under §8(a) of the Act subject to the fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit of $6,954.14 under §8(j) of the Act; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

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

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: NOV - 6 2015

Charles J. DeVriendt

Ruth W. White

Joshua D. Luskin

SE/
O: 10/27/15
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RAMIREZ, DENISE
Employee/Petitioner

Case# **10WC027212**

VALLEY VIEW PUBLIC SCHOOL DISTRICT 365U
Employer/Respondent

15IWCC0823

On 8/13/2014, 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:

0412 RIDGE & DOWNES
AMYLEE HOGAN SIMONOVICH
101 N WACKER DR SUITE 200
CHICAGO, IL 60606-7307

4866 KNELL O'CONNOR DANIELEWICZ PC
BRIAN WOJCICKI
901 W JACKSON BLVD SUITE 301
CHICAGO, IL 60607

15IWCC0823

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

- [ ] 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

Denise Ramirez
Employee/Petitioner

v.

Valley View Public School District 365U
Employer/Respondent

Case # 10WC 27212

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 **Gerald Granada**, Arbitrator of the Commission, in the city of **New Lenox**, on **July 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. [ ] 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 **April 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.

In the year preceding the injury, Petitioner earned $**53,914.38**; the average weekly wage was $**1,036.81**.

On the date of accident, Petitioner was **52** years of age, ***married*** with **1** child under 18.

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 $**15,206.62** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**15,206.62**.

Respondent is entitled to a credit of $**6,954.14** under Section 8(j) of the Act.

ORDER

Respondent shall pay to Petitioner reasonable and necessary medical services of $14,678.80, subject to the fee schedule as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $6,954.14 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 $691.21/week for 31-6/7 weeks, commencing April 27, 2010 through September 27, 2010, and June 15, 2011 through August 22, 2011, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $15,206.62 for temporary total disability benefits that have been paid for 22 weeks, commencing April 27, 2010 through September 27, 2010.

Respondent shall pay Petitioner permanent partial disability benefits of $622.09/week for 25.625 weeks, because the injuries sustained caused the 12.5 % loss of the right 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

8/12/14
Date

AUG 13 2014

15IWCC0823

FINDINGS OF FACT

Petitioner is claiming a repetitive trauma injury with a manifestation date of April 6, 2010 involving her right thumb. In dispute are the following issues: accident, causation, medical expenses, TTD and the nature and extent of Petitioner's injuries.

Petitioner began working for Respondent in 1988. Around the time of her claimed accident date, she was working in Respondent's the maintenance department, which included maintaining the Respondent's baseball and soccer fields. Her duties required Petitioner to break-up ground with a shovel, raking, digging, removing water from fields, emptying 55 gallon garbage drums, sweeping, putting up wind screens around the baseball fields, putting up nets in the tennis courts, painting lines on the fields, and loading dirt onto the fields.

Petitioner testified that she is right hand dominant. Beginning on April 6, 2010, she began to notice pain and weakness in her right hand while raking. She would perform the raking activity by placing her right hand on the end of the rake and her left hand on the middle of the rake. She experienced pain while using the rake to break up the dirt along the base lines of the field. This pain became constant as she continued working. She reported this to her supervisors the next day and an accident report was prepared by Mr. Wayne – one of her supervisors. (RX 1)

Petitioner testified that she did not work on the baseball fields every day, but in April, 2010, the fields were particularly bad due to the rain and cold, which made breaking up the dirt and raking the fields more difficult. She testified that she would also use a tractor to maintain the fields during the season, but she did not use it in the spring while preparing the fields. Petitioner also had another employee helping in many of her work activities, including dragging the fields, lifting heavy items and other activities involved in preparing and maintaining the fields.

Prior to the alleged accident date, Petitioner was on permanent work restrictions of no lifting more than 15 pounds with no repetitive, vigorous activities. These restrictions were due to Petitioner's unrelated breast cancer and were limited to her left upper extremity. Petitioner testified that at times Respondent failed to accommodate these restrictions. Petitioner testified that prior to April 6, 2010, she did not have any restrictions on the use of her right upper extremity and she denied having any problems with her right hand or thumb.

On April 20, 2010 Petitioner sought medical treatment at Edwards Immediate Care. The visit note states that on April 6, 2010, she was preparing the ball fields with some raking and shoveling when she had sudden severe pain at the base of the thumb. (PX 3) Petitioner informed the physician that she could hardly pick up anything with her right hand, including her tooth brush. She had never had difficulty brushing her teeth prior to this. She was diagnosed with tendonitis and placed on light duty restrictions of no more than five (5) pounds and no repetitive use of the arm. She was provided with a splint. On May 17, 2010, Dr. Verma at Edwards completed a disability statement indicating that the principal cause of Petitioner's disability was "tendonitis/sprain R thumb s/p injury." When Petitioner followed-up for tendinitis of her right thumb on June 7, 2010, she was referred to Dr. Welch for an orthopedic consult and her work restrictions relative to her right hand continued.

On June 14, 2010, Dr. Robert Welch examined the Petitioner. Dr. Welch's impression was CMC arthritis of the right thumb with a concomitant CMC sprain, which likely set off the symptoms. Dr. Welch recommended light duty, medication, and therapy, and thumb spica splint. On July 14, 2010, Dr. Welch gave Petitioner a cortisone injection which provided her temporary relief. On August 23, 2010, she was authorized to return to work with

15IWCC0823

the use of a brace. Dr. Welch discussed possible surgery in the future. After undergoing another injection with limited relief, the Petitioner ultimately underwent surgery. Dr. Welch performed surgery in the form of ligament reconstruction tendon interposition arthroplasty of the right thumb at Naperville Surgical Center on June 15, 2011. Petitioner followed-up with Dr. Welch on June 27, 2011 and was authorized to remain off work and participate in therapy. This was continued at her follow-up on July 25, 2011. On August 22, 2011 Dr. Welch released Petitioner from care and authorized her to return to work full duty. Dr. Welch testified via evidence deposition on April 27, 2012 that he believed Petitioner's condition in her right thumb and her need for surgery were related to the work activities she described to him, particularly the raking activity .

Respondent had Petitioner evaluated by Dr. Vender on September 10, 2010. Dr. Vender diagnosed Petitioner with degenerative arthritis of the right thumb carpometacarpal joint. He opined that the he did not believe the Petitioner's arthritic condition was either caused or aggravated by her activities at work. He testified consistently with this opinion in his evidence deposition on June 22, 2012 and November 30, 2012. (See RX 8 & 9) Dr. Vender testified that Petitioner's work activities, including raking and shoveling, did not contribute to the aggravation of her degenerative arthritis in this case and he felt that the activities he observed in a video purporting to show Petitioner's job duties would be considered relatively normal use of the hands. (RX 9, p. 16-17) Dr. Vender elaborated in his testimony that she did not have persistent or regular activity with the thumb. (R.E. 9, p. 34). Dr. Vender testified that even if someone was handling a rake or a shovel for multiple hours over multiple days, it would still be limited exposure. (RX 9, p. 34, 43) Dr. Vender opined that Petitioner's use of her hands in this manner over a period of days did not cause her arthritis to become symptomatic, but he was unable to indicate what did cause Petitioner to become symptomatic. (RX 9, p. 39)

Respondent called Mr. Howard "Bill" Cherry to testify. Mr. Cherry has been Building Engineer with Respondent for 13 years. Mr. Cherry is responsible for assigning work, checking work, and doing work. Mr. Cherry testified that there were four ball fields in use, all of which required raking or mat dragging for preparation. The baseball fields would require hand raking along the first and third baselines, home plate, and the pitcher's mound. During the course of the season, maintenance of these fields would require them to be nail dragged, then mat dragged, and lines would be chalked. These were duties Petitioner would perform, but she had assistance hooking-up the nail and mat drags, as well as lifting the paint. For the preparation of the fields to transition from the winter season, the fields would be saturated with moisture. The preparation would start after March 1st, depending on what the weather would allow. Games would begin in the middle of March. Mr. Cherry confirmed that Petitioner did do raking. Mr. Cherry testified that after the water from a "good rain" has been pumped off a field, the "really bad spots" would have to be hand-raked to cut grooves in the dirt to help the wind pass through and dry the field. This was especially required in areas where more water would accumulate. These areas were approximately five (5) or six (6) feet by five (5) or six (6) feet and were usually located around the baselines where the kids would stand and kick the dirt.

Respondent also called Mr. Michael Lopez to testify. Mr. Lopez is Director of Facility Operations for Respondent. He confirmed that the Petitioner provided notice of her accident pursuant to the Respondent's normal protocol. He also confirmed that the Respondent had notice of Petitioner's physical restrictions before April 6, 2010 and had communicated with Petitioner in an effort to accommodate those restrictions. Mr. Lopez confirmed that Ms. Ramirez's position as a maintenance person did require her to perform raking and shoveling activities. Her position also required her to set-up wind screens and nets. Mr. Lopez did not observe Petitioner's day to day activities during the period of March and April 2010.

Petitioner never returned to work for the Respondent following her surgery. She instead took another job with the local library, doing light work for less hours. She still complains of weakness and pain, but less so than

15IWCC0823

before her surgery. She has difficulties with opening jars, handling buttons and takes anti-inflammatory medication along with occasional use of a brace for her right hand and thumb.

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 finding, the Arbitrator relies on both the Petitioner's credible testimony and the medical evidence. In this case, the Petitioner's unrebutted testimony is that she began having problems with her right thumb that she related to her work activities on April 6, 2010. At that time, she was performing various activities that were both repetitive and required forceful gripping, particularly while she was raking the dirt in the baseball fields. The record is replete with testimony to support the forceful grasping and repetitive exertional activities Petitioner was performing with her right hand in March and April 2010. While the testimony of Respondent's witness, Mr. Cherry may have indicated Petitioner had help in performing her job duties, he did confirm the Petitioner's description of her job duties, including her having to rake rough spots after it rained. Based on the totality of the evidence, the Arbitrator concludes that the Petitioner sustained an accident, that manifested itself on April 6, 2010.

2. With regard to the issue of causation, the Arbitrator finds that the Petitioner has met her burden of proof. In support of this finding the Arbitrator relies on the medical evidence and finds persuasive the opinions of Petitioner's treating physician, Dr. Welch, who diagnosed Petitioner with CMC arthritis of the right thumb with a concomitant CMC sprain . Dr. Welch ultimately performed surgery on Petitioner's thumb, involving ligament reconstruction tendon interposition arthroplasty. Dr. Welch credibly testified that both the diagnosis and the need for surgery were related to the activities described to him by Petitioner. The Arbitrator is persuaded by Dr. Welch's opinion that forceful, twisting, grasping activities, such as those described by Petitioner in performing her work duties, would contribute to the aggravation of her degenerative arthritis.

3. Based on the Arbitrator's conclusions with regard to the issue of accident and causation, the Arbitrator finds that the Petitioner is entitled to TTD. This finding is supported by both the Petitioner's credible testimony and the medical evidence, indicating that she was taken off work either with restrictions that the Respondent could not accommodate or taken off work completely from April 27, 2010 through September 27, 2010, and from May 15, 2011 through August 22, 2011 – a period of 36-2/7 weeks. The parties stipulated that the Respondent has paid 22 weeks of TTD. Accordingly, the Arbitrator awards the Petitioner the TTD she seeks, less the TTD already paid by Respondent.

4. Based on the findings above, the Arbitrator further finds that the Petitioner's medical expenses related to the treatment of her thumb were both reasonable and necessary. Accordingly, the Arbitrator awards the Petitioner the medical expenses as set forth in the evidence, subject to the Fee Schedule in accordance with Sections 8(a) and 8.2 of the Act. Respondent shall receive a credit for any expenses it has already paid, and shall hold the Petitioner harmless for any expenses it has paid through group health insurance. Any outstanding, related medical expenses shall be paid directly to the Petitioner.

5. With regard to the issue of the nature and extent of the Petitioner's injuries, the Arbitrator finds that as a result of her injury, the Petitioner sustained 12.5% loss of use of her right hand. In support of this finding, the Arbitrator relies on the medical evidence, which shows Petitioner sustained a sprain to her right thumb, which aggravated her CMC arthritis of her thumb and required her to undergo surgery to that thumb. The Arbitrator further relies on the Petitioner's credible, unrebutted testimony that she still experiences some weakness and pain in her hand, for which she takes anti-imflammatory medication and occasionally uses a brace.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James Ledbetter,

Petitioner,

vs. NO: 10 WC 45772

State of Illinois
Big Muddy River Correctional Center,
Respondent,

15IWCC0822

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of the nature and extent of petitioner's disability and being advised of the facts and law, 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 had bilateral thoracic outlet decompressions. His treating physician returned him to full duty as a correctional officer. On September 4, 2014, his treating physician found an excellent range of motion bilaterally, good grip strength, no active spasm, and no ischemic changes. (Petitioner Exhibit 3)

The Commission finds that Petitioner sustained a loss of use of 20% of the person as a whole.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $655.89 per week for a period of 100 weeks, as provided in §8(d)(2) of the

Act, for the reason that the injuries sustained caused the loss of use to the person as a whole to the extent of 20%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner pay all unpaid related medical bills under §8(a) of the Act and pursuant to 8-2.

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: NOV - 6 2015

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

HSF
O: 10/20/15
049

[illegible]

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LEDBETTER, JAMES
Employee/Petitioner

Case# **10WC045772**

SOI/BIG MUDDY RIVER CORR CTR
Employer/Respondent

15IWCC0822

On 4/14/2015, 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 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

4948 ASSISTANT ATTORNEY GENERAL
WILLIAM H PHILLIPS
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

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

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

APR 14 2015

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

15IWCC0822

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

James Ledbetter
Employee/Petitioner

v.

SOI/Big Muddy River Corr. Ctr.
Employer/Respondent

Case # **10** WC **45772**

Consolidated cases: **None**

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 **Michael Nowak**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **December 12, 2014**. By stipulation, the parties agree:

On the date of accident, **November 22, 2010**, 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 $**56,843.80**, and the average weekly wage was $**1,093.15**.

At the time of injury, Petitioner was **41** years of age, ***married*** with **2** dependent children.

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

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

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury:

The issues of causation, accident, and necessity of medical treatment were resolved by a prior 19(b) decision issued by Arbitrator Falcioni and affirmed by the Commission. (PX 7) After that decision, Petitioner underwent bilateral thoracic outlet syndrome surgery. The first surgery occurred on 8 April 2013 in the form of a right thoracic outlet decompression, including anterior and middle scalenectomy, resection of the first rib and bilateral pectoralis tenotomy. Following surgery, Petitioner underwent a lengthy course of physical therapy. His second surgery took place on 15 November 2013 and consisted of the same procedures. Objective findings of perineural scar tissue and aberrant fascial bands were identified during both surgeries. Following the second surgery, Petitioner underwent additional physical therapy.

At Arbitration, Petitioner testified that both the surgery and the rehabilitation improved his condition and allowed him to return to work without restriction. Despite the improvement resulting from surgery, Petitioner still has pain in his upper back and neck. Prior to surgery, Petitioner experienced numbness, pain and tingling in both his upper extremities. While this has improved, he is left with numbness and tingling in his last two fingers. His symptoms are increased with heavy lifting and he has difficulty lifting things above chest level. For his symptoms he takes Tramadol, Methocarbamol and applies over-the-counter cream twice each day. At the end of a shift, his arms are tired and sore. Petitioner used to be active in his community as a Mason and Shriner, and tries to be involved with the Moose and Elks clubs. He does not have the strength and endurance to volunteer his time as he did in the past. He also has difficulty sleeping through the night and awakens frequently. Based upon the foregoing, the Arbitrator finds that Petitioner sustained serious and permanent injuries that resulted in the 30% loss of the body as a whole.

ORDER

Per Stipulation of the parties, all TTD has been paid and none is owed.

Respondent shall pay all unpaid related medical bills pursuant to the fee schedule.

Respondent shall pay Petitioner the sum of **$655.89**/week for a further period of **150** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **the 30% loss of Petitioner's body as a whole.**

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

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

Signature of Arbitrator

3/31/15
Date

APR 14 2015

11 WC 20735

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

Sally Boyle,
Petitioner,

vs.

NO: 11 WC 20735

15IWCC0824

State of Illinois/Office of Attorney General,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on April 20, 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: NOV 10 2015
MJB:ell
disc-11/6/15
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Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BOYLE, SALLY M
Employee/Petitioner

Case# **11WC020735**

15IWCC0824

ST OF IL/OFFICE OF ATTORNEY GENERAL
Employer/Respondent

On 4/20/2015, 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 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1130 BUCKLIN LAW OFFICE
BRADFORD C BUCKLIN
PO BOX 2346
SPRINGFIELD, IL 62705

4980 ASSISTANT ATTORNEY GENERAL
COLIN KICKLIGHTER
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 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

APR 20 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

Sally M. Boyle
Employee/Petitioner

v.

State of Illinois/Office of Attorney General
Employer/Respondent

Case # 11 WC 20735

Consolidated cases: n/a

15IWCC0824

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 February 26, 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 Mileage Expense Reimbursement

FINDINGS

On March 31, 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 $47,148.00; the average weekly wage was $906.70.

On the date of accident, Petitioner was 53 years of age, married with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

Respondent has not paid all appropriate charges for all reasonable and necessary medical services. Respondent stipulated that all medical bills had been or would be paid.

Respondent shall be given a credit of $15,112.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $15,112.00. The parties stipulated at trial that all TTD benefits had been paid in full.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $544.02 per week for 129 weeks because the injuries sustained caused the 60% loss of use of the left leg, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner $815.36 for reimbursement of mileage expense.

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

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

William R. Gallagher, Arbitrator

April 15, 2015
Date

APR 20 2015

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 March 31, 2010. According to the Application, Petitioner "Fell into pot hole in employer's parking lot" and sustained an injury to the left leg/knee. At trial, Petitioner and Respondent stipulated that Petitioner sustained a work-related accident and that temporary total disability benefits had been paid in full. In regard to medical bills, Petitioner and Respondent stipulated that all medical bills had or would be paid in full. Respondent disputed causal relationship and Petitioner also claimed entitlement to reimbursement for mileage to/from St. Louis for 1,456 miles.

Petitioner testified that she sustained a slip and fall in Respondent's parking lot on March 31, 2010, and sustained an injury to her left knee. Other than some minor occasional soreness, Petitioner denied any prior left knee injuries or symptoms.

Petitioner initially sought medical treatment from Dr. Robert Bussing on April 2, 2010. He aspirated Petitioner's left knee removing some fluid and ordered an MRI scan. The MRI revealed tricompartmental osteoarthritis, joint effusion and a slight anterior extrusion of the anterior horn of the medial meniscus. Dr. Bussing referred Petitioner to Dr. Ronald Romanelli, an orthopedic surgeon (Petitioner's Exhibit 1).

Dr. Romanelli first evaluated Petitioner on April 14, 2010, and his impression was injury to left knee with osteoarthritis. Dr. Romanelli initially treated Petitioner's left knee conservatively with cortisone injections and medication; however, Petitioner's condition did not improve. In his record of June 16, 2010, Dr. Romanelli opined that Petitioner had severe osteoarthritis of the left knee. In regard to causality, Dr. Romanelli noted that Petitioner had sustained an "...acute exacerbation of her preexisting condition." He recommended Petitioner have a total knee replacement (Petitioner's Exhibit 1).

Dr. Romanelli performed total knee replacement surgery on July 19, 2010. Subsequent to the surgery, Dr. Romanelli ordered physical therapy which Petitioner received from August 16, 2010, through January 16, 2011. Petitioner's left knee condition did not improve to any significant degree and her complaints of pain and swelling continued (Petitioner's Exhibit 1).

Dr. Romanelli saw Petitioner several times from January through June, 2011. When Dr. Romanelli saw Petitioner on May 4, 2011, he opined that Petitioner had synovitis and a diagnostic arthroscopy was indicated. On June 9, 2011, Dr. Romanelli performed left knee arthroscopy, synovectomy with arthroscopic lateral release and removal of bone spur (Petitioner's Exhibit 1).

Following the June 9 surgery, Dr. Romanelli again ordered physical therapy which Petitioner received from July 18 through October 6, 2011. Petitioner's left knee condition improved and, when Dr. Romanelli saw her on November 11, 2011, his findings on examination only revealed a little bit of crepitation, clicking and popping (Petitioner's Exhibit 1).

Petitioner was again seen by Dr. Romanelli on January 11, 2012. At that time, Petitioner complained of significant pain and discomfort. Dr. Romanelli examined Petitioner and was uncertain as to the etiology of Petitioner's persistent complaints. He referred Petitioner to Dr. Ryan Nunley, an orthopedic surgeon in St. Louis.

Dr. Nunley evaluated Petitioner on March 26, 2012. Dr. Nunley's initial impression was painful left knee arthroplasty and possible instability. Dr. Nunley ultimately opined that Petitioner had a failed total knee arthroplasty due to instability and loosening of femoral component. Dr. Nunley performed surgery on December 21, 2012, and the procedure consisted of left total knee arthroplasty revision (Petitioner's Exhibit 2).

Following the surgery, Dr. Nunley ordered physical therapy. When Dr. Nunley saw Petitioner on April 29, 2014, Petitioner was working full time without restrictions. When Dr. Nunley saw Petitioner for the last time on December 8, 2014, Petitioner had mild discomfort, wore a knee sleeve as needed and was able to walk 20 to 30 minutes without pain. His examination revealed some tenderness, but the knee was stable (Petitioner's Exhibit 2).

At the direction of Respondent, Petitioner was examined by Dr. Robert Kramer, an orthopedic surgeon, on July 17, 2012. In connection with his examination of Petitioner, Dr. Kramer reviewed medical records provided to him by Respondent. Dr. Kramer opined that Petitioner had a painful left total knee arthroplasty and possible instability which he causally related to the accident of March 31, 2010. He was in agreement with Dr. Nunley's treatment recommendations (Respondent's Exhibit 2).

At trial, Petitioner testified that she was fitted with a knee brace and that she wears it whenever she is going to walk 20 minutes or longer. Petitioner still has complaints of pain and swelling and she is unable to kneel. She avoids stairs as much as possible and standing for any length of time causes swelling. Petitioner also stated that she uses a wheelchair whenever she takes trips or vacations that required her to be on her feet for any extended period of time.

Petitioner was able to return to work to her regular job; however, Respondent purchased a stool for her so she can keep her left leg elevated. Petitioner also testified that she made seven trips to/from St. Louis. Each trip was 208 miles so the total mileage incurred was 1,456 miles. Petitioner claimed entitlement to reimbursement for mileage expenses.

Conclusions of Law

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

The Arbitrator concludes that Petitioner's current condition of ill-being is causally related to the accident of March 31, 2010.

In support of this conclusion the Arbitrator notes the following:

Petitioner's testimony that, other than some minor occasional soreness, she had no prior left knee injuries or symptoms was unrebutted.

Both Dr. Romanelli and Respondent's Section 12 examiner, Dr. Kramer, opined that Petitioner's left knee condition was related to the accident of March 31, 2010.

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 60% loss of use of the left leg.

In support of this conclusion the Arbitrator notes the following:

Petitioner had three surgical procedures performed on her left knee, a total knee replacement; an arthroscopic synovectomy, lateral release and bone spur removal; and a total knee arthroplasty revision.

While Petitioner's left knee condition has improved, Petitioner still has a significant amount of pain and swelling, regularly uses a knee brace, is not able to kneel, avoids stairs, and uses a wheelchair on occasions that require her to be on her feet for any extended period of time.

Petitioner was able to return to work to her regular job; however, Respondent has provided her with a stool so that she may elevate her left leg.

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

The Arbitrator concludes Petitioner is entitled to reimbursement of mileage expense for seven roundtrips to/from St. Louis that totaled 1,456 miles. At $.56 per mile, the total amount is $815.36.

William R. Gallagher, Arbitrator

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

Elroy Norris,
Petitioner,

15IWCC0832

vs.

NO: 12 WC 4048

SOI Dept of Corrections,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 15, 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: NOV 12 2015
KWL/vf
O-11/9/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0832

NORRIS, ELROY
Employee/Petitioner

Case# **12WC004048**

07WC014188

SOI DEPT OF CORRECTIONS
Employer/Respondent

On 4/15/2015, 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 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0924 BLOCK KLUKAS & MANZELLA PC
MICHAEL D BLOCK
19 W JEFFERSON ST SUITE 100
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CERTIFIED as a true and correct copy pursuant to 820 ILCS 305/14

APR 15 2015

RONALD A.RASCIA, 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

15IWCC0832

Elroy Norris
Employee/Petitioner

v.

State of Illinois, Department of Corrections
Employer/Respondent

Case # 12 WC 4048

Consolidated cases: 07 WC 14188

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 **March 6, 2015**. 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 February 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 as explained *infra*.

Timely notice of this accident *was* given to Respondent as explained *infra*.

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

In the year preceding the injury, Petitioner earned $44,200.00; the average weekly wage was $850.00.

On the date of accident, Petitioner was 38 years of age, *married* with 3 dependent children.

Petitioner *has* received all reasonable and necessary medical services 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 $N/A for TTD[1], $N/A for TPD, $ N/A for maintenance, and $ N/A for other benefits, for a total credit of $ N/A. *See* AX2.

Respondent is entitled to a credit $0, under Section 8(j) of the Act. *See* AX2.

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner has established a causal connection between his right shoulder and neck condition and his accidents at work on January 31, 2006 and February 3, 2009.

Medical Benefits

Respondent shall pay reasonable and necessary medical services reflected in Petitioner's Exhibits 21-26 for treatment beginning February 3, 2009 incurred by Petitioner that remain unpaid pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall receive a credit as agreed by the parties, 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: Schedule Injury (Neck)

Respondent shall pay Petitioner permanent partial disability benefits of $510.00/week for 12.5 weeks, because the injuries sustained caused the 2.5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

[1] As agreed by the parties, no claim is made for temporary total disability benefits. *See* AX1.

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

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

Signature of Arbitrator

April 13, 2015
Date

APR 15 2015

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Elroy Norris
Employee/Petitioner

v.

State of Illinois, Department of Corrections
Employer/Respondent

Case # **12** WC **4048**

Consolidated cases: **07** WC **14188**

FINDINGS OF FACT

A consolidated hearing was held in both of Petitioner's above-captioned cases. Arbitrator's Exhibit[2] ("AX") 2; AX1. The issues in dispute in this case include accident, notice, causal connection, Respondent's liability for certain unpaid medical bills, and the nature and extent of Petitioner's injury. AX2. The issues in dispute related to Petitioner's claimed accident on January 31, 2006 are addressed in the concurrent decision issued in Case No. 07 WC 14188. The parties have stipulated to all other issues. AX2.

Background

Petitioner testified that he began working for Respondent in November of 2003 as a correctional officer. His duties since that time have remained the same and include ensuring the safety, security and restraint of inmates, if necessary. Petitioner testified that he worked segregation with the "worst of the worst" of the inmates. Previously, Petitioner sustained a right shoulder injury, which healed after some physical therapy. Otherwise, before January 31, 2006, Petitioner testified that he had no problems in his neck, hands or wrists.

Respondent submitted a Workers' Compensation Employee's Notice of Injury dated January 30, 2006. RX1. The report indicates that Petitioner was escorting an inmate in the Cook County Courthouse and the inmate "twisted (R) hand of officer with box in chain. Numbness, pain to wrist[.]" *Id.* Two witnesses to the incident, A. Johnson and N. Brown, were listed. *Id.* Petitioner indicated that "Inmate kept trying to run at officer, kept pulling away from me twisting + turning[.]" *Id.*

At trial, Petitioner testified that he was involved in an inmate altercation. He was escorting an inmate to court. The inmate was cuffed around the belt to a lead chain as well as a hoop with a chain so that Petitioner could gain control of the inmate. The inmate got into a verbal altercation with another officer. As Petitioner was walking the inmate up the stairs, the inmate started running back down the stairs. Petitioner testified that he fell with his hand outstretched and landed on his right shoulder with the inmate on top of him. He explained that the lead chain was still wrapped around his wrist.

Medical Treatment

The medical records reflect that Petitioner went to the Provena St. Joseph Emergency Room the same day on January 30, 2006 where he was given a sling, ice and a wrist brace. PX1 at 1-20. Petitioner's wrist x-rays were negative for fracture. *Id.* He was diagnosed with a right hand wrist strain, given an ace bandage and Ibuprofen,

[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.

restricted from lifting over five lbs. for two days, and discharged home with instructions to follow up with his primary care physician. *Id.*

Petitioner followed up with his primary care physician at Sanitas Medical Group on February 2, 2006. PX2 at 1. Dr. Gurfinchel ordered right wrist x-rays for Petitioner's right wrist pain. PX3 at 6-7. The x-rays showed no fracture, maintained radial carpal joints, and unremarkable carpal bones. *Id.* On March 10, 2006 at which time he was referred to a specialist, Dr. Richa Vohra. PX2 at 1-3.

On May 9, 2006 Dr. Vohra diagnosed Petitioner with right shoulder pain, impingement syndrome with possible tendonitis, right hand pain, right extensor synovitis, and possible nerve traction injury causing numbness in hand. PX4 at 2-5. He ordered physical therapy, an MRI or the right hand and shoulder, and placed Petitioner on light duty with no lifting over 10 lbs. and no forceful pushing or pulling. *Id.* Petitioner underwent physical therapy at Richart Sports & Spinal Rehabilitation on May 15, 2006 through October 17, 2006. PX5. The physical therapy addressed Petitioner's right shoulder, right hand, and later his neck. *Id.*

In the interim, Petitioner continued to see Dr. Vohra. PX4. On May 23, 2006, Petitioner underwent a right shoulder MRI which the interpreting radiologist noted to show the following: (1) acute subacromial/subdeltoid bursitis; (2) acromioclavicular degenerative change with tendinosis of the rotator cuff tendons without focal tear and no suggestion of a full thickness tear; and (3) glenohumeral degenerative change without abnormality of the labrum. PX4 at 9-10; PX6. The following day, on May 24, 2006, Petitioner underwent an EMG/NCV with Dr. Vohra. PX4 at 12-14. The results were normal with no evidence of carpal tunnel syndrome, peripheral neuropathy or any other entrapment neuropathy. *Id.* On June 27, 2006, Petitioner underwent a right hand MRI, which the interpreting radiologist noted showed evidence of extensor tenosynovitis of the index and middle fingers and no tendon tears or subluxations. PX4 at 17; PX6A.

On July 6, 2006, Petitioner present at Provena St. Joseph Medical Center with a laceration to the right hand that occurred approximately two hours before while remodeling his home when he caught his hand on an exposed screw in the wall. PX1 at 68-69. Petitioner had a 3 cm laceration that was repaired. *Id.* He was discharged home and instructed to follow up with his primary care physician. *Id.* Petitioner followed up with Dr. Vohra on July 8, 2006. PX4 at 19-20. Petitioner reported that he was doing better with the shoulder, but his hand was still very painful. *Id.* Dr. Vohra diagnosed Petitioner with right shoulder pain, subacromial bursitis and rotator cuff syndrome, and right hand pain and tenosynovitis. *Id.* He kept Petitioner restricted to light duty work. *Id.*

On August 19, 2006, Dr. Vohra injected Petitioner's right hand to address the tenosynovitis. PX4 at 25-26. Petitioner also reported an onset of occasional neck pain radiating into the shoulder. *Id.* Dr. Vohra added a diagnosis of neck pain radiating to the shoulder. *Id.* He ordered ongoing physical therapy and kept Petitioner restricted to light duty work. *Id.* On September 14, 2006, Dr. Vohra ordered an MRI of the cervical spine and maintained Petitioner's work restrictions. PX4 at 28-29. Petitioner underwent the recommended MRI on September 23, 2006 for neck pain radiating into both shoulders and down both arms, right side worse than left. PX4 at 30; PX6B. The interpreting radiologist found that the cervical spine MRI was unremarkable. *Id.*

Dr. Vohra noted on September 27, 2006 that Petitioner may need a second opinion with an orthopedist. PX4 at 32-33. On October 14, 2006, he released Petitioner to full duty work effective October 16, 2006. PX4 at 34-35. Petitioner testified that he underwent treatment for neck, right shoulder and hand through October 17, 2006.

On October 19, 2006, Dr. Vohra ordered a functional capacity evaluation and referred Petitioner out for an orthopedic consultation. PX4 at 36-37. He restricted Petitioner to light duty work from October 19, 2006 to

October 26, 2006. *Id.* At a follow up visit on October 26, 2006, Dr. Vohra reiterated his recommendation for a functional capacity evaluation and referral for an orthopedic consultation. PX4 at 38-39. He kept Petitioner restricted to light duty work through November 9, 2006. *Id.* On November 30, 2006, Dr. Vohra referred Petitioner to Dr. Durkin and maintained Petitioner's light duty work restrictions. PX4 at 41.

On December 5, 2006, Petitioner saw Dr. Michael Durkin at Hinsdale Orthopaedics. PX7 at 1-2. He reported his injury at work involving an inmate "who he had in restraints with his restraints wrapped around his arm leading him up some stairs, pulled his arm sharply. He reports having a forced external rotations injury and then he fell down the stairs." *Id.* Petitioner also reported pain in the right wrist, pain in the shoulder down the front, and some neck pain." *Id.* After an examination, Dr. Durkin referred Petitioner to his colleague, Dr. Urbanosky, for the wrist and ordered a cervical spine MRI to rule out disc herniations and right shoulder MRI to look at the subscap and labrum. *Id.*

On December 15, 2006, Petitioner underwent the recommended cervical spine MRI. PX7 at 2-3. The interpreting radiologist noted the following: (1) mild degenerative disc disease at C5-6 with small disk bulging and endplate degenerative changes with slight asymmetric narrowing right of midline; (2) minimal degenerative changes at C4-5 along the vertebral endplates; (3) straightening of the normal lordotic curve; and (4) no intrinsic spinal cord lesions. *Id.* Petitioner also underwent the recommended right shoulder MRI. PX7 at 3-4. The interpreting radiologist noted the following: (1) mild supraspinitus tendinosis without discrete full thickness rotator cuff tear and with mild subacromial bursitis; (2) degenerative change at the level of the AC joint mildly effacing the adjacent myotendinous junction; and (3) mild tendonopathy of the long head of the biceps tendon. *Id.*

On January 10, 2007, Dr. Durkin noted that Petitioner was waiting to see Dr. Urbanosky and would return to see him after that visit and an EMG. PX7 at 4. Dr. Durkin placed Petitioner off work. *Id.* On January 19, 2007, Petitioner underwent the recommended right upper extremity EMG, which showed no mono polyneuropathy, obvious radiculopathy, or plexopathy. *Id.* The evaluating physician, Dr. Marie Kirincic, noted that the EMG was normal. *Id.*

Petitioner then saw Dr. Leah Urbanosky on January 29, 2007. PX7 at 6-7. After an examination, Dr. Urbanosky recommended a bone scan to determine if he had any distal radius or ulna pathology, given Petitioner's persistent symptoms despite normal x-rays. *Id.* Dr. Urbanosky also recommended an MR arthrogram to assess any interarticular pathology. *Id.* She suspected that Petitioner may have a scapholunate ligament tear and/or TFCC tear or possible occult scaphoid fracture for which thumb spica casting would be recommended. *Id.* Dr. Urbanosky maintained Petitioner's work restrictions per Dr. Durkin's orders. *Id.*

Petitioner testified that from May 15, 2006 he began receiving extended benefits through January 31, 2007.

On February 21, 2007, Dr. Durkin noted Petitioner's report of continued shoulder pain with popping. PX7 at 8. He ordered one month of physical therapy to focus on postural training and rotator cuff strengthening to be followed by an MR arthrogram if Petitioner showed no real improvement. *Id.*

On March 28, 2007, Dr. Durkin administered an injection into the biceps tendon and subacromial space around the AC joint. PX7 at 9. After noting a lack of improvement and minimal relief from the injection, on April 25, 2007 Dr. Durkin recommended a shoulder arthroscopy surgery with probable subacromial decompression and repair of the subscap tendon. *Id.*

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On June 7, 2007, Petitioner underwent right shoulder surgery at Provena St. Joseph's Medical Center. PX1 at 39-40; PX9. Pre-operatively, Dr. Durkin diagnosed Petitioner with right shoulder subscapularis tear, biceps tendonitis and impingement, and acromioclavicular joint impingement. *Id.* Dr. Durkin performed a right shoulder arthroscopy, debridement of the biceps tenodesis, repair of the subscapularis tendon, supraspinitus tendon, and an arthroscopic subacromial decompression and distal clavicle excision. *Id.* Post-operatively, Petitioner was diagnosed with right shoulder subscapularis tear, biceps tendonitis and impingement, acromioclavicular joint impingement, a tear of the supraspinitus and acromioclavicular joint impingement. *Id.*

Petitioner returned to Dr. Durkin on June 20, 2007, at which time he ordered post-operative physical therapy. PX7 at 10. Petitioner then began physical therapy at ATI. PX15. At a follow up visit on September 12, 2007, Dr. Durkin noted that Petitioner would be transitioning from physical therapy to work conditioning. PX7 at 11. Petitioner then returned to Dr. Durkin on October 17, 2007 at which time he administered an injection to decrease tightness and swelling in the front of the shoulder. PX7 at 14.

The prior day, on October 16, 2007, Petitioner underwent a right wrist arthrogram to evaluate for scapholunate or TFCC tear. PX3 at 28-29. The interpreting radiologist noted findings consistent with disruption of the triangular fibrocartilage likely at the level of the radial portion with no evidence of scapholunate or lunotriquetral ligament injury. *Id.* Petitioner then saw Dr. Urbanosky on October 29, 2007. PX7 at 15-16. He reported that his symptoms had not changed. *Id.* She recommended an injection versus surgery, but wished to review Petitioner's prior treatment records first. *Id.*

As of November 14, 2007, Dr. Durkin continued to keep Petitioner off work and in work conditioning. PX7 at 18. On December 19, 2007, he released Petitioner back to work with no use of firearms, 35 pound restrictions, and no overhead work. PX7 at 20.

On December 31, 2007, Dr. Urbanosky noted that Petitioner continued to have a positive Finkelstein's test on evaluation of the wrist and complaints of numbness and tingling that he reported were distinctly different than what he experienced at the time of his last EMG. PX7 at 21-22. Dr. Urbanosky ordered an updated EMG/NCV and recommended an open right-sided de Quervain release and right wrist arthroscopy with debridement as needed of the TFCC. *Id.* Petitioner underwent the recommended EMG with Dr. Kirincic on January 9, 2008. PX7 at 23. She noted no evidence of neuromuscular disease, no mononeuropathy, peripheral neuropathy, cervical radiculopathy, or plexopathy on the right upper extremity. *Id.*

On January 16, 2008, Dr. Durkin put Petitioner's continued work conditioning on hold while he addressed his right wrist condition with Dr. Urbanosky. PX7 at 24. On February 26, 2008, Dr. Urbanosky noted her review of Petitioner's normal EMG, but noted continued numbness and tingling in the index, long, ring and small fingers consistent with subclinical carpal tunnel syndrome. PX7 at 26-27. She again recommended surgery. *Id.*

Petitioner underwent surgery to the right wrist on February 28, 2008. PX10; PX11 at 22-23. Pre- and post-operatively, Dr. Urbanosky diagnosed Petitioner with right wrist de Quervain's tenosynovitis, slight carpal tunnel syndrome and transjugular fibrocartilage complex tear. *Id.* She performed a right-sided de Quervain's release, a right-sided dexamethasone injection, right wrist arthroscopy with repair of the transjugular fibrocartilage complex, and debridement of synovitis. *Id.*

Petitioner returned to Dr. Urbanosky for follow up on March 17, 2008. PX7 at 28. He reported no change in numbness and tingling after the injection, but definite relief of thumb pain and soreness in the appropriate surgical sites. *Id.* Dr. Urbanosky placed Petitioner off work and ordered physical therapy. *Id.* Several days

later, Petitioner saw Dr. Durkin and reported that after a strain-type injury in work conditioning he has had continued deep pain in the shoulder. PX7 at 29. Dr. Durkin recommended a second opinion. *Id.*

Petitioner then saw Dr. Durkin's colleague, Dr. Giridhar Burra, on April 11, 2008 and ordered an MR arthrogram and CT scan. PX7 at 30-31. After reviewing Petitioner's MR arthrogram and CT scan, Dr. Burra recommended another shoulder surgery involving a release of adhesions. PX7 at 34. Petitioner returned to Dr. Durkin on May 9, 2008 at which time he released Petitioner to light duty work with a 35 pound lifting restriction, minimal overhead work, and no use of firearms. PX7 at 35.

On May 12, 2008, Dr. Urbanosky recommended a second surgery for the right wrist. PX7 at 36. She noted Petitioner's report that his paresthesias returned. *Id.* She recommended a carpal tunnel release surgery to be performed at the time of his shoulder surgery. *Id.* As of June 23, 2008, Dr. Urbanosky noted that Petitioner was hesitant to have further surgery, but that he was unable to work at that time. PX7 at 38. As of August 4, 2008, Dr. Urbanosky placed Petitioner at maximum medical improvement and released Petitioner back to full duty work with regard to the wrist effective August 5, 2008. PX7 at 39.

Four days later, Petitioner returned to Dr. Durkin at which time he was released to light duty work with a 30 pound lifting restriction, no climbing ladders, and no overhead activity. PX7 at 40. Petitioner was instructed to follow up when he was ready to pursue the second adhesion removal surgery in the shoulder. *Id.*

Petitioner testified that he returned to work on August 18, 2008.

On September 29, 2008, Petitioner returned to Dr. Urbanosky reporting wrist popping while handcuffing prisoners. PX7 at 43. She prescribed a custom splint and continued Dr. Durkin's work restrictions. *Id.* As of January 13, 2009, Petitioner continued to report popping in the wrist. PX7 at 45. Dr. Urbanosky recommended a repeat MR arthrogram of the right wrist to check for possible extensor carpi ulnaris subsheath tear, inflammation, instability, or possible recurrent TFCC tear. *Id.*

February 3, 2009

On February 3, 2009, Petitioner testified that he was working with inmates in the showers in a cell house. He explained that two inmates began fighting. He was slammed against the shower and hurt his neck and right shoulder. Petitioner completed an incident reported the incident to Lieutenant Knalls.

The medical records reflect Petitioner returned to Dr. Durkin one week later on February 10, 2009. PX7 at 46. Dr. Durkin noted Petitioner's report that he was in an altercation at "with an inmate in which he was slammed against the shower, and he is now having pain in the top of his right shoulder. He has shooting pain down the right side when he turns his neck. This is a new symptom. He is still having the pain in the lateral aspect of the shoulder with decreased range of motion that he has been doing home exercises on, and he is coming in today to discuss surgical options at this point." *Id.* Dr. Durkin again prescribed right shoulder surgery. *Id.*

As of March 25, 2009, Dr. Durkin restricted Petitioner from lifting over 35 pounds and he again recommended surgery including an arthroscopy, debridement, release of adhesions, and rotator interval debridement. PX7 at 47-48. While waiting for approval for the recommended surgery, Dr. Durkin ordered some physical therapy on May 20, 2009. PX7 at 49. Petitioner saw Dr. Durkin from June 19, 2009 through August 26, 2009 for a knee and ankle condition that is not at issue in the above-captioned cases. PX7 at 50-55.

Petitioner returned to Dr. Urbanosky on August 28, 2009. PX7 at 56. Dr. Urbanosky noted that the MRI arthrogram of the right wrist had finally been approved. *Id.* She noted that he had ruptured his repair and had a recurrent TFCC tear. *Id.* Dr. Urbanosky prescribed medications and a repeat TFCC repair surgery with ulnar shortening osteotomy. *Id.* She reiterated her recommendation for surgery on December 11, 2009. PX7 at 62-63. At a visit on January 4, 2010, Dr. Urbanosky noted that Petitioner was trying to obtain a second opinion. PX7 at 64. From February 5, 2010 through August 31, 2010 Petitioner continued to receive treatment to the right knee and ankle with Dr. Durkin. PX7 at 65-66.

On September 7, 2010, Petitioner returned to Dr. Durkin to address his shoulder. PX7 at 67. He reported that he could likely not tolerate being off work for the amount of time required after a repeat surgery and he indicated that he would consider surgery. *Id.* Dr. Durkin noted that Petitioner would continue with home exercises. *Id.* Petitioner testified that this is the last time he saw Dr. Durkin for the shoulder.

Petitioner returned to Dr. Urbanosky on November 10, 2010. PX7 at 68-70. Petitioner reported that he was unable to get a second opinion, the same complaints in the right wrist, and difficulty fishing. *Id.* Petitioner also reported that he had to re-certify on the shooting range the prior day. *Id.* Dr. Urbanosky placed Petitioner off work for two days and released him to full duty effective November 12, 2010. *Id.*

Petitioner testified that he declined to have the recommended second surgeries. He understood from the doctors that the surgeries could make him worse, and he was in fear of being put out of work permanently.

Petitioner's Independent Medical Evaluation & Deposition Testimony – Dr. Coe

On March 5, 2013, Petitioner saw Dr. Jeffrey Coe at his attorney's request. PX19. After reviewing various medical records, taking a history from Petitioner, and examining him, Dr. Coe rendered various opinions. *Id.* Specifically, he opined that there was a causal relationship between Petitioner's first injury at work on January 31, 2006 and his right shoulder, arm and wrist condition. *Id.* He also opined that there was a causal relationship between Petitioner's second injury at work and his right shoulder and neck condition. *Id.* Dr. Coe also agreed with the recommended surgeries prescribed by Dr. Durkin and Dr. Urbanosky. *Id.*

Petitioner called Dr. Coe as a witness at an evidence deposition taken on November 25, 2013. PX27. Dr. Coe testified consistent with the opinions and conclusions that he rendered in his March 5, 2013 report and specifically explained how Petitioner's structural problems in the right shoulder, right wrist, and neck—as well as the need for additional medical treatment including surgeries which he indicated Petitioner reasonably declined to undergo given the risks and chronic nature of the conditions at that point—were directly caused or aggravated by both injuries at work. *Id.*

Additional Information

Regarding his current right shoulder condition, Petitioner testified that it has not gotten any better. He explained that his symptoms seem to be worsening. Petitioner testified that he still does not have the range of motion he should have and he continues to have aches. In the morning, Petitioner testified that he has to wind up his shoulder and stretch it out. He also experiences numbness and explained that he has about 10-20% strength in his right shoulder.

Petitioner also explained a reference to him "just barely hanging on." He explained that this means that he has sleepless nights, feels he is not able to perform his job as required, and he takes a lot of over-the-counter pain medications.

When he is performing his duties, Petitioner testified that he now leads with the left side of his body when engaging in activities such as opening a door, which could weigh over 100 pounds, or restraining an inmate. On a daily basis, Petitioner testified that he "keys out" about 80 inmates using a Keystone key for lunch and healthcare appointments. He has to slide the doors open and back. Petitioner described the pain after these activities as excruciating. Petitioner also testified that he experiences a lot of sharp shooting pains and aches in his shoulder during bad weather.

With regard to his neck, Petitioner testified that he wakes up with crooks and cranks in it. He also testified that he has trouble sleeping.

With regard to his right wrist, Petitioner testified that his wrist seems to be worsening. He has a lot of numbness and tingling in the wrist and he experiences popping with any movement in the wrist. Petitioner estimated that he has no strength in the right wrist. He explained that he is unable to open cell doors with his right hand without feeling excruciating pain, so he now uses his left hand to turn the keys.

Petitioner also testified that he felt depressed. He explained that he is not able to throw a football very far. He also described problems starting his car every day, opening doors, and performing his job duties. Petitioner testified that it also hurts to fish and wind the rod up. He testified that he used to weight-lift, but he no longer does that. He also testified that he does not run anymore because it jars the shoulder and makes the wrist act up. Petitioner testified that he takes Advil over-the-counter on a daily basis and takes hot baths.

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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 hearing as follows:

In support of the Arbitrator's decision relating to Issue (C), whether Petitioner sustained an accident 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).

The record reflects the uncontroverted testimony of Petitioner describing an altercation with an inmate while at work on February 3, 2009. Specifically, he testified that he was slammed against the shower and hurt his neck and right shoulder. The records of Dr. Durkin confirm Petitioner's testimony. A February 10, 2009 progress note reflects Petitioner's report that he was in an altercation at "with an inmate in which he was slammed against the shower, and he is now having pain in the top of his right shoulder." Dr. Durkin also noted Petitioner's report that he "has shooting pain down the right side when he turns his neck. This is a new symptom." There is no evidence that Petitioner had any condition in the neck that prevented him from working or any medical treatment to the neck before this date.

Based on all of the foregoing, the Arbitrator finds that Petitioner sustained an accident on February 3, 2009 that arose out of and in the course of his employment as claimed.

In support of the Arbitrator's decision relating to Issue (E), whether timely notice of the accident given to Respondent, the Arbitrator finds the following:

Notice of an accident shall give the approximate date and place of the accident, if known, and may be given orally or in writing, but not later than 45 days after the accident with some very limited exceptions. 820 ILCS 305/6(c). The purpose of the notice requirement is to enable an employer to investigate an alleged accident. *Seiber v. Industrial Comm'n*, 82 Ill. 2d 87, 95 (1980). A claimant's compliance with the notice requirement is established by placing the employer in possession of the known facts related to the accident within the statutory period. *Seiber*, 82 Ill. 2d at 95.

As noted in the accident analysis above, Petitioner testified about an injury sustained at work during an altercation with an inmate. His testimony is corroborated by Dr. Durkin's medical records within a week

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thereafter. Petitioner also testified that he notified his supervisor, Lieutenant Knalls, immediately after the incident and informed him of the injury. Petitioner's testimony is uncontroverted.

Based on all of the foregoing, the Arbitrator finds that Petitioner gave proper and timely notice of his accident to Respondent.

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:

The Arbitrator finds that Petitioner's claimed current condition of ill-being in the right shoulder is causally related to the injury sustained at work on January 31, 2006, as addressed in the concurrent decision in Case. No. 07 WC 14188, and the aggravating accident at work on February 3, 2009. The Arbitrator further finds that Petitioner's condition in the neck is causally related to his injury at work on February 3, 2009. In so concluding, the Arbitrator relies on the credible testimony of Petitioner which is corroborated by contemporaneous medical records as well as the opinions of his treating physicians, Dr. Durkin, Dr. Burra, and Dr. Urbanosky, as well as the opinion of Petitioner's independent medical examiner, Dr. Coe, which are uncontroverted.

Petitioner's right shoulder condition had been compromised by the accident at work on January 31, 2006 and aggravated as a result of his accident on February 3, 2009, and there is no evidence that Petitioner had any prior condition in the neck before February 3, 2009 requiring treatment. The medical records confirm a consistent and plausible chain of events resulting in Petitioner's reported neck and worsened right shoulder symptoms correlating to his accident at work. Petitioner immediately reported these symptoms to his supervisor at work and sought medical attention shortly after his accident with Dr. Durkin. He continued to report such symptoms to Dr. Durkin and Dr. Coe (his independent medical evaluator) as corroborated by the medical records, Dr. Coe's report, and Dr. Coe's deposition testimony. Notably, no contrary opinion was offered by Respondent to refute any of the findings of Petitioner's treating physicians or Dr. Coe.

Given the chain of events, plausible explanation by these physicians as to Petitioner's conditions and the relation to the accident at work, and lack of contrary opinion, the Arbitrator adopts the opinions of Dr. Durkin and Dr. Coe.

Based on all of the foregoing, the Arbitrator finds that Petitioner's condition of ill-being with respect to his right shoulder and neck is causally related the work accident he sustained on February 3, 2009.

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 right shoulder and neck conditions are causally related to his accident at work relying on Petitioner's credible testimony as well as the opinions of his Dr. Durkin and his own independent medical examiner, Dr. Coe. The medical bills submitted into evidence are for the reasonable and necessary medical treatment rendered to Petitioner to address these conditions.

Accordingly, the Arbitrator finds that the medical bills after February 3, 2009 incurred by Petitioner that remain unpaid (as reflected in Petitioner's Exhibits 23 and 24, which is a bill total for the amounts listed in Petitioner's Exhibits 21 thru 26) are to be paid by Respondent as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive a credit, if any, as agreed by the parties.

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 sustained a neck injury requiring minimal conservative care with no time off work—the Arbitrator finds that Petitioner has established permanent partial disability to the extent of 2.5% loss of use of the man as a whole pursuant to Section 8(d)2 for his neck injury.

The Arbitrator denies any additional award for further compensation as a result of Petitioner's right shoulder condition. Petitioner has been compensated for this injury as explained more fully in the decision in Case No. 07 WC 14188 for permanent partial disability stemming from his injuries on both January 31, 2006 and February 3, 2009 as a result of a consolidated full trial on the merits of both cases.[3]

[3] The Arbitrator notes that the evidence presented at the consolidated hearing in these matters was insufficient to "delineate and apportion the nature and extent of permanency attributable to each accident." *See City of Chicago v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 258, 265 (1st Dist. 2011). As such, the permanency award in this case encompasses and compensates Petitioner for his injuries alleged in both of the above-captioned claims and no separate award is made in Case No. 12 WC 4048. *See Baumgardner v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 274, 279-80 (1st Dist. 2011) ("From a procedural and practical standpoint, where a claimant has sustained to separate and distinct injuries to the same body part in the claims are consolidated for hearing and decision, it is proper for the commission to consider all of the evidence presented to determine the nature and extent of his permanent disability as of the date of the hearing.").

'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 ST. CLAIR)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☒ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Christopher Wasser,

Petitioner,

vs. NO: 12 WC 40970

15IWCC0821

Troy Police Department,

Respondent,

DECISION AND OPINION ON REVIEW

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

The Commission finds that Petitioner is entitled to a loss of use of 10% of a person as a whole as a result of his injuries on June 23, 2012.

Petitioner had three prior workers compensation injuries involving the same left shoulder. The surgery performed on the Petitioner for this accident was a muscle transfer, which was previously discussed with Dr. Yagamuchi on September 17, 2008. Yagamuchi testified that because of the Petitioner's substantial increase in pain after this accident, the muscle transfer was now causally connected to this accident because of that increase in pain. (Petitioner Exhibit 3 Pgs. 64-66)

As a result, the Commission finds that Petitioner suffered a loss of use of an additional 10% person as a whole because of this accident.

All else is affirmed and adopted.

15IWCC0821

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $767.78 per week for a period of 21 2/7 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 $691.05 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 loss of use of the person as a whole to the extent of 10%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $3,754.50 for medical expenses under §8(a) of the Act and 8-2 as well as $331.04 in out-of- pocket medical expenses.

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: NOV - 6 2015

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

HSF
O: 10/21/15
049

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WASSER, CHRISTOPHER
Employee/Petitioner

Case# **12WC040970**

TROY POLICE DEPARTMENT
Employer/Respondent

15IWCC0821

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:

0384 NELSON & NELSON
BOB NELSON
PO BOX Y
BELLEVILLE, IL 62222

1001 SCHREMPF KELLY NAPP & DARR
MATTHEW KELLY
307 HENRY ST SUITE 415
ALTON, IL 62002

15IWCC0821

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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Christopher Wasser
Employee/Petitioner

v.

Troy Police Department
Employer/Respondent

Case # 12 WC 040970

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 **Belleville**, on **10/30/14**. 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. [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 **06/23/12**, 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 $**59,891.00**; the average weekly wage was $**1,151.75**.

On the date of accident, Petitioner was **36** years of age, ***married*** with **2** dependent children.

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

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

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

Respondent is entitled to a credit for $**all group payments and agrees to hold Petitioner harmless from any subrogation claim** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of $3,754.50, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall reimburse Petitioner the sum of $331.04 for out-of-pocket medical expenses.

Respondent shall pay Petitioner temporary total disability benefits of $**767.78/week** for **21 2/7** weeks, commencing **11/26/12** through **04/23/13**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the sum of **$691.05/week** for **87.5** weeks because Petitioner sustained permanent partial disability to the extent of **17.5% loss of use of person as a whole** pursuant to § 8(d)2 of the Act.

Respondent shall pay Petitioner compensation that has accrued between June 23, 2012 and October 30, 2014 and shall pay the remainder of the award, if any, in weekly installments.

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

December 23, 2014
Date

JAN 5 - 2015

Christopher Wasser v. Troy Police Department: Case No. 12 WC 040970

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner sustained an undisputed accident to his left shoulder on June 23, 2012. The issues in dispute are causation, medical bills, TTD, nature and extent.

The Arbitrator finds as follows:

Petitioner's medical treatment for his left shoulder goes back to 2004.

Petitioner was seen by Dr. Lawrence Kriegshauser on April 8, 2004, at which time he reported an onset of pain in his left shoulder following an accident which occurred on February 4, 2004. Petitioner initially suffered a traumatic anterior dislocation. Dr. Kriegshauser diagnosed persistent anterior subluxation which was status post-dramatic dislocation of the shoulder with a possible anterior labral tear. Dr. Kriegshauser's records reflect that Petitioner would likely have a ninety percent incidence of repeated dislocations and instability as a result of this injury. Dr. Kriegshauser recommended an open reconstruction of Petitioner's left shoulder. Petitioner underwent his first left shoulder surgery on April 23, 2004. Dr. Kriegshauser undertook an exam under anesthesia, an athroscopic debridement of the left shoulder and an open anterior capsular shift on that date. Dr. Kriegshauser's post-operative diagnosis was of a recurrent anterior dislocation of Petitioner's left shoulder. (RX 2, 3)

Following this initial surgery, Petitioner continued to have difficulties with his left shoulder, including an onset of pain in June of 2004, where Petitioner felt a rip in his left shoulder in connection with his post-operative physical therapy.

Petitioner saw Dr. Timothy Penn on October 27, 2004 at which time Petitioner advised Dr. Penn that he had been having trouble with his shoulder, including pain and weakness, ever since his initial injury in February of 2004. Dr. Penn recommended an MRI arthrogram which was completed on November 8, 2004. Dr. Penn reviewed the results of the MRI arthrogram, concluded that it was difficult to visualize Petitioner's biceps tendon, his subscapularis tendon and his muscle and, as such, referred Petitioner to Dr. Yamaguchi in St. Louis for further treatment considerations. (RX 5)

Petitioner saw Dr. Ken Yamaguchi on December 22, 2004 at which time Petitioner advised as to his ongoing left shoulder symptoms. Dr. Yamaguchi reviewed an MRI which revealed a subscapularis tear with detachment. Dr. Yamaguchi then recommended an open subscapularis repair versus a pectoralis major muscle transfer. As of that evaluation, Dr. Yamaguchi concluded that Petitioner's prognosis was guarded due to the length of time between the initial tear and the recommendation for this revision surgery. No further surgery was undertaken at that time. (RX 2)

A little over two years later, Petitioner returned to Dr. Yamaguchi's office on January 24, 2007, at which time he advised as to another injury to his left shoulder, which injury occurred on January 19, 2007. Petitioner advised that he thought he had sustained another tear. As of February 5, 2007, Petitioner had advised that he had been having some difficulty in his left shoulder ever since 2004 and then been involved in another altercation two weeks earlier. Dr. Chen, Dr. Yamaguchi's partner, diagnosed a contusion/irritation of a pre-existing subscapularis tear for Petitioner as of February 5, 2007. An updated MR arthrogram had been completed on January 31, 2007 and same confirmed subscapularis insufficiency. On February 5, 2007, after reviewing the MR arthrogram, Dr. Chen concluded that Petitioner had left subscapularis insufficiency which had been exacerbated, and as a result of the chronicity of the injury, a repair was not indicated. A pectoralis muscle transfer could be a less predictable option but he felt Petitioner needed his shoulder "to cool down" first. Dr. Yamaguchi discussed the possibility of an injection versus a pectoralis major transfer at that time.

As of March 19, 2007, Petitioner advised Dr. Yamaguchi's office that he wanted to move forward with the pectoralis major transfer and confirmed that he had been having intermittent problems with his left shoulder since 2004; however, he again noted that it became dramatically worse following an altercation in January 2007, as Dr. Yamaguchi would have expected. As of that date, Dr. Yamaguchi felt that a pectoralis major transfer was the likely procedure of choice.

Petitioner had an injection which failed to improve his condition by a return evaluation with Dr. Yamaguchi on May 7, 2007. At that time, Dr. Yamaguchi again discussed the possibility of a surgical subscapularis repair versus a pectoralis major transfer. Dr. Yamaguchi was again of the opinion that a pectoralis major transfer was the likely procedure of choice as a result of the chronic nature of Petitioner's tear. (RX 4)

After an IME with Dr. James Emanuel, Petitioner had his second left shoulder surgery at Barnes Jewish Hospital on August 27, 2007. Dr. Yamaguchi performed an open left subscapularis repair. As of September 5, 2007, Dr. Yamaguchi expressed the opinion, in his office note, that this most recent surgery was a complication from Petitioner's prior surgery. As of January 2, 2008, Dr. Yamaguchi allowed Petitioner to return to work full duty as Petitioner advised that there was almost no possibility of being involved in further altercations at work.

Petitioner returned to Dr. Yamaguchi on April 22, 2008 at which time he advised that he had had a spontaneous onset of left shoulder difficulties in February of 2008, with no history of additional accident or injury. Petitioner advised that he had complaints of left shoulder pain which rose to the level of 6 out of 10, including substantial complaints at night. Petitioner was advised he could engage in patrol duty but not SWAT training. (RX 4)

After additional diagnostic studies, including an MRI and a left shoulder sonogram, Dr. Yamaguchi concluded that Petitioner had an intact rotator cuff and, somewhat to his surprise, an intact subscapularis tendon. Dr. Yamaguchi undertook another injection on

April 29, 2008 following which Dr. Yamaguchi recommended additional physical therapy. (RX 4)

As of July 2, 2008, Petitioner continued to complain of substantial left shoulder pain which Dr. Yamaguchi found difficult to understand. However, Dr. Yamaguchi recommended another injection and further diagnostic studies, including EMG/nerve conduction studies.

The EMG/nerve conduction study was completed on July 30, 2008 and was reported as being abnormal. The report indicated that Petitioner had atrophy along the biceps area as a result of an unusual injury, with an unusual mechanism of injury. It was further noted that Petitioner had weakness and occasional numbness and tingling into his fingers.

On August 20, 2008, Dr. Yamaguchi concluded that Petitioner had evidence of chronic atrophy as though he had lost his upper subscapular nerve and that, given the MRI findings, Petitioner had a torn subscapularis tendon for which he was a probable candidate for a pectoralis major transfer. (RX 4)

As of September 17, 2008, Dr. Yamaguchi concluded that Petitioner had evidence of chronic atrophy of the upper subscapularis tendon and that it almost looked like Petitioner had lost his upper subscapularis nerve altogether. Dr. Yamaguchi placed work restrictions on Petitioner and again discussed a possible revision repair of the subscapularis tendon with a pectoralis major transfer procedure. On that date, Petitioner advised that he wanted to proceed with surgery.

Dr. Yamaguchi's office note of November 11, 2008 reflected that Petitioner's claim for further surgery had been denied, in part, because Petitioner had participated in an ATV event. Dr. Yamaguchi noted his confusion as to that decision as he felt whatever Petitioner had done didn't seem to mean he didn't have a shoulder problem. Dr. Yamaguchi felt that Petitioner's need for surgery as of November 11, 2008 was directly related to Petitioner's need for his first surgery. Petitioner had a well known subscapularis problem which had become chronic. Petitioner had undergone an earlier repair which healed but resulted in acquired atrophy, a known possibility of previous repairs or injuries. Petitioner requested that he be released to full duty on patrol. Since pain was viewed as Petitioner's major issue and because he still had reasonable strength he would be allowed to do so. Petitioner was advised that if he was involved in an altercation he was at an increased risk of injury due to his compromised suscapular issue. (RX 4)

Petitioner carried on his duties as a police officer without missing work, seeing a physician or taking medications for the shoulder in the nearly four year interval until 06/23/12, the date of the accident herein. He would physically restrain individuals on a weekly or bi-weekly basis. Petitioner testified that his shoulder was not normal but he could engage in recreational activities such as golf, running, biking, swimming, playing softball and going to the gym with difficulty. He golfed fourteen to fifteen times a year.

On the 23rd of June, 2012 while working as a patrol sergeant Petitioner was dispatched to a hotel responding to a complaint of someone breaking into cars. The suspect was a large man at six feet, four inches tall and two hundred and eighty pounds. He was very intoxicated; he resisted arrest. Petitioner attempted to grab him and wrestle him to the ground. In the altercation Petitioner's left shoulder was injured. He reported the injury immediately. The pain was as severe as the complete dislocation of the shoulder Petitioner had had originally in 2004. Laughlin Ambulance personnel evaluated the left shoulder and advised the Petitioner to seek treatment (Petitioner's Exhibit 8).

Petitioner went to emergency room at Oliver C. Anderson hospital later on the day of the event. Petitioner complained of left shoulder pain and he told staff about his previous shoulder dislocation. Petitioner could move his shoulder without any difficulty. Petitioner declined any medication, was released to return to work, and told to follow up with his orthopedic surgeon (PX 1).

After the emergency room visit Petitioner followed up with his family physician, Dr. Dean Schueler. Petitioner explained that he felt a pull, but no pop, at the time of the accident and had gone to the emergency room. Petitioner was noted to be taking Vicodin. Due to "acute shoulder pain and trauma" an MRI was ordered and performed on July 11, 2012 revealing a small bursal sided partial tear of the supraspinatus tendon and chronic changes. Petitioner was diagnosed with a supraspinatus tendon tear, given medications, and allowed to keep working. Dr. Schueler referred Petitioner to Dr. Yamaguchi. (PX 2)

Thereafter Petitioner consulted with Dr. Aaron Chamberlain, a doctor at Barnes Hospital, on 07/18/12 (Petitioner's Exhibit 5). He gave a consistent history and reported worsened pain since the injury. He described the pain as sharp and continuous but worse when "doing anything with the arm".

Dr. Yamaguchi saw the Petitioner on 08/01/12. In the physical exam he reported a very painful arc raising the arm above shoulder height.

Petitioner testified that he continued to work until his surgery on 11/26/12 but did not return to his regular patrol duties and simply sat in the office. His police chief and other officers took care of any altercations or arrests. He was not able to return to his ordinary physical activities after the altercation on 06/23/12 and, for example, played no golf.

Dr. Yamaguchi performed a left shoulder open revision subscapularis repair on 11/26/12 for a recurrent subscapularis tear (Petitioner's Exhibit 5) Workers' compensation again refused to authorize the surgery. Petitioner testified that this time he did not decline the operation since the condition was intolerable. He submitted the surgery charges to his group insurer and cashed in sick days he could have used as a credit for his retirement. Respondent agrees that treatment for Petitioner's left shoulder condition caused him to be temporarily totally disabled from 11/26/12 to 04/23/13, a

period of 21 2/7 weeks but disputes whether the left shoulder condition is causally related to the accident.

Petitioner's most recent post-operative course of care went well. As of April 29, 2014, Dr. Yamaguchi concluded that Petitioner was capable of performing 40 pushups, that he had full overhead range of motion and excellent strength with external rotation. Dr. Yamaguchi noted that Petitioner had a completely negative stomach compression test as of April 29, 2014, a sign of lack of further issues with Petitioner's subscapularis tendon, and that he had only occasional burning with significant activities. That was the last office visit for Petitioner with Dr. Yamaguchi.

Dr. Yamaguchi testified on behalf of Petitioner in this matter on May 30, 2014. Dr. Kenneth Yamaguchi's testimony is marked as Petitioner's Exhibit 3. He is a chief of shoulder and elbow surgery at Barnes Hospital in St. Louis and has been for 20 years (Petitioner's Exhibit 3 Page 4 line 21). He has 200 plus total publications and is a distinguished professor of orthopedic surgery at Washington University Medical School teaching medical students, residents and fellows as well as internationally (Petitioner's Exhibit 3 p 5). Dr. Yamaguchi had seen the Petitioner repeatedly since approximately 2004. He sought authorization from the Respondent for approval of left shoulder surgery following the altercation "Because it appeared to be a work-related injury" (Petitioner's Exhibit 3 p 10). He testified "I do believe that the injury he had in June 2012 led to the necessity of subsequent surgery in 2012" (Petitioner's Exhibit 3 p 14). Dr. Yamaguchi testified that his surgical findings "strongly suggests to me that he had a recent tear of that muscle again and, obviously, because he had the incident in June, that would be by far the most likely cause of that" ((Petitioner's Exhibit 3 p 12). Had the tear been present for a long time he would not have been able to fix it. A long time for subscapularis tear is more than six months. Dr. Yamaguchi's surgical findings "strongly suggest the tear was relatively recent. Since he had that injury in June, I mean, it's obvious that the two are related in my mind" (Petitioner's Exhibit 3 p 13).

On cross-examination, Dr. Yamaguchi admitted that he did not fully recall the details of Petitioner's lengthy and complicated prior history of treatment for left shoulder difficulties, including but not limited to the details surrounding Petitioner's prior left shoulder surgeries and Dr. Yamaguchi's multiple prior recommendations for surgeries, including the two surgeries which were never undertaken. After reviewing the prior history in some detail, Dr. Yamaguchi concluded that he was no longer certain as to his opinion regarding causation, but that it was still "possible" that Petitioner's most recent surgery could have been causally related to the incident Petitioner experienced on June 23, 2012. He noted that if Petitioner's pain complaints increased after June 23, 2012 the surgery would be causally related.

Respondent had Petitioner examined by Dr. Michael Nogalski for an independent medical evaluation on October 31, 2012. He was later deposed. Dr. Nogalski was unaware of Petitioner's condition in the months and years prior to the trauma. Dr. Nogalski did not know whether Petitioner was or was not taking medications in the weeks, months and roughly four years before the incident on June 23, 2012

(Respondent's Exhibit 1 p 24, ln 1). He did not know whether the incident in question had led to an increase in any sort of symptoms whatsoever (Respondent's Exhibit 1 p 24, ln 6). The doctor did not ask whether Petitioner's compromised abilities, post altercation complaints or other symptoms were present in 2009, 2010 or 2011 or the first half of 2012 (Respondent's Exhibit 1 p 23, ln 13-18). Petitioner complained to the doctor that following the incident he had difficulty when tried to push objects, swing a golf club, etc. The doctor thought those complaints did not represent a change in the condition after June 12, 2012 (Respondent's Exhibit 1 p 24, ln 19). Dr. Nogalski agreed that if Petitioner was not having complaints, was working full-time and had not seen a physician for nearly four years he would not have suggested surgery on the shoulder (Respondent's Exhibit 1 p 28, ln 17-23). Following the trauma Dr. Nogalski felt it was reasonable to recommend surgery to optimize the function with a tendon transfer if the tendon were not reasonably repairable (Respondent's Exhibit 1 p 12, ln 11-13). He reported on 10/31/12, one month prior to the surgery by Dr. Yamaguchi, that the Petitioner's current diagnosis was related to a temporary aggravation. Initially Dr. Nogalski claimed he had not made the statement (Respondent's Exhibit 1 p 17, ln 2) and, upon being asked to review his report, agreed that he had reported, "I believe his current diagnosis and subscapular issues relate to a temporary aggravation of a pre existing issue" (Respondent's Exhibit 1 p 17, ln 10). The aggravation was from the trauma in June of 2012 (Respondent's Exhibit 1 p 17, ln 20). Dr. Nogalski reported that the treatment up until the date of his examination had been reasonable and necessary with respect to the claimed work injury (Respondent's Exhibit 1 p 21, ln 20-23). At the time of the deposition he did not change his mind (Respondent's Exhibit 1 p 22, ln 21-22). The treatment included injections (Respondent's Exhibit 1 p 23, ln 15-17).

Petitioner last saw Dr. Yamaguchi, his surgeon, on April 29, 2014. Petitioner was doing reasonably well and was back at his job. He could perform forty push-ups on a regular basis but, every now and then, he notices a strain and burning sensation. He has full overhead elevation to 160 with excellent strength in external rotation and a completely negative stomach compression test. Dr. Yamaguchi explained to Petitioner that give two subscapularis surgeries, he was doing remarkably well and occasional burning with significant activities was to be expected. A pectoralis major transfer would be the next step and probably make him worse, not better. Petitioner declined any further imaging studies for the time being. He was advised to do internal rotation against resistance exercises in a gradually progressive fashion and to return as needed. (PX 4)

Petitioner testified that he doesn't believe he is as well off as he was after the surgery he had before his June 23, 2012 accident. He doesn't really think he has ever gained back the strength he had before the June 23, 2012 accident. Since June 23, 2012 he has not golfed. He lacks strength when sweeping out his garage or playing with his children. He is limited in swimming, biking and ordinary day to day activity. He can no longer hold his two year old without noticing discomfort in his shoulder. He can shovel or do landscaping activities only a short period of time. He cannot use a weed whacker for more than a few minutes. The arm motion in running aggravates his arm so to stay in shape he now uses an elliptical but does not use the arm levers. He no longer has the arm strength to move heavy furniture although shortly before the incident he moved his entire

home without difficulty. He has lost strength and range of motion in the shoulder especially with overhead activities or reaching behind his back. On the job he avoids making arrests and works more to protect his shoulder. His co-workers often try to be the first on a scene. Petitioner has changed handcuff pouch styles to allow easier accessibility to remove the handcuffs from behind his back. He drives with his right arm most of the time although before June 2012 he drove with both. He currently takes over the counter medications daily. He alternates between Tylenol and ibuprofen to avoid health concerns. He also ices his shoulder and takes hot showers.

Petitioner paid $331.04 in out of pocket expenses for this treatment. The Respondent's group medical insurance paid most of the charges for treatment to the left shoulder after 06/23/12. The Respondent claims a credit under Section 8 (j) for payments made by its group insurer and agrees to hold the Petitioner harmless from any subrogation claims by the group carrier in the event the claim is found compensable. Petitioner alleges that a bill from Barnes Jewish Hospital for $3,754.50 on the date of service 08/22/12 for treatment to the left shoulder remains unpaid. The Respondent agrees that the treatment was reasonable but disputes whether the left shoulder condition is causally related to the acknowledged trauma.

At the time of arbitration the parties agreed that Respondent should be given a credit against any award of TTD the 12 hours of personal time Petitioner took while off work. They also agreed to submit a stipulation with their proposed decisions as to what the exact amount of 12 hours would be. In the absence thereof, a general credit of 12 hours was to be given. In an e-mail marked as AX 5 (and included with the exhibits) Respondent waived the credit issue altogether.

The Arbitrator Concludes

1. Issue (F) Causal Connection

Petitioner's current condition of ill-being in his left shoulder is causally connected to his undisputed accident of June 23, 2012. Petitioner had an underlying condition in his shoulder prior to the incident in question. The Arbitrator finds Petitioner's testimony credible and straight forward. He did not have significant left shoulder symptoms in the months and years prior to the work accident on June 23, 2012. After the work accident his shoulder never went back to the low pain level as it had been prior to 06/23/12. There was no evidence or witness presented suggesting that he missed work, sought medical care, reframed from activity or was limited in the months and years before the work incident on 06/23/12. After wrestling with the suspect, there was a sudden change in his pain level and activity level. He began treating again after the nearly four year hiatus culminating in a third shoulder surgery.

Two physicians addressed the causation issue in their depositions. This case isn't really about a pectoralis muscle transfer as Respondent might contend. It's about a torn subscapularis tendon that was noted on the July 11, 2012 MRI taken after Petitioner's undisputed accident. A subsequent MRI dated August 22, 2012 confirmed the tear. Dr.

Yamaguchi's notes repeatedly address a possible tear with the treatment plan being to explore the area and attempt a repair, not necessarily a transfer. As it turned out, surgery was performed on November 26, 2012 and Petitioner underwent a repair to a recurrent subscapularis tear. Petitioner's symptoms were increased after the June 23, 2012 accident and Dr. Yamaguchi noted that the symptoms were the major consideration in having surgery (Petitioner's Exhibit 3, p 63) Dr. Yamaguchi's opinions and testimony are found more persuasive than those of Dr. Nogalski. Dr. Nogalski's opinions as stated in his report and during his deposition were inconsistent. The doctor was somewhat difficult during his deposition, especially when Petitioner's attorney was asking him questions about the inconsistencies between his report and his testimony. The doctor's report clearly opined that Petitioner's current diagnosis and subscapularis issues related to a temporary aggravation of a pre-existing issue present back in 2008. While he felt a tendon transfer would be a continuation of previously recommended treatment going back to 2008, he agreed that, to date, all treatment had been reasonable and necessary with regard to the claimed work injury. In sum, the Arbitrator finds the treating doctor's opinions to be more persuasive than those of Dr. Nogalski, Respondent's examining physician.

2. Issue (J) Medical Bills.

Respondent shall reimburse Petitioner the out-of-pocket charge of $331.04 and pay $3,754.50 to Barnes Jewish Hospital.

3. Issue (K) Temporary Total Disability

Petitioner is entitled to receive $767.78 per week for the 21 2/7 weeks the Petitioner was temporarily permanently disabled between 11/26/12 and 04/23/13. Respondent did not dispute the period of time, only liability for same.

4. Issue (L) Nature and Extent

Since this injury occurred after September 1, 2011, the Arbitrator analyzes permanent partial disability under the five factors set forth in Section 8.1(b).

First, the Arbitrator observes that there has been no reported level of impairment pursuant to AMA guidelines.

Second, the Arbitrator considers the occupation of the injured employee in so far as it is relevant to this determination. Petitioner's occupation is that of a police sergeant. He is required to use his shoulders in a forceful manner in response to those violating the law. He is also required to use physical force to insure his safety and the safety of the public. Petitioner is working full duty. He has no formal restrictions but is getting assistance from co-workers who are familiar with his shoulder condition as he is at a risk of re-injury. The Arbitrator gives weight to this factor.

Third, the Arbitrator considers age of the employee at the time of the injury. Petitioner was 36 years old at the time of his accident and has many years ahead of him to work.

Dr. Yamaguchi noted that Petitioner will have some early arthritis that will be problematic on cold wet days. Aches and pain most people have after age 50 he will have after age 40. Petitioner, while relatively young at this time, will live with the effects of this injury for longer than older workers and has a shoulder, more effectively aged, than those of others his age. The Arbitrator gives great weight to this factor.

Fourth, the Arbitrator observes that Petitioner has not shown a reduction in earning capacity as a result of his injury.

Fifth, the Arbitrator notes that there is evidence of disability corroborated by the treating medical records. Dr. Yamaguchi "always found [Petitioner] to be very credible as a patient, without any secondary gain type issues" (Petitioner's Exhibit 3 p 15). After three surgeries Dr. Yamaguchi testified that "to have persistent discomfort is unfortunately expected" (Petitioner's Exhibit 3 p 15). The doctor felt the Petitioner's range of motion will be compromised (Petitioner's Exhibit 3 p 16). His power has been compromised in light of the event of June 2012 (Petitioner's Exhibit 3 p 16). Petitioner last saw Dr. Yamaguchi, his surgeon, on April 29, 2014 and could do forty push-ups. Petitioner acknowledged that ability but has difficulty with other activities he could perform well before the forceful trauma. Petitioner credibly testified to those difficulties. Petitioner testified that since June 23, 2012 he has not golfed. He lacks strength when sweeping out his garage or playing with his children. He is limited in swimming, biking and ordinary day to day activity. He can no longer hold a two year old without causing discomfort in his shoulder. He can shovel or do landscaping activities only a short period of time. He cannot use a weed whacker for more than a few minutes. The arm motion in running aggravates his arm so to stay in shape he now uses an elliptical but does not use the arm levers. He no longer has the arm strength to move heavy furniture although shortly before the incident he moved his entire home without difficulty. He has lost strength and range of motion in the shoulder especially with overhead activities or reaching behind his back. On the job he avoids making arrests and works more with supervision to protect the shoulder and is seldom the first to arrive and make an arrest as he was at the time of the incident. His co workers protect him and make sure they respond to calls be he does. He has changed handcuff pouch styles to allow easier accessibility to remove the handcuffs from behind his back. He drives with his right arm most of the time although before June 2012 he drove with both. He currently takes over- the-counter medications daily. He alternates between Tylenol and ibuprofen to avoid health concerns. He ices his shoulder and takes hot showers. Dr. Yamaguchi testified that the Petitioner still had intermittent pain and cannot do all the activities he would normally do (Petitioner's Exhibit 1 p 13). Multiple surgeries, he explained, create chronic scarring changes to the muscle and to the nerves and those things are generally irreversible (Petitioner's Exhibit 1 p 14).

Having considered all of the factors above and giving more weight to Petitioner's age combined with his occupation, and the evidence of disability as corroborated by the treating records, the Arbitrator concludes that Petitioner has sustained a 17.5% loss of his body as a whole pursuant to section 8(d)2.

****

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

Tammy Tellor,
Petitioner,
vs.

NO: 13 WC 6939
13WC 6940

SOI/Choate Mental Health,
Respondent,

15IWCC0830

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 2, 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: NOV 12 2015
MJB/bm
o-11/9/2015
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

TELLOR, TAMMY
Employee/Petitioner

Case# **13WC006939**

13WC006940

SOI/CHOATE MENTAL HEALTH
Employer/Respondent

15IWCC0830

On 4/2/2015, 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:

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

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

0558 ASSISTANT ATTORNEY GENERAL
KYLEE J JORDAN
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1745 CMS - RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

APR 2 - 2015

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Tammy Tellor
Employee/Petitioner

v.

SOI/Choate Mental Health
Employer/Respondent

Case # **13** WC **6939**

Consolidated cases: **13 WC 6940**

15IWCC0830

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **February 10, 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? **(Second injury only [13 WC 6940])**
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **10/9/11 and 10/19/12**, 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 accidents that arose out of and in the course of employment.

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

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

In the year preceding the injuries, Petitioner earned **$68,656.06/$70,464.00**; the average weekly wage was **$1,320.31/$1,355.07**.

On the dates of accident, Petitioner was **52/53** 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 $- for TTD, $- for TPD, $- for maintenance, and $- for other benefits, for a total credit of $-.

Respondent is entitled to a credit of $**any benefits paid through group** under Section 8(j) of the Act.

ORDER

Respondent shall pay the medical expenses delineated in the Arbitrator's finding, which exclude the expenses for treatment to Petitioner's left foot, as provided in § 8(a) of the Act. Respondent shall have credit for any benefits which have been paid by its group health carrier and shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in § 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $695.78/week for 2.28 weeks, because the injuries sustained caused the 3% loss of the left thumb, as provided in § 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $695.78/week for 25.05 weeks, because the injuries sustained caused the 15% loss of the right foot, as provided in § 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

3/27/15
Date

APR 2 - 2015

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

15IWCC0830

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

TAMMY TELLOR
Employee/Petitioner

v.

Case # 13 WC 6939
13 WC 6940

STATE OF ILLINOIS/CHOATE MENTAL HEALTH
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner filed two Applications for Adjustment of Claim for injuries which occurred to her left thumb on 9 October 2011 (13 WC 6939) and to her right foot on 19 October 2012 (13 WC 6940). Respondent stipulated to accident for Petitioner's first claim, but disputed accident for Petitioner's second claim. Causal connection, liability for medical expenses, and the nature and extent of the injury is in dispute for both claims.

13 WC 6939

Petitioner worked for the State of Illinois for 36 years and 7 months. (T.11). The Parties stipulated that on October 9, 2011, Petitioner sustained an accidental injury when she was working overtime in the dietary department and slashed her thumb while trying to open an industrial sized can. (T.12, 13). Petitioner's cut became infected with MRSA. (T.13). Prior to October 9, 2011, Petitioner was not experiencing any purulent discharge, exudation, boils, swelling or similar symptoms in her left thumb. (T.14). Petitioner testified to prior MRSA outbreaks, but these were not on her left thumb. (T.13-15).

Respondent called Teresa Smith as a witness, who serves as a Health Services Coordinator at Choate Mental Health Center. (T.48). Ms. Smith testified that she tracks any potential exposures to infectious diseases at Respondent's facility and keeps a log. (T.49). She testified that there is no logged exposure to MRSA by a patient or staff. (T.51). On cross examination, she testified that MRSA is a staph infection that resides on the skin, and that once a person is a carrier, they remain a carrier. (T.52). She testified that an outbreak can be triggered by things such as cuts, rubbing up against a foreign surface, insect bites, or anything traumatic or abrasive to the skin. (T.52).

Petitioner reported to Dr. William Ribbing at Rural Health the following day, who noted that Petitioner developed swelling and bruising around her cut with a lymphangitis extending just past the left elbow. (PX3, 10/10/11). Petitioner was given Rocephin and placed on Doxycycline. *Id.* Petitioner was instructed to report to the emergency room if her condition worsened and to follow up in 24 hours. *Id.* When Petitioner returned the following day, the swelling and bruising around her thumb was much more intense, especially right in the area of Petitioner's cut, with much more tenderness. (PX3, 10/11/11). Dr. Ribbing referred Petitioner to the emergency room at Carbondale Memorial Hospital to be evaluated by a surgeon, orthopedist or wound surgeon for immediate evaluation and possible debridement. *Id.*

Petitioner reported to the Memorial Hospital of Carbondale on the same day, where she was placed on Vancomycin, and Dr. Barr performed debridement of her left thumb abscess, skin and subcutaneous tissue. (PX7, 10/11/11-10/12/11). Petitioner followed up with Dr. Barr of the Orthopedic Institute of Southern Illinois on October 14, 2011. (PX4, 10/14/11). Dr. Barr noted that Petitioner's thumb abscess improved, but that Petitioner had some raw dermal tissue where she had the cut of her thumb. *Id.* Petitioner was switched to an oral antibiotic and instructed to use diluted peroxide soaks with antibiotic ointment and daily dressing changes. *Id.* Petitioner was returned to unrestricted work on October 31, 2011. (PX4, 10/28/11).

Petitioner testified that she suffers from pain, discomfort and a loss of grip strength as a result of the thumb laceration and subsequent infection. (T.16, 17). Petitioner has a long scar on her left thumb that is sensitive to heat and extreme cold. (T.15, 16). Petitioner testified that she has difficulty cooking as a result thereof. (T.16). She testified that she has lost strength in her thumb, which has negatively impacted her hobby of gardening. (T.17). Petitioner testified that she has not had any MRSA outbreaks at all since she retired from working for Respondent in May of 2014. (T.33, 44).

13 WC 6940

On the date of her second accident, Petitioner was a Human Resources Specialist. (T.11). Petitioner testified that her job duties entailed hiring, posting positions, and tracking the positions until they were filled. (T.12). On Friday, October 19, 2012, Petitioner was bitten on the ankle by a spider from Respondent's file room, which resulted in another MRSA infection. (T.24-26). Petitioner testified that the file room and the areas leading to the file room were highly unsanitary and home to numerous pests, from bats to the dreaded brown recluse, and that the personnel files themselves had insects. (T.17-19). She testified:

> A: Okay. We would go up either the side or the back stairs to our file rooms. And to get to that file room, you pass areas where there's dirt, there's straw, there's bird feathers, feces, bad wood, peeling paint, dirt daubers' nests. It's very bad condition, extremely bad condition.
>
> ARBITRATOR LEE: Did you say this was a storage area?

THE WITNESS: Our file rooms.

ARBITRATOR LEE: Okay.

THE WITNESS: We actually had dirt daubers in our files, the personnel files themselves. When we tried to bring in extra cabinets for extra space, we had to actually move the dirt dauber nests.

Q: (MR. RICH CONTINUING) When you actually get to the file room, what other creatures are you greeted by?
A: Some of them we don't really know what they were. They looked like a little centipede with lots of little legs on them, bright yellow. There were the dirt daubers, some wasps, spiders, the brown recluse we had seen there several times.

Q: And can you tell me what a brown recluse spider looks like?
A: They're thin, they're brown, and they've got a fiddle, violin shape on their back.

ARBITRATOR LEE: How big are they, are they as big as a half dollar?

THE WITNESS: Well, maybe a quarter.

Q: (MR. RICH CONTINUING) Smaller than a giant wolf spider or something like –
A: Oh, yeah, yeah.

Q: And had you seen these brown recluse spiders in the file room on several occasions when you went to retrieve files?
A: Yes.

Q: Are there bats?
A: Yes.

Petitioner offered pictures corroborating her description of these work conditions into evidence. (PX14).

Respondent called Chris Doctorman, a chief engineer at Choate Mental Health, who testified that his job includes maintenance of the facility. (T.54, 55). Mr. Doctorman testified that the engineers maintain the pest control/spray schedule. (T.56). He testified that Respondent's buildings are sprayed quarterly, with spot treatments done as necessary. (T.56, 57). He testified, however, that Respondent's main building where Petitioner works is treated every two months rather than quarterly, and that pest control is present in Respondent's main building on a weekly basis. (T.57). He testified that he did not believe that the main building was "infested" with brown recluse spiders, but essentially acknowledged that they were present on grounds. (T.57, 58). He acknowledged that there were also bats in the human resources building. (T.59, 60). When shown the pictures submitted by Petitioner, he acknowledged that they depicted

Respondent's file room and the surrounding area. (T.61-64). He testified that these areas, which the pictures demonstrate to be infested despite treatment, are sprayed regularly. (T.65).

The Arbitrator notes that spraying is the only method Mr. Doctorman testified was utilized. He did not testify as to what objects were treated or sprayed, such as whether it was simply the baseboards or whether attention was given to all crevices. The Arbitrator notes that the pictures show significant dilapidation of the premises.

Petitioner testified that she was wearing New Balance tennis shoes with a dip in the back of the shoe and nylon parachute pants or "breezers" when she went to the file room on the date of the accident. (T.26, 42). Petitioner testified that the pants zip on the sides and that she wears them unzipped. (T.42, 43). Petitioner testified that she went to the file room on the morning of the date of the accident, took some nursing job descriptions from the file room to her desk and set them down beside her feet in a metal expandable file. (T.26, 27, 38). After Petitioner sat down at her desk and began working on position requests, she felt a sting on the back of her right ankle, and a knot subsequently developed. (T.27, 38). Petitioner testified that it began to itch horribly, so she cleaned it, applied triple antibiotic ointment on it, and placed a band aid over it. (T.27). Petitioner testified that by Saturday, the next day, it began festering. (T.27). By Sunday, Petitioner testified that her ankle was "huge" and painful. (T.27). Petitioner testified that the rotting and pain that she began to experience in her ankle was unbearable and unlike any prior MRSA infection she experienced in the past. (T.28, 29). Petitioner described her MRSA outbreaks as "topical" lesions, whereas the brown recluse bite began to eat away at her flesh and created a black pit shaped like dragonfly wings in the back of her ankle. (T.29). Petitioner testified that she initially believed that the bite was a reoccurring MRSA infection, but later learned that it was a brown recluse bite that was developing a MRSA infection. (T.28, 35).

Consistent with her testimony, Petitioner went to the Union County Hospital emergency room on October 21, 2012, and reported severe pain and difficulty walking. (PX5, 10/21/12). Dr. Reach, the attending physician, noted that Petitioner had recently received 6 weeks of Vancomycin through a PICC line, completed approximately around October 2nd or 3rd, which resolved her unrelated left toe osteomyelitis. *Id.* Dr. Reach stated in his note that he felt it was extremely unusual that an abscess developed on Petitioner's contralateral side, and that it happened so quickly. *Id.* On October 23, 2012, Dr. Earnhart noted that Petitioner stated that her ankle pain was "some of the wors[t] pain she has ever had." (PX5, 10/23/12). On October 24, 2012, Petitioner underwent a staged incision and drainage of her posterior right ankle abscess. (PX5, 10/24/12). Prior to the operation, Dr. Kaye discussed his belief that Petitioner sustained a spider bite with both Petitioner and Dr. Reach, and Dr. Reach stated, "I feel this is possible." *Id.* The intraoperative findings supported Dr. Kaye's conclusion. The operative report states:

> It was noted upon dissection that the patient had a superficial abscess to the skin and a large deep hematoma in the deeper layers of the tissue. However,

there was no infection or drainage to the Achilles tendon. Mild tissue necrosis. Appeared as a brown recluse necrosis. . . . (PX5, 10/24/12).

The subjective postoperative comments noted as follows:

> **Per Dr. Kaye, who did the procedure it was not as deep as he had feared, and it did not look as much purulent as necrotic. Based on this, it is felt this most likely was a spider bite *initially*. (Emphasis added). (PX5, 10/25/12).**

Aerobic (wound) cultures from the abscess showed staph growth. Significantly, however, the microbiology culture comments document that no MRSA was isolated in the cultures from either Petitioner's blood or nasal passages. (PX5, Microbiology, 10/21/12-10/27/12). Thus, Petitioner's MRSA did not migrate internally. Petitioner was given oral Doxycycline and intravenous Vancomycin for her infection and her pain was controlled with intravenous morphine as needed. (PX5, 10/21/12-10/29/12).

Following her discharge, Petitioner continued to require antibiotic intravenous infusions. (PX5, 11/6/12-11/29/12; PX6). Petitioner was given Norco for pain. *Id.*; (PX9, 11/8/12). Petitioner began physical therapy and aquatic therapy shortly thereafter, which helped her to regain function in her right ankle. (PX5, 1/2/13-2/25/13). Petitioner was discharged from Dr. Kaye's care on February 28, 2013. (PX9, 2/28/13). Dr. Kaye noted, however, that Petitioner continued to walk with a slight antalgic gait due to pain. *Id.*

Petitioner attended an independent medical examination at Respondent's request with Dr. Gary Schmidt on January 21, 2013. (T.34; PX12). Dr. Schmidt's report reflected a history consistent with Petitioner's testimony and the medical records. (PX12). Dr. Schmidt noted that Petitioner was admitted and diagnosed with a spider bite before undergoing irrigation and debridement of her right ankle wound. *Id.* Petitioner reported burning and soreness in the posterior aspect of her right foot, as well as limitations on her ability to drive, stand, walk, lift, carry, bend, push, pull, climb, squat and kneel. *Id.* During physical examination Petitioner was unable to do a single or double limb heel rise on her right side. *Id.* After reviewing Petitioner's Report of Injury and the medical records of Petitioner's attending physicians at Union County Hospital, Dr. Schmidt stated:

> At this time she has a significant Achilles tendon contracture and this would be directly related to the spider bite she had on the posterior aspect of her ankle. I do feel that her condition and the need for her two surgeries was caused by her claim of being bit by a brown recluse spider. They are known to cause significant tissue necrosis and pain and based on the description this is consistent with that. *Id.*

Dr. Schmidt believed that the treatment given to Petitioner was reasonable and necessary and that Petitioner should continue with physical therapy. *Id.* He also noted that Petitioner still had an equinus contracture secondary scarring in the right posterior ankle. *Id.*

As a result of her infected spider bite, Petitioner required irrigation and debridement, extensive antibiotic treatment, and intensive pain management and therapy for her condition post-surgically. Petitioner testified that she continues to experience soreness and tenderness in her ankle as a result of the brown recluse bite. (T.31). Petitioner demonstrated her scarring before the Arbitrator. (T.29, 30). She testified that she can only wear certain shoes as a result of the scarring and tenderness. (T.31). Her fitness hobby of running has been adversely affected as a result. (T.31). Petitioner testified that she used to walk 3 to 5 miles a day, but can no longer do so. (T.31). Petitioner testified that if she wears anything other than open back shoes, the shoe back runs right into her scar and cause it to swell. (T.31). Petitioner also testified to significant loss of strength in her right foot. (T.31). Petitioner avoided driving for two years because she did not feel that she was able to put enough pressure on the brake if she needed to stop quickly. (T.31). Petitioner also testified that she has difficulty ambulating stairs, especially descending, and even fell a couple of times. (T.31, 32). Petitioner testified that she never had any limitations on function solely as a result of a MRSA outbreak on her right ankle. (T.32).

CONCLUSION

Issue (C): Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent? (13 WC 6940 only)

Respondent disputes that Petitioner sustained accidental injuries that arose out of and in the course of her employment on October 19, 2012, as a result of a spider bite that became infected with MRSA.

The Workers' Compensation Act is a humane law of a remedial nature that should be liberally construed to achieve its purpose. *Hagene v. Derek Polling Const.*, 902 N.E.2d 1269, 1273 (5d Dist. 2009). The word 'accident' is not a technical legal term and has been held to mean anything that happens without design, or an event which is unforeseen by the person to whom it happens. *Laclede Steel Co. v. Indus. Comm'n*, 128 N.E.2d 718, 720 (Ill. 1955). An injury is accidental within the meaning of the Act when it is traceable to a definite time, place and cause, and occurs in the course of the employment unexpectedly and without affirmative act or design of the employee. *Id.* An injury is in the course of employment when it occurs within the period of employment at a place where the employee can reasonably be expected to be in the performance of his duties and while he is performing those duties or something incidental thereto. *Lubin Management Co. v. Indus. Comm'n*, 558 N.E.2d 189 (1st Dist. 1990).

Petitioner was at her desk working on position requests when she felt a sting which was followed by the development of a knot. (T.25-27, 38). Petitioner later learned that this was a brown recluse bite. (PX5). Petitioner testified without rebuttal that before the bite occurred she had just retrieved some files from Respondent's file room and sat them by her feet. (T.25-27). Petitioner testified that she had also seen brown recluse spiders in Respondent's file room before and also that the personnel files themselves actually had insects in them. (T.18, 19). It is clear from the pictures, the testimony of Respondent's chief engineer and Respondent's extensive pesticide spraying schedule that Respondent has a problem with spiders, insects and other pests. Bites sustained from pest as a result of unsanitary conditions which harbor the pests in the work environment constitute accidental injuries; the unsanitary conditions at the workplace where the general public is not allowed create an increased risk of injury from pests and are an environment to which the general public is not equally exposed. *Like v. Parkland College*, 10 I.W.C.C. 0934 (2010).

The case of *Like v. Parkland College* is particularly illustrative. *Like v. Parkland College*, 10 I.W.C.C. 0934 (2010). In *Like*, the claimant was bitten by "*something* by the dumpster" after emptying a garbage can. *Id.* The claimant testified that he had previously seen insects in the area surrounding the dumpster in which he had emptied the waste. *Id.* The Commission found that the claimant's job required him to be in an area where the general public is not allowed, and exposed him to a greater risk of unsanitary conditions; therefore, the claimant's accident was deemed to have arisen out of and occurred in the course of his employment. *Id.*

In *Chad Collins v. State of Illinois/Menard Corr. Ctr.*, another case involving a bite from a pest harbored by unsanitary conditions, the claimant was bitten by a rat as he was changing assignments and walking from the cell house to the tower. *Chad Collins v. State of Illinois/Menard Corr. Ctr.*, 13 I.W.C.C. 0344 (2013). On the way to his assignment, the claimant passed by a gated area that housed trash cans with food and refuse. *Id.* Scavenger animals, including rats, usually visited the area. *Id.* Since the claimant was acting in his employment capacity when the bite occurred and the bite was traceable to a definite time, place and cause, the Commission affirmed the Arbitrator's finding that the claimant sustained accidental injuries that arose out of and in the course of his employment with Respondent. *Id.*

Similarly, Petitioner was performing her job duties when she was bitten by a brown recluse, and the bite was traceable to a definite time, place and cause. Petitioner was also subjected to an increased risk of injury by virtue of the unsanitary conditions harboring pests in and around the file room of a State mental health facility, an area where the general public is not allowed. Therefore, the Arbitrator finds that Petitioner's brown recluse spider bite constituted an accidental injury that arose out of and in the course of her employment with Respondent.

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

Respondent disputes causal connection for both of Petitioner's accidental injuries due to the MRSA infections that developed as a result in breaches of Petitioner's skin. Respondent contests that Petitioner was exposed to MRSA at the workplace and asserts that Petitioner is colonized with the resistant staph. The Arbitrator notes, however, that whether Petitioner was exposed to MRSA at the workplace or whether she was infected by her own native staph has no bearing on the issue of causal connection. The MRSA outbreaks in dispute were not "idiopathic" in origin and did not spontaneously erupt without an inciting cause. They were a consequence of Petitioner's accidental work injuries.

"Every natural consequence that flows from the injury which arose out of and in the course of the claimant's employment is compensable under the Act, unless caused by an independent intervening accident." *Vogel v. Indus. Comm'n*, 821 N.E.2d 807, 813 (2nd Dist. 2005) citing *Teska v. Indus. Comm'n*, 640 N.E.2d 1, 3 (4th Dist. 1994). See also *Caterpillar, Inc. v. Industrial Comm'n*, 591 N.E.2d 894 (3rd Dist. 1992). **That other incidents, whether work-related or not, may have aggravated the claimant's condition is irrelevant.** *Vogel v. Indus. Comm'n*, 821 N.E.2d 807, 813 (2nd Dist. 2005); *Teska v. Indus. Comm'n*, 640 N.E.2d 1, 3 (4th Dist. 1994). A claim is compensable when the claimant's condition "would not have progressed to the point it did but for [the] original work-related accident." *Teska*, N.E.2d at 4. Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it is *a* causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672 (Ill. 2003). [Emphasis original]. In short, Petitioner's MRSA was a pre-existing condition that was aggravated by her accidental injuries.

Petitioner's MRSA can be likened to the claimant's diabetic Charcot condition in *Sisbro, Inc.* In *Sisbro Inc.*, the claimant sustained injury when he stepped out of his truck into a pothole and twisted his ankle. *Sisbro, Inc.*, N.E.2d at 668. The claimant's Charcot condition was a longstanding condition which preexisted the work injury, and the employer argued that no greater risk existed because any normal daily activity could have caused the injury and produced the same result. *Sisbro, Inc.*, N.E.2d at 668, 673. While this was true, the Supreme Court held that where a work-related injury is shown to be an actual causal factor in bringing about an employee's disabling condition, recovery should not be denied simply because a normal daily activity could have brought on the claimant's disabling condition. *Id.* at 674-75, 76-77.

The Appellate Court recently decided a particularly instructive case in which the claimant developed a wide-spread systemic infection as a result of abrasions from a fall that occurred as a result of a weakened condition, which in turn occurred as a result of a workplace injury. *Compass Grp. v. Illinois Workers' Comp. Comm'n*, 2014 IL App (2d) 121283WC. The claimant initially sustained a back injury from picking up a case of bottled soda weighing approximately 40 pounds. *Id.* Later, the claimant fell down the stairs of his of his home when his left foot gave

way due to severe back pain radiating down his leg. *Id.* The claimant sustained abrasions, lacerations and/or bruises on his head, elbows, arms, fingers and chest. *Id.* The claimant developed olecranon bursitis in both elbows and later a blood infection. *Id.* This in turn spread to claimant's spine, intestinal tract and kidneys. *Id.* Petitioner's physician stated that the infection to claimant's spine, intestinal tract, and kidneys was caused by the abrasions on the claimant's elbows arising from work-related fall down stairs. *Id.* The Commission and the Appellate Court relied on this opinion and held that the claimant was entitled to benefits despite the negative opinion of Respondent's examining physician. *Id.*

The Court held that when a primary injury is shown to have arisen out of and in the course of employment, as required for a claimant to be entitled to workers' compensation for the injury, every natural consequence that flows from the injury likewise arises out of the employment. *Id.* Citing *Sisbro*, the Court stated, "Moreover, we note that employment need be only a cause, not the sole or primary cause, of a claimant's condition, that an employer takes an employee as it finds him, and that the existence of a preexisting condition does not preclude recovery under the Act." *Id.* Citing *Caterpillar, Inc. v. Industrial Comm'n*, the Court stated, "When a " 'primary injury is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury likewise arises out of the employment.' " *Id.*

In Petitioner's case, it is clear that the left hand and right ankle MRSA infections were the direct result of her traumatic work-related injuries in these locations. Petitioner introduced photographs of the progression of the infection at the precise locations of her traumatic injuries. (PX13). The evidence shows that but for the traumatic incidents, Petitioner's condition would not have arisen and progressed to the extent that it did. Petitioner testified that she had no prior MRSA outbreaks on her left thumb. (T.13-15). With regard to her right foot/ankle, the Arbitrator notes that Dr. Reach, one of the Union County Hospital attending physicians, found it "unusual" that Petitioner's MRSA would spontaneously develop in her contralateral right foot so soon after intravenous antibiotic treatment for MRSA in her left great toe, and that it was ultimately concluded that Petitioner's woes began as a "a spider bite initially." (PX5, 10/21/12, 10/25/12). Respondent's examiner, Dr. Schmidt, agreed with this conclusion. (PX12). Therefore, the Arbitrator finds that Petitioner credibly established that her current condition of ill-being is causally related to her work related accidental injuries to her thumb and right ankle.

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?

Having found that Petitioner established that she sustained compensable injuries on the claimed dates, the Arbitrator finds that Petitioner is entitled to recovery for the medical expenses incurred for the diagnosis and treatment of same. Petitioner stipulates that none of the medical

bills relating to treatment or evaluation of the left great toe should be awarded, as they are unrelated to either of Petitioner's claimed injuries. The Arbitrator therefore awards the following medical expenses:

Dr. William Ribbing (10/10/11 through 10/11/11)	$	215.00
Dr. Roland Barr (10/12/11 through 10/28/11)	$	188.00
Union County Hospital (10/21/12 through 2/25/13)	$	117,900.80
St. Joseph's Memorial Hospital (11/2/12 through 12/13/12)	$	9,541.24
Yates Emergency Physicians (10/21/12)	$	931.00
Personal Medical Equipment & Services (1/4/13 through 2/4/13)	$	110.00
Memorial Hospital of Carbondale (10/11/11 through 10/12/11)	$	9,031.56
Dr. Linda Bobo (11/2/12 through 12/17/12)	$	780.00
Dr. Michael Kaye (10/23/12 through 2/28/13)	$	1,567.00
TOTAL:	$	**140,264.60**

The following medical expenses are denied:

Union County Hospital (8/15/12 through 9/30/12)	$	12,168.00
St. Joseph's Memorial Hospital (8/13/12)	$	1,257.29
Memorial Hospital of Carbondale (7/10/12)	$	1,918.38
Dr. Michael Kaye (8/6/12 through 10/1/12)	$	978.00
TOTAL:	$	**16,321.67**

Issue (L): What is the nature and extent of the injury?

Pursuant to §8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 are to be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. The Act provides that, "No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b)(v).

(i) **Level of Impairment**: Neither Party submitted an AMA rating. Therefore, the Arbitrator appropriately used the remaining factors to evaluate Petitioner's permanent partial disability.

(ii) **Occupation**: After 36 years and 7 months of working for Respondent, Petitioner has retired. She was a Human Resource Specialist at the time of her retirement. (T.11).

(iii) **Age**: Petitioner was 52 and 53 years of age respectively at the time of her injuries. She has diminished healing capacity as a result thereof.

15IWCC0383

(iv) **Earning Capacity**: There is no evidence of reduced earning capacity in light of Petitioner's retirement.

(v) **Disability**: Petitioner sustained a laceration to her left thumb on October 9, 2011, (13 WC 6939) and a brown recluse bite on the back of her right ankle on October 19, 2012 (13 WC 6940). Both of these injuries became infected with MRSA and required surgical debridement and antibiotic treatment. (PX3; PX4; PX5).

With respect to her left thumb, Petitioner testified that she suffers from pain, discomfort and a loss of grip strength. (T.16, 17). Petitioner has a long scar on her left thumb that is sensitive to heat and extreme cold. (T.15, 16). Petitioner testified that she has difficulty cooking as a result thereof. (T.16). She testified that her loss of strength in her thumb has negatively impacted her hobby of gardening. (T.17).

With respect to her right foot, as a result of her infected spider bite, Petitioner required a staged irrigation and debridement, extensive antibiotic treatment, and intensive pain management and therapy for her condition post-surgically. Petitioner testified that she continues to experience soreness and tenderness in her ankle as a result of the brown recluse bite. (T.31). Petitioner demonstrated her scarring before the Arbitrator. (T.29, 30). She testified that she can only wear certain shoes as a result of the scarring and tenderness. (T.31). Her fitness hobby of running has been adversely affected as a result. (T.31). Petitioner testified that she used to walk 3 to 5 miles a day, but can no longer do so. (T.31). Petitioner testified that if she wears anything other than open back shoes, the shoe back runs right into her scar and cause it to swell. (T.31). Petitioner also testified to significant loss of strength in her right foot. (T.31). Petitioner avoided driving for two years because she did not feel that she was able to put enough pressure on the brake if she needed to stop quickly. (T.31). Petitioner also testified that she has difficulty ambulating stairs, especially descent, and even fell a couple of times. (T.31, 32). Petitioner testified that she never had any limitations on functions as a result of a MRSA outbreak on her right ankle. (T.32).

Based upon the foregoing, the Arbitrator finds that Petitioner sustained serious and permanent injuries that resulted in the 3% loss of her left thumb, and the 15% loss of her right foot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARION BLAYLOCK,

Petitioner,

15IWCC0836

vs. NO: 13 WC 11999

PROGRESSIVE CAREERS & HOUSING,

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, temporary total disability, and nature and extent of disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission finds the Arbitrator improperly admitted Petitioner's Exhibit 20 into evidence. Petitioner's Exhibit 20 contained the following: July 2, 2014 "To Whom It May Concern" letter from Tina Vivian, executive assistant at Cerebral Palsy of Southwestern Illinois, advising as to Petitioner's employment status and hourly pay; copy of Petitioner's July 3, 2014 paycheck from Cerebral Palsy of Southwestern Illinois; and, Petitioner's W-2 for 2013 from Cerebral Palsy of Southwestern Illinois. Respondent's counsel objected to the admission of Petitioner's Exhibit 20, arguing the documents are hearsay. The Commission agrees the documents are hearsay and should have been excluded by the Arbitrator, having found no exception to the hearsay rule.

The Commission vacates the § 8(d)1 award of $60.00 per week commencing July 23, 2009. The Commission finds, based upon a review of the record as a whole, that the evidence tendered into evidence was insufficient to prove Petitioner's entitlement to a Section 8(d)1 award. On the Request for Hearing form, ARB EX1, Petitioner sought an award under § 8(d)1

15IWCC0836

of the Act, or, in the alternative, an award of under §8(d)2 of the Act. She failed to prove her right to recover under § 8(d)(1), having failed to lay a proper foundation for the evidence she offered regarding what she was earning at her new job as a residential services director, with the Commission rejecting the evidence as hearsay. Thus her claim for a § 8(d)(1) wage differential is denied.

Petitioner's date of accident falls after September 1, 2011, and therefore § 8.1b of the Act, Determination of Permanent Partial Disability, shall be discussed concerning the permanent partial disability award being issued herein.

With regard to § 8.1b(a) and § 8.1b(b)(i), no permanent partial disability impairment report was tendered into evidence by either party. This factor is thereby waived.

With regard to § 8.1b(b)(ii), Petitioner was employed as a residential services director for Respondent, and her credible testimony indicates her job involved working with combative residents. This factor is given some weight when determining the permanency award.

With regard to § 8.1b(b)(iii), Petitioner was 35 years-old as of the date of loss, and the Commission considers Petitioner's disability will likely be more extensive than that of an older individual because she will likely have to work and live with the disability for a longer period of time than that of an older person. This factor is given great weight when determining the permanency award.

With regard to § 8.1b(b)(iv), Petitioner was released to return to work with permanent restrictions of no lifting over 20 pounds in October 2013, and Petitioner subsequently obtained employment with a new employer as a residential services director working with non-combative residents. There is no evidence with regard to Petitioner's future earning capacity. This factor is given some weight when determining the permanency award.

With regard to § 8.1b(b)(v), Petitioner described some residual symptoms in her back, legs, neck and shoulder, which are corroborated by her treating records. This factor is given great weight when determining the permanency award.

The determination of permanent partial disability is not simply a calculation, but an evaluation of all five factors as stated in the Act. In making this evaluation of permanent partial disability, consideration is not given to any single enumerated factor as the sole determinant. Therefore, applying § 8.1b, of the Act, Petitioner has sustained accidental injuries that caused the 25% loss of use to the person as a whole pursuant to Section 8(d)2 of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's January 6, 2015 Decision is modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's Section 8(d)1 award of $60.00 per week as of July 29, 2013 is hereby vacated.

15IWCC0836

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $397.33 per week for a period of 32 weeks, from July 12, 2012 through September 11, 2012, and from February 13, 2013 to July 29, 2013, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $357.60 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 permanent partial disability to the extent of 25% man as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $118,536.54 for medical expenses under §8(a) and pursuant to §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit of $3,519.26 for temporary total disability benefits previously paid under §8(b) of the Act.

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

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

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

DATED: NOV 12 2015
KWL/kmt
09/21/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0836

BLAYLOCK, MARION
Employee/Petitioner

Case# **13WC011999**

PROGRESSIVE CAREERS AND HOUSING
Employer/Respondent

On 1/6/2015, 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:

1956 JUNCKER, DANIEL K PC
1803 N BELT WEST
BELLEVILLE, IL 62226

2593 GANAN & SHAPIRO PC
IAN WHITE
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON,)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 15IWCC0836

MARION BLAYLOCK,
Employee/Petitioner

v.

PROGRESSIVE CAREERS AND HOUSING,
Employer/Respondent

Case # 13 WC 11999

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 **Mt. Vernon**, on **October 15, 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. 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 **July 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 causally related to the accident.

In the year preceding the injury, Petitioner earned $; the average weekly wage was **$596.00**.

On the date of accident, Petitioner was **35** 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 **$3,519.26** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of **$3,519.26**.

Petitioner is entitled to 32 weeks of Temporary Total Disability benefits from July 12, 2012 to September 11, 2012 and from February 13, 2013 to July 29, 2013. Respondent is entitled to a credit of $3,519.26 for Temporary Total Disability benefits paid.

The Arbitrator finds that Petitioner should be compensated under Section 8(d)(1) of the Act because the accidental injury has caused a partial incapacity that prevents Petitioner from pursuing her usual and customary line of employment and has caused an impairment of her earning capacity.

The Arbitrator finds that Petitioner has obtained suitable employment as of July 29, 2013 at an average wage rate of $506.00 per week. Therefore, two-thirds of the difference between the average weekly wage of $596.00 and the earnings per week of $506.00 is the sum of $60.00 per week to which Petitioner is entitled to for the duration of her disability to age 67.

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

ORDER

1. Respondent shall pay per Illinois Fee Schedule the sum of $118,536.54 for reasonable and necessary medical services incurred by Petitioner and Respondent shall receive a credit for payments made under Section 8(j) of the Act.
2. Respondent shall pay Petitioner 32 weeks of Temporary Total Disability benefits and Respondent shall be entitled to a credit of $3,519.26 for Temporary Total Disability benefits previously paid.
3. Respondent shall pay the Petitioner the sum of $60.00 per week beginning July 29, 2013 for the duration of her disability to age 67 as provided in Section 8(d) (1) of the Act, because the disability has caused a partial incapacity that prevents Petitioner from pursuing her usual and customary line of employment and has caused an impairment of her earning capacity.

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

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

Carl Lee
Signature of Arbitrator

12/20/14
Date

JAN 6 - 2015

MARION BLAYLOCK vs. PROGRESSIVE CAREERS AND HOUSING
Docket No. 13-WC-11999

The Arbitrator hereby makes the following findings of fact:

On July 11, 2012, Petitioner was employed by Respondent, Progressive Careers and Housing, a group home for disabled adults with combative disorders. On that date, a resident became aggressive and attacked Petitioner, knocking her to the ground and jumped on top of her and began kicking her. This incident lasted for approximately 3 to 5 minutes. Respondent does not dispute the accident or notice of the accident.

Petitioner testified that she injured her low back, neck, right shoulder and her right knee. Her supervisor gave her an ice pack and Tylenol, and helped her fill out a written incident report. The supervisor performed Petitioner's job for the rest of the day and Petitioner left work early, went home, took more Tylenol and laid down to rest.

The pain persisted and she went to the emergency room at St. Elizabeth's Hospital on the evening of the incident, at which time she was taken off work.

Petitioner followed up with her primary care physician, Dr. Bernard, on July 16, 2012 and was restricted from work. Dr. Bernard referred her to Dr. Bassman, who then referred her to Dr. Kitchens and Dr. Lee. Dr. Lee referred her to Dr. Coleman in pain management.

Petitioner saw Dr. Thomas Lee, a board certified orthopedic surgeon, with spine subspecialization, having performed thousands of back surgeries in his career, on October 23, 2012. Petitioner provided a consistent history of the work injury of July 11, 2012 to Dr. Lee who ordered various MRIs, epidural injections and physical therapy.

The physical examination of Dr. Lee revealed decreased range of motion in the low back. Dr. Lee interpreted a lumbar MRI as a protrusion at L5-S1 with associated annular signal change consistent with an annular tear. Dr. Lee testified that a direct intraoperative look at a disk protrusion is the most accurate way to diagnose an annular tear. Dr. Lee testified that the annular tear was not detectible on the October 26, 2012 MRI.

Dr. Lee testified that although a June, 2010 MRI indicated a small protrusion of the L5-S1 disk without evidence of stenosis or nerve compression, Dr. Lee testified that it is very unlikely that an annular tear was present at that time, since the November, 2010 MRI indicated that the disk protrusion had resolved and the disk signal was reported as normal. Dr. Lee testified that any protrusion that Petitioner may have had in June of 2010 had resolved itself in November of 2010.

After conservative treatment over several months, Dr. Lee ordered motion x-rays which indicated instability in the low back. The diagnosis of Dr. Lee was L5-S1 disk protrusion with annular tear and anterolisthesis, right shoulder impingement and cervical disk protrusions.

Dr. Lee testified in his deposition within a reasonable degree of medical certainty that the work incident of July, 2012 was an aggravating or contributing factor in causing the medical conditions diagnosed and that the surgery was causally connected to the work incident and that the shoulder and cervical conditions were caused by the work incident. Dr. Lee testified that his review of the prior MRI reports of June and November of 2010 did not change his opinion with respect to causation and that the radiologist interpreted the November, 2010 MRI as unremarkable at that time.

On the first visit, Dr. Lee restricted Petitioner to sedentary work until April 10, 2013, when she was restricted from work altogether pending back surgery.

On May 3, 2013, Dr. Lee performed an L5-S1 anterior lumbar interbody fusion with diskectomy, a fusion cage with anterior fixation and bone grafting. Dr. Lee testified that the observations that he made during the surgery confirmed the annular tear suspected on the October, 2012 MRI and the need for back surgery.

After follow-up treatment, on October 1, 2013, Dr. Lee released Petitioner with a permanent 20 pound lifting restriction and referred Petitioner to Dr. Benz, a shoulder specialist, for her right shoulder pain. Additional treatment for the neck was withheld at that time.

Dr. Lee testified that Petitioner sustained permanent injury as a result of the work injury to her low back, neck and shoulder with restricted motion of the neck and low back due to the fusion. Dr. Lee testified that Petitioner may have periods of exacerbation and remission of her symptoms on a permanent basis and that a complaint of shoulder pain reaching overhead would be consistent with shoulder impingement diagnosed. Dr. Lee testified Petitioner may need future treatment for her neck as a result of the work injury and that Dr. Lee had referred her to Dr. Benz in his office for evaluation of her shoulder. Additionally, Dr. Lee testified that a fusion causes a permanent reduction in the range of motion of the back to protect the injured area from instability.

The Section 12 Examiner, Dr. Russell Cantrell, testified for Respondent that he is board certified in physical medicine and rehabilitation. Dr. Cantrell admitted that he is not a surgeon.

Dr. Cantrell examined Petitioner only on one occasion on March 6, 2013. Dr. Cantrell testified that Petitioner's spondylolisthesis was not causally related or aggravated by the July 11, 2012 work injury and was not causally related to her surgery.

Dr. Cantrell testified that, at a minimum, Petitioner sustained a cervical strain, a lumbar strain, a shoulder strain or a knee strain as a result of this incident. On cross-examination, Dr. Cantrell admitted that the traumatic event of July, 2012 could have aggravated pre-existing conditions to the extent that Petitioner might need surgery. Dr. Cantrell opined in his medical report of March 6, 2013 that the translumbar interbody fusion at L5-S1 is not necessary solely as a result of her injury sustained on July 11, 2012. Dr. Cantrell testified that the lumbar fusion at L5-S1 was not an unreasonable surgery particularly if conservative measures have been exhausted. Since Dr. Cantrell had not examined Petitioner since her back surgery, he admitted that he has no opinions as to any restrictions on her activities. Dr. Cantrell testified that he did not review any actual MRI films, but only reviewed the radiologist's reports. Dr. Cantrell did not dispute Dr. Lee's testimony that he observed an annular tear at L5-S1 at the time of surgery.

Petitioner was off work from the date of the accident, July 11, 2012 until September 11, 2012 by Dr. Bernard. Petitioner was paid temporary total disability during this time period of 9 weeks. After September 11, 2012, Petitioner worked light-duty until February 13, 2013, when she was taken off work by Dr. Bernard until May 3, 2013 at which time she had back surgery by Dr. Lee who took her off work until she was released to return to work by Dr. Lee on July 29, 2013 with a 20 pound permanent lifting restriction. No Temporary Total Disability was paid from February 13, 2013 through July 29, 2013 and Petitioner is entitled to 23 weeks of temporary total disability during this time period.

Petitioner testified that she has pain in her back, legs, neck and shoulder, including pain with bending, vacuuming, housework, and lifting. Dr. Lee has released Petitioner to return to work with a 20 pound permanent lifting restriction.

Petitioner testified that in June of 2006, she had back pain from cutting grass and painting, but that the pain resolved thereafter, Petitioner also testified that she had 2 prior work injuries while working for Respondent. Both work injuries occurred in September of 2010.

In one incident, she slipped and fell in the kitchen at work and she injured her back and neck in this incident. She was taken to the hospital by ambulance because of chest pain and had one follow-up visit with her primary care physician.

In the other work injury, Petitioner was traveling for work when she used the hotel gym and an exercise bar fell on her right shoulder. Petitioner went to the emergency room at Unity Point Hospital.

In November of 2010, Petitioner had an MRI which was unremarkable. Petitioner testified that she made a complete recovery from these 2 work incidents and that she had no further treatment for her neck, back or right shoulder between November of 2010 when she had the MRI and the work injury of July 11, 2012. Petitioner testified that no physician recommended back surgery at any time prior to the July, 2012 work injury.

The medical records of Dr. Bernard indicate Petitioner did not receive any medical treatment following the MRI in November of 2010 until the work injury of July 11, 2012 and there is no evidence of any symptoms during this time period.

Petitioner was terminated by Respondent in July of 2013 after her Family Medical Leave time expired. Petitioner had an average weekly wage of $596.00 while employed by the Respondent and was employed by Cerebal Palsy of Southwest Illinois on July 29, 2013 at an average weekly wage of $506.00. This is a wage differential of $60.00 per week.

Therefore, The Arbitrator Concludes:

1. Petitioner sustained an accident which arose out of and in the course of Petitioner's employment by Respondent and Petitioner's current condition of ill-being is causally related to the work injury. The Arbitrator finds that the opinions of Dr. Lee, a board certified orthopedic surgeon, to be more credible than the opinions of Dr. Cantrell, the Section 12 Examiner who is not a surgeon, but is board certified in physical medical and rehabilitation.

2. Respondent shall pay per Illinois Fee Schedule, reasonable and necessary medical bills of $118,536.54 and Respondent shall receive a credit for payments made pursuant to Section 8(j) of the Act.

3. Petitioner was temporarily and totally disabled from July 11, 2012 through September 11, 2012 and from February 13, 2013 to July 29, 2013 and Respondent shall pay Petitioner the sum of $397.29 per week for 32 weeks, which is the period of temporary total disability for which compensation is payable, less a credit of $3,519.26.

4. Respondent shall pay Petitioner the sum of $60.00 per week beginning July 29, 2013 for the duration of the Petitioner's disability to age 67 pursuant to Section 8 (d) (1) of the Act, because the injuries sustained caused a permanent partial incapacity that prevents Petitioner from pursuing her usual and customary line of employment and has caused a permanent

impairment of earnings. The sum of $60.00 per week is based upon a calculation of two-thirds of the difference Petitioner was earning on the date of the accident ($596.00) minus the weekly wage of $506.00 Petitioner is receiving in her new employment.

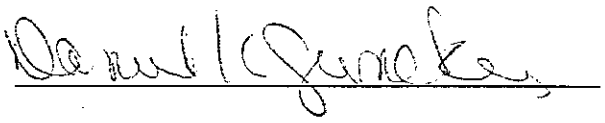
15IWCC0836

PROOF OF SERVICE

The undersigned certifies that a true and correct copy of the above and foregoing Proposed Arbitrator Decision, 13-WC-11999, was deposited in the United States Mail at Belleville, Illinois on the 7th day of November, 2014 at 5:00 p.m. with proper postage prepaid, addressed to each of the following with the stated address appearing on the envelope:

Honorable Edward Lee
Arbitrator
115 East Ogden Avenue
Suite 117-350
Naperville, Illinois 60563

Ian White
Ganan and Shapiro, P.C.
411 Hamilton Boulevard, Suite 1006
Peoria, Illinois 61602



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

Jerome Felske,
Petitioner,
vs.

NO: 13WC 12495

City of Chicago,
Respondent,

15IWCC0819

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 nature and extent and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 25, 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: NOV - 6 2015
o102915
DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

FELSKI, JEROME
Employee/Petitioner

Case# **13WC012495**

13WC003015

CITY OF CHICAGO
Employer/Respondent

15IWCC0819

On 3/25/2015, 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 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2221 VRDOLYAK LAW GROUP LLC
MICHAEL P CASEY
741 N DEARBORN ST 3RD FL
CHICAGO, IL 60654

0010 CITY OF CHICAGO
ELIZABETH MANNION
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

15IWCC0819

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
CORRECTED ARBITRATION DECISION

Jerome Felske
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **13** WC **12495**

Consolidated cases: **13 WC 3015**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maria Bocanegra**, Arbitrator of the Commission, in the city of **Chicago**, on **1/26/2015**. 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. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **credit for overpayment of TTD in amount of $131.25**

***CORRECTED* FINDINGS**

On **2/15/2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**70,408.00**; the average weekly wage was $**1354.00**.

On the date of accident, Petitioner was **69** 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 $**51,970.30** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**51,970.30**.

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

***CORRECTED* ORDER SEE ATTACHED ORDER**

Respondent shall pay Petitioner permanent partial disability benefits of $712.55/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.

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

3-25-15
Date

MAR 25 2015

15IWCC0819

CORRECTED FINDINGS OF FACT
13 WC 3015, 13 WC 12495

At trial, the parties stipulated on 7/28/12 and on 2/15/13, Jerome Felske ("Petitioner") and City of Chicago ("Respondent") were operating under the Illinois Workers' Compensation Act and their relationship was one of employee and employer and that on each date, Petitioner sustained accidental injuries that arose out of and in the course of his employment with Respondent and timely notified Respondent of same. Ax1-2.

Petitioner testified he worked for Respondent for approximately 6 years prior as a motor truck driver towing vehicles for the city. On 7/28/12, he was right hand dominant and 69 years of age.

On 7/28/12, Petitioner injured his right shoulder while lifting and stacking road cones over his head and onto his work truck. Px1. He felt immediate right shoulder pain and notified his supervisor. Prior to 7/28/12, he did not have any problems with his right shoulder that caused him to seek any medical treatment.

On 7/28/12, Petitioner treated with Mercy Hospital. Px2. He gave a history of right shoulder pain after stacking orange cones onto a work struck and a feeling a pull of right neck and right shoulder. *Id.* at 16. He was diagnosed with cervical and shoulder sprain/strain. *Id.* at 17. He was discharged with a work note, muscle relaxant, recommendation for therapy and a referral to Mercy Works. *Id.*

On 8/10/12, Dr. William A. Heller examined Petitioner. Px3. Petitioner gave history of injuring his right shoulder at working on 7/28/12 after lifting cones, feeling a sharp pain in his right shoulder. *Id.* at 3. No prior injury or symptoms were noted. *Id.* Dr. Heller ordered an MRI and took Petitioner off work. *Id.* On 8/17/12, Petitioner returned to Dr. Heller complaining of pain in the right shoulder. Motion was limited by pain. Petitioner remained off of work. *Id.* at 6. On 8/21/12 MRI of the right shoulder showed: 1) high grade partial thickness and possibly full thickness tearing of the supraspinatus tendon; 2) moderate partial thickness under surface tearing of the infraspinatus tendon; 3) detached non-displaced posterior labral tear and 4) mild glenohumeral and moderate acromioclavicular osteoarthritis. *Id.* at 13-14, Px4. On 8/24/12, Dr. Heller reviewed MRI and diagnosed full thickness insertional rotator cuff tear. *Id.* at 8. The doctor ordered conservative care, administered a Depo Medrol injection, ordered therapy and ordered Petitioner to light duty of no lifting of the right arm. *Id.* at 8.

On 10/02/12, Dr. Heller noted some right shoulder symptom improvement following the injection. *Id.* at 11. The doctor noted weakness and suggested surgery. *Id.* Petitioner opted to return to work full duty and was released. *Id.*

Petitioner returned to work with Respondent full duty on 10/6/12. He testified he continued have pain in his right arm. He was able to do his job but not in the normal way he was used to doing it. He favored his right shoulder and used his left shoulder more. On 11/14/12 Dr.

15IWCC0910

Heller issued Vicodin to following complaints of right shoulder pain with weather changes. Px3. Petitioner testified he continued to work.

On 2/15/13 Petitioner testified he injured his left shoulder while trying to pull a tow part known as a "Stinger" up with his arms using both shoulders and his hands to move it so that it could swing out. In trying to pull the Stinger, felt pain in his left shoulder. Px8. He testified he had never felt pain like that in his left shoulder before. He notified the supervisor and was directed to Mercy Hospital. He had no prior left shoulder problems so as to cause him seek medical treatment.

On 2/15/13 Petitioner treated with Mercy Hospital's emergency room and gave a history injured himself at work trying to shove an apparatus and immediately felt pain on the left neck and left back. Px9:22. No prior history was noted. *Id.* Pain was described a tight and somewhat stabbing, radiating from the left occipital down to the mid-left back. *Id.*

On 2/18/13, Mercy Works examined Petitioner. Px10. He related a work injury following pulling forward and lifting a stinger and felt a significant pain on the left side of his back, neck and legs. *Id.* at 2. Examination revealed complaints of pain 7/10 on the left side of the neck, left occiput and left shoulder near the trapezius and the acromioclavicular joint. Diagnosis was strain, left side of the neck, left upper back and lower back. *Id.* He was ordered off work due to "work related condition" and prescribed medication. *Id.* at 3. On 2/25/13, Petitioner followed up with Mercy Works, where pain was unchanged from the prior visit with neck pain still radiating to the left arm with tingling down to the fingers and thumb. *Id.* Left shoulder exam showed abduction to 90 degrees, forward elevation to 90, internal rotation to the left posterior lumbar and tender trapezius. *Id.* On 2/27/13 Petitioner began a course of physical therapy at ATI Physical Therapy. Px6.

On 3/12/13, Petitioner followed up with Mercy Works. Px10:4. They noted neck pain radiating to the left arm only when he raised his left arm up with tingling down to the fingers particularly the thumb. *Id.* Left shoulder pain was 4/10 and an MRI was ordered to rule out rotator cuff tear. *Id.* On 3/15/13, Petitioner treated with Dr. Giriseen. Px11:4. He gave history of injury at work on 2/15/13 pulling a bar from the truck to break it loose when he started to have pain in the neck area. *Id.* Dr. Giriseen noted that the pain did not radiate to the extremities. *Id.* He diagnosed intervertebral disc disorder aggravated as result of work related injury. *Id.* at 5. He ordered a left shoulder MRI. *Id.*

On 3/22/13, MRI of the left shoulder showed 1) full-thickness incomplete tear of the distal supraspinatus tendon; 2) minimal interstitial tearing of the distal infraspinatus and subscapularis tendons without full-thickness tearing, intact teres minor tendon; 3) suspected posterior labral tear; 4) moderate acromioclavicular joint degeneration with associated mass effect on the underlying proximal supraspinatus tendon and 5) small amount of subacromial/subdeltoid bursal fluid without significant joint effusion. Px12:6-7. On 3/25/13, Dr. Giriseen reviewed the MRI of the left shoulder and ordered a cervical spine MRI to rule out whether Petitioner's symptoms were referred Petitioner's prior unrelated cervical fusion. Px11:6-7. On 3/26/13, Mercy Works read the left shoulder MRI as positive for rotator cuff tear

and referred Petitioner to an orthopedic specialist. Px10:4. On 4/9/13 Dr. Giriseen read the MRI of the left shoulder as positive for rotator cuff tear following his injury at work. Px11:8.

On 5/9/13, Dr. Cole examined Petitioner. Petitioner gave three-month history of left shoulder pain following a work accident on 2/15/13 while lifting a tow with immediate pain to his left shoulder. Dr. Cole performed examination and reviewed MRI and recommended arthroscopic repair of the left shoulder rotator cuff. Dr. Cole noted that it was unlikely Petitioner had any prior conditions of the left shoulder, as he had no complaints and was able to fully perform all job activities and was working full duty. Dr. Cole ordered light duty with restrictions of no lifting, pushing or pulling and desktop work only. Px15:32-33. On 5/13/13, Dr. Giriseen noted Petitioner's complaints of pain in the left shoulder and ordered him off of work. Px11:10-11. On 6/14/13 and 8/6/13, Petitioner underwent pre-operative work up with ErgoMedica. Px14:8, 11.

On 9/11/13 Dr. Cole performed and Petitioner underwent a left shoulder arthroscopic rotator cuff repair, left shoulder distal clavicle excision; left shoulder subacromial decompression and left shoulder biceps tenodesis. Px15:35-36. Post-operatively, Dr. Cole diagnosed left shoulder rotator cuff tear, impingement syndrome, and acromioclavicular joint arthritis and bicep tendinosis. *Id.* On 9/20/2013 Dr. Cole ordered light duty and physical therapy. *Id.* at 27.

On 10/21/13 Dr. Cole noted persistence of symptoms bilaterally and had been dealing with the right shoulder conservatively. *Id.* at 30. The doctor noted difficulty with sleeping at night. *Id.* at 23. The doctor continued Petitioner to light duty and physical therapy. *Id.*

On 12/2/13, Petitioner followed up with Dr. Cole and complained of left shoulder pain with cold weather and nighttime pain. *Id.* at 28-29. Dr. Cole noted that Petitioner also reported injury and chronic pain to the right shoulder and that Petitioner had continued to work through treatment. *Id.* Dr. Cole requested the MRI of the right shoulder from the previous physician. *Id.*

On 1/13/14, Dr. Cole noted Petitioner's continued left shoulder pain at night and weakness in the cuff. Px5:2-3. Left shoulder exam showed active forward flexion to 110 passively to 120, external rotation to 50, internal rotation to the lumbar spine. *Id.* The doctor also noted ongoing right shoulder pain since Petitioner's 7/24/13 injury. *Id.* Right shoulder exam showed weakness of the rotator cuff and significant AC joint discomfort. *Id.* Dr. Cole recommended right shoulder arthroscopic AC joint resection based upon failed pain management, failure of conservative care and continuation of pain as well as continued physical therapy for the left shoulder. *Id.*

On 2/24/14, Dr. Cole documented left shoulder difficulty in internal rotation and forward elevation. *Id.* at 4. Petitioner was continued for light duty for the left shoulder and physical therapy. *Id.*

On 3/31/14, physical exam of the left shoulder showed improved range of motion, forward elevation to 170, external rotation to 45, internal to L1. *Id.* at 6. Petitioner was placed at

maximum medical improvement for the left shoulder. *Id.* Physical exam of the right shoulder showed periscapular atrophy, forward elevation to 160, external rotation to 45 and internal rotation to L2 with pain over the AC joint and bicipital groove. *Id.* Petitioner was placed on restrictions for the right shoulder. *Id.*

On 5/14/14, Dr. Cole performed and Petitioner underwent a right shoulder arthroscopic subacromial decompression and distal clavicle excision. *Id.* at 8-9. Post-operatively, Dr. Cole diagnosed right shoulder acromioclavicular joint arthritis and impingement syndrome. *Id.*

On 6/23/14, Dr. Cole noted limited range of active lifting due to weakness in the right shoulder. *Id.* at 11. Exam of the right shoulder showed active forward flexion to 140, external rotation to 40, internal rotation to the lumbar spine, along with AC joint tenderness. *Id.* Petitioner felt significantly weak and the doctor noted his laborious job as a tow truck driver. *Id.* Therapy and light duty were continued. *Id.*

On 7/28/14, Dr. Cole noted Petitioner's continued discomfort with overhead and reaching across the body in the superior aspect of the right shoulder. *Id.* at 13. Exam showed 175 degrees forward elevation and abduction, mild residual tenderness of the AC joint, pain with cross arm adduction and reaching behind and over head. *Id.* The doctor noted ongoing residual pain and prescribed sedentary work with no use of the right arm. *Id.*

On 9/28/14, Dr. Cole noted improved right shoulder strength, rotation with some tenderness to palpation. *Id.* at 15. Petitioner had full strength, full range of motion and was ready to return to full duty. *Id.* Petitioner was released to full duty and placed at maximum medical improvement for the right shoulder.

Petitioner testified he returned to work full duty in the same job with Respondent in September 2014. He had not injured his right or left shoulder in any other accidents or had any other injuries from September 2014 through the date of hearing. Petitioner has no pending doctor's appointments for either his left or right shoulder and he is not on any prescription medical for either shoulder. Although his wages were not affected upon his return to full duty work and although he continues to earn the same pay or higher with union wage increases, he has declined overtime on 2 or 3 occasions due to pain in both of his shoulders. Before the injuries to the right and left shoulders he would accept overtime 85% to 90% of the time.

Petitioner testified when he returned to his job he noticed that he was not like he was before the accident and has slowed down in the performance of his duties. As far as lifting he is cautious and if he has to lift something above his shoulders, it bothers him. He does very little lifting on the job now and requests help whenever he has to do lifting. If he does lift he feels pain in the shoulders. Driving the truck with his hands on the wheels aggravates his shoulders. He has to take a break. After a day of driving, his right shoulder is stiff because he is right-hand dominant and uses his right hand to drive the truck. He takes Tylenol for both shoulders, which helps a little with pain. He takes no prescription medications.

He testified he has pain in both shoulders, right greater than left. Sleeping on any shoulder causes pain to that shoulder the next morning. He tried push-ups and noticed pain, greater on the right. Now, he avoids traditional push-ups and opts for wall push-ups. He used to weight lift and after noticing he has no strength, he avoids this too. Petitioner still does his own exercises at home, but testified he is cautious to workout. He admitted no physician told him he cannot workout.

On 11/11/14, Petitioner underwent an AMA impairment evaluation with Dr. John Cherf at the request of Respondent. Rx2, 4. Dr. Cherf evaluated both shoulders. For the right shoulder, Dr. Cherf a 0% upper extremity impairment for the right shoulder with a 0% whole person impairment rating. For the left shoulder, Dr. Cherf assessed 0% upper extremity impairment, with 0% whole person impairment.

On 12/12/14, Petitioner underwent an AMA impairment evaluation on his own with Dr. Blair Rhode for both shoulders. Px7. Dr. Rhode assessed 4% right shoulder impairment and 5% left shoulder impairment, with 7% of the whole person impairment rating. *Id.*

CORRECTED CONCLUSIONS OF LAW

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

Petitioner testified in open hearing before the Arbitrator who had opportunity to view his demeanor under direct examination and cross-examination. The Arbitrator considered the testimony of the witness in light of all of the other evidence in the record. The Arbitrator finds the Petitioner to be a credible witness.

i. Right Shoulder

The Arbitrator concludes that Petitioner right shoulder injury and current condition of ill being is causally related Petitioner's undisputed work accident occurring on 7/28/12 in case number 13 WC 3015. Petitioner had no prior history of injury, accident or condition to the right shoulder prior to his 7/28/12 work accident. Following the work accident he immediately reported to Respondent and presented to Mercy Hospital with credible, timely and consistent complaints about the right shoulder. Petitioner's right shoulder complaints and history was consistent through out the medical records. Right shoulder surgery was recommended and Petitioner declined. When Petitioner did not improve, he underwent right surgery as a result of his 7/28/12 work accident. Petitioner's uncontroverted testimony was prior to 7/28/12, his right shoulder was injury and symptom free and that he was otherwise in a state of good health. This is also supported by the medical records. Thus, his resultant right shoulder conditions of acromioclavicular joint arthritis and impingement syndrome are causally related to his work accident and the result of failure of conservative cares for which surgical repair was reasonable and necessary.

There is some evidence that would support a finding that Petitioner's right shoulder became aggravated with the onset of his second injury. Despite this, the medical evidence shows that Petitioner's right shoulder was symptomatic such that his treating physicians had

recommended surgical intervention long before Petitioner's second injury. Petitioner testified credibly that he did not injure his right shoulder in any accident after 7/28/12. Petitioner testified that when he returned to work he favored his right shoulder and was using his left shoulder more. He credibly testified that he continued to have pain in the right shoulder. When under the treatment of Dr. Cole for the left shoulder injury he gave history to Dr. Cole of the ongoing complaints of pain in the right shoulder from the work accident of 7/28/12. The Arbitrator finds Petitioner's treating medical records credible, persuasive and adopts and incorporates those medical findings as though full set forth herein. Based on a chain of events theory, Petitioner's right shoulder injuries and right shoulder current right shoulder condition of ill being is causally related to the work accident of 7/28/12 in case number 13 WC 3015.

ii. Left Shoulder

The Arbitrator concludes that Petitioner's left shoulder injury and resultant current condition of ill being is causally related to the undisputed work incident of 2/15/13 in case number 13 WC 12495. Petitioner testified he injured his left shoulder when trying to hook up a vehicle to his tow truck, feeling immediate pain on his left shoulder. He timely reported his incident and presented to Mercy Hospital, who noted his injury was work-related. Px8, Px9:23. Petitioner's uncontroverted testimony was prior to 2/15/13, his left shoulder was injury and symptom free and that he was otherwise in a state of good health. This is also supported by the medical records. Contrary to Dr. Cherf's suggestion that Petitioner's rotator cuff pathology was from age, the medical evidence suggests Petitioner's left shoulder symptom onset was acute and following his work accident. As a result of his left shoulder injury and following failed conservative care, Dr. Cole recommended surgery. The resultant left shoulder rotator cuff tear, impingement syndrome, and acromioclavicular joint arthritis and bicep tendinosis is the result of the 2/15/13 work accident.

The Arbitrator finds Petitioner's treating medical records credible, persuasive and adopts and incorporates those medical findings as though full set forth herein. Therefore, under a chain of events theory the Arbitrator finds Petitioner's left shoulder injuries and current left shoulder condition of ill being to be causally related to his 2/15/13 work accident.

Issue (L): What Is The Nature And Extent Of The Injury?

The undisputed facts of these cases demonstrate that Petitioner sustained injuries in two separate accidents to his right and left shoulders. Pursuant to *Will County Forest Preserve*, any award of benefits for Petitioner's bilateral shoulder injuries are to be awarded under 8(d)(2) or person as a whole award. 970 N.E.2d 16, 19, 361 Ill.Dec. 16 (3d Dist. 2012).

However, our Supreme Court has expressed a preference for wage-differential awards over schedule awards. *Gen. Electric Co. v. Indus. Comm'n*, 89 Ill. 2d 432, 438, 433 N.E.2d 671 (1982). The plain language of Section 8(d) prohibits awarding a percentage-of-the-person-as-a-whole award where the claimant has presented sufficient evidence to show a loss of earning capacity. *Gallianetti v. Indus. Comm'n*, 315 Ill. App. 3d 721, 728, 734 N.E.2d 482 (3d Dist.

2000). Unless expressly waived, are required to consider whether Petitioner is entitled to a wage differential award. See also, *Levato v. Ill. Worker's Comp. Comm'n*, 2014 IL App(1st) 130297WC. In this case, there is no evidence Petitioner affirmatively waived his right to recover under 8(d)(1). In briefly considering whether Petitioner's injuries entitle him to an award under 8(d)(1), Petitioner testified he returned to work full time, without restriction and is earning the same if not more in terms of wages but has had to forego overtime on occasion. Thus, because there is no evidence Petitioner has suffered a loss of earning capacity, any awards for his bilateral shoulder injuries are proper under 8(d)(2).

a. Right Shoulder – 13 WC 3015

Petitioner's 7/28/12 resulted in a suspected right shoulder partial and possibly full thickness tearing of the supraspinatus tendon, moderate partial thickness undersurface tearing of the infraspinatus tendon and insertion, detached non-displaced posterior labral tear, mild glenohumeral and moderate acromioclavicular osteoarthritis. Px3:13-14. On 5/14/14, Dr. Cole eventually performed a right shoulder arthroscopic subacromial decompression by performing a bursectomy, releasing the CA ligament and converting the type II acromion to type I (acromioplasty) and performed a distal clavicle excision. Px5:8-9. Postoperative diagnosis confirmed right shoulder acromioclavicular joint arthritis and impingement syndrome. No rotator cuff tear was found.

Post operatively, Petitioner related he experiences pain in the right shoulder. He is right-hand dominant and drives the truck with his hands on the wheel that aggravates his shoulders. After a day of driving his right shoulder is stiff. He takes Tylenol for the right shoulder pain. He testified credibly that he has slowed down a lot in performance of his job and is careful when he has to lift. He calls for a coworker to assist when he has to lift on the job. If he sleeps on the right shoulder he wakes up with pain in the shoulder. Petitioner testified he has modified his weight lifting and push up routine to avoid causing pain to his right shoulder.

Dr. Rhode assessed an AMA impairment rating for Petitioner's right shoulder of 4% and 5% for the left shoulder resulting in a combine whole person impairment of 7%. Px7. Dr. Cherf, on the other hand, assessed an AMA impairment rating for Petitioner's right shoulder of 0% and whole person impairment of 0%.

Dr. Rhode notes that patient did not undergo formal rotator cuff repair on the right but continues to suffer from rotator cuff symptomology. This finding is inconsistent with the report of Dr. Cherf. The Arbitrator has found Petitioner to be a credible witness and Petitioner did testify he continues to have right shoulder symptomology. The Arbitrator finds that the opinion of Dr. Rhode is consistent with the evidence of record and therefore is more credible than the opinion of Dr. Cherf.

In determining permanent partial disability, Section 8.1(b) provides that permanent partial disability shall be established using the following criteria: (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.

Regarding (i) or the reported level of impairment, Dr. Rhode found the 7/28/12 work accident resulted in an AMA impairment rating of 4% to the right shoulder. Dr. Cherf assessed 0% impairment on the right based on his conclusion that Petitioner's impingement injury resulted in a Class 0 diagnostic criteria for which modifiers were not applicable. In adopting Dr. Rhode's right shoulder impairment rating as more persuasive over that of Dr. Cherf's, the Arbitrator notes that Dr. Cherf ignored the undisputed post-operative diagnosis of AC joint arthritis as well as the distal clavicle procedure. Rx2, *Cf.* Px5:8-9. Thus, the diagnosis alone placed Petitioner in the incorrect class for impairment rating purposes.

Regarding (ii), Petitioner's occupation was and continues to be a tow truck driver. This job requires occasional heavy lifting pushing or pulling and reaching. Petitioner has stated that although he is able to complete his duties, it is not without modification or help from coworkers when necessary. The Arbitrator finds this factor capable of increasing the level of permanent partial disability.

Regarding (iii), Petitioner's age at the time of the injury was 69 years. The Arbitrator finds that this factor increasing Petitioner's level of permanent partial disability because the right shoulder injury and current condition imposed upon the natural aging process and degeneration of a person of this advanced age.

Regarding (iv) or future earning capacity, the evidence shows Petitioner works full-time, without restriction in his same position at or more than the same rate of pay prior to his work accident. On 2 or 3 occasions he declined overtime due to pain in the shoulder. Although his declination of these isolated overtime opportunities is certainly something to consider in this factor, there was no additional evidence adduced at trial to suggest that Petitioner's overall future earning capacity has diminished in any substantial or meaningful way. Further, given Petitioner's age at the time of injury, any future earning capacity may diminish by virtue of that age. Having considered this factor, the Arbitrator does not find any diminished future earning capacity as a result of his right shoulder injury that would increase permanent partial disability.

Regarding (v) or evidence of disability corroborated by the treating medical records, the Arbitrator weighs this factor in favor of Petitioner. Petitioner's uncontroverted testimony was that he has pain in both shoulders, right greater than left. He works slower, now lifts with care, requests help with lifting, notices shoulder pain when using his work truck's steering wheel, takes Tylenol and avoid weight lifting and certain home exercises. On his MMI date, Dr. Cole noted that had "full strength and full range of motion." However, the Arbitrator finds it significant that leading up to this MMI date for the right shoulder, Petitioner had been working accommodated restrictive duty. Px5. At discharge, ATI noted inability to hold/carry grocery bag, lifting overhead, pull objects to complete work related tasks. Px6:15. Thus, Petitioner's credible testimony is consistent with and corroborated in the treating records.

Considering all of the factors pursuant to Section 8.1(b) in conjunction with Section 8(d)(2), the Arbitrator concludes that the work accident of 7/28/12 in case number 13 WC 3015 caused injury to Petitioner's right shoulder resulting in permanent partial disability of 13.5% of man as a whole at a rate of $712.55 per week for 67.5 weeks.

b. Left Shoulder - 13 WC 12495

Petitioner's 2/15/13 work accident resulted in a left shoulder injury. What was initially believed to be a sprain/strain later was confirmed as full thickness incomplete tear of the distal supraspinatus tendon, minimal interstitial tearing of the distal supraspinatus tendon, minimal interstitial tearing of the distal infraspinatus and subscapularis tendon without full thickness tearing on imaging. On 9/1/13, Petitioner underwent left shoulder arthroscopic rotator cuff repair, bicep tenodesis and distal clavicle excision. Px15:35-36. Operative procedure confirmed left shoulder partial thickness rotator cuff tear, impingement syndrome, acromioclavicular joint arthritis and bicep tendinitis. *Id.*

Post operatively, Petitioner related he still experiences pain in the left shoulder. Maneuvering his work truck's driving wheel causes shoulder discomfort and pain. He testified credibly that he has slowed down a lot in performance of his job and is careful when he has to lift. He calls for a coworker to assist when he has to lift on the job. He testified to difficulty sleeping on his shoulders. He has also modified his weight lifting and push-up routine to avoid causing pain to his right shoulder.

Regarding (i) or the reported level of impairment, Dr. Rhode found the 2/15/13 work accident resulted in an AMA impairment rating of 5% to the left shoulder. Dr. Cherf assessed 0% impairment on the left based on his conclusion that Petitioner's sprain/strain injury resulted in a Class 0 diagnostic criteria for which modifiers were not applicable. In adopting Dr. Rhode's left shoulder impairment rating as more persuasive over that of Dr. Cherf's, the Arbitrator notes that Dr. Cherf ignored Petitioner's left shoulder rotator cuff pathology, instead attributing the pathology to age rather than accident. Using his unsolicited opinion on relatedness of Petitioner's rotator cuff injury, by taking rotator cuff pathology out of the equation, this resulted in an automatic Class 0 for which modifiers are not applicable. Rx4, *Cf.* Px5:5:8-9. Thus, the diagnosis alone placed Petitioner in the incorrect class for impairment rating purposes.

Regarding (ii), Petitioner's occupation was and continues to be a tow truck driver. This job requires occasional heavy lifting pushing or pulling and reaching. Petitioner has stated that although he is able to complete his duties, it is not without modification or help from coworkers when necessary. The Arbitrator finds this factor capable of increasing the level of permanent partial disability.

Regarding (iii), Petitioner's age at the time of the injury was 69 years. The Arbitrator finds that this factor increasing Petitioner's level of permanent partial disability because of the left shoulder injury and current condition imposed upon the natural aging process and degeneration of a person of this advanced age.

Regarding (iv) or future earning capacity, the evidence shows Petitioner works full-time, without restriction in his same position at or more than the same rate of pay prior to his work accident. On 2 or 3 occasions he declined overtime due to pain in the shoulder. Although his declination of these isolated overtime opportunities is certainly something to consider in this factor, there was no additional evidence adduced at trial to suggest that Petitioner's overall future earning capacity has diminished in any substantial or meaningful way. Further, given Petitioner's age at the time of injury, any future earning capacity may diminish by virtue of that age. Having considered this factor, the Arbitrator does not find any diminished future earning capacity as a result of his left shoulder injury that would increase permanent partial disability.

Regarding (v) or evidence of disability corroborated by the treating medical records, the Arbitrator weighs this factor in favor of Petitioner. Petitioner's uncontroverted testimony was that he has pain in both shoulders, right greater than left. He works slower, now lifts with care, requests help with lifting, notices shoulder pain when using his work truck's steering wheel, takes Tylenol and avoid weight lifting and certain home exercises. Dr. Cole noted that, leading up to Petitioner's MMI date for his left shoulder, Petitioner had forward elevation of 155, external rotation to 45, internal rotation to L1, abduction to 100 and had remained under restrictions of no lifting, pushing, pulling greater than 5 pounds and no overhead lifting. Px15. At discharge, ATI noted improvement by 60%, soreness with reaching back and across, inability to work overhead, and pulling objects. Px16:18. Thus, Petitioner's credible testimony of ongoing residual problems in use of the left shoulder is consistent with and corroborated in the treating records.

Considering all of the factors pursuant to Section 8.1(b) in conjunction with Section 8(d)(2), the Arbitrator concludes that the work accident of 2/15/13 in case number 13 WC 12495 caused injury to Petitioner's left shoulder resulting in permanent partial disability of **15%** of man as a whole at a rate of $712.55 per week for 75 weeks.

Issue (O): Other - Credit For Overpayment Of TTD In Amount Of $131.25

Respondent seeks credit for overpayment of TTD for case number 13 WC 12495. Ax2. At trial, the parties stipulated that Petitioner was entitled to TTD from 2/26/13-4/4/14, which would have equated to approximately $51,838.47 due and owing. The parties further stipulated that Respondent actually paid $51,970.30 in TTD. This equates to overpayment of $131.83. Although Respondent seeks a credit of $131.25, that portion of Ax2 is not an issue that can be stipulated to or denied. Therefore, despite Respondent's minor miscalculation, the Arbitrator awards Respondent credit in the amount of $131.83 for overpayment of TTD consistent with the parties' trial stipulations in case number 13 WC12495. Ax2.

Arbitrator Signature

3-25-15
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Larry Thies,

Petitioner,

vs. NO: 14 WC 4148

Chester Mental Health Center,

15IWCC0828

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 17, 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.

15IWCC0828

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: NOV 1 0 2015
O10/20/15
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

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

15IWCC0828

THIES, LARRY
Employee/Petitioner

Case# **14WC004148**

CHESTER MENTAL HEALTH CENTER
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:

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

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

0558 ASSISTANT ATTORNEY GENERAL
KENTON OWENS
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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

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

NOV 17 2014

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

15IWCC0828

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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Larry Thies
Employee/Petitioner

v.

Chester Mental Health Center
Employer/Respondent

Case # 14 WC 4148

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 **09/26/14**. 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. [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 [ ] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

15IWCC0828

FINDINGS

On the date of accident, **11/27/13**, 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 $**61,237.28**; the average weekly wage was $**1177.64**.

On the date of accident, Petitioner was **47** years of age, ***married*** with **1** dependent children.

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

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

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

ORDER

Petitioner has failed to meet his burden of proof to show by a preponderance of the evidence that a variance from the standards of care used in the Utilization Review of Dr. Rozman is reasonably required to cure or relieve the effects of his injury pursuant to 820 ILCS 5/305 (8.7)(West 2014).

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

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

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

Carl Lee
Signature of Arbitrator

11/7/14
Date

ICArbDec19(b)

NOV 17 2014

LARRY THIES v. CHESTER MENTAL HEALTH CENTER, 14 WC 004148

The Arbitrator finds the following facts:

This is a 19(b) decision. The issues in dispute are causation and prospective medical care.

Petitioner is a 47 year old employee of the State of Illinois at the Chester Mental Correctional Center.

On November 27, 2013 Petitioner sustained an injury while working for Respondent when a violent patient attacked him hitting him about his head and neck. Petitioner went to the Memorial Hospital in Chester following the assault. (Px. 3)

At that time, he had complaints of cervical pain, among others. (Id.) A CT scan was performed on his cervical spine which showed no acute findings. (Id.) Petitioner was given motrin and told to follow up with his family physician. (Id.)

Petitioner presented to his family physician, Dr. David Walls, on December 5, 2013. (Px. 4) At that time Petitioner complained of headaches. (Id.) On December 27, 2013 Petitioner again saw Dr. Walls. (Id.) At that time, he had complaints of neck pain and tingling in the left hand. (Id.) Dr. Walls recommended an MRI of the cervical spine. (Id.)

At the request of his attorney, Thomas C. Rich, Petitioner began treating with Dr. David Raskas on February 24, 2014. (Px. 5) Petitioner had complaints of neck pain, numbness in his left hand and facial numbness. (Id.) Dr. Raskas diagnosed a cervical strain and recommended physical therapy. (Id.)

On March 24, 2014, Petitioner returned to Dr. Raskas with continued complaints of neck pain with some improvement. (Id.) Dr. Raskas ordered an MRI of the cervical spine. (Id.) On April 4, 2014, Petitioner returned to Dr. Raskas. (Id.) At that time, Dr. Raskas noted that the MRI showed age related changes of the cervical spine. (Id.) A trial of non-steroidal anti-inflammatory medication was ordered. (Id.)

Petitioner returned to Dr.Raskas on May 30, 2014. (Id.) At that time, Dr. Raskas referred Petitioner to Dr. Hurford for pain management. (Id.)

Petitioner was examined by Dr. Hurford on June 6, 2014. (Id.) Dr. Hurford diagnosed Petitioner as having myofascial pain symptoms after a cervical spine strain. (Id.) Dr. Hurford performed trigger point injections. (Id.) On June 18, 2014 Petitioner returned to Dr. Hurford for repeat trigger point injections for myofascial symptoms. (Id.)

On July 9, 2014, Petitioner returned to Dr. Hurford. (Id.) At that visit, it was reported that Petitioner did fantastic following trigger point injections but that he had a flare up

following a physical activity at a family picnic. (Id.) Petitioner was prescribed corticosteroids and a cervical traction unit and told to follow up in one month. (Id.)

Petitioner last saw Dr. Hurford on August 20, 2014. (Id.) It was noted that Petitioner had left side neck pain with no marked improvement following trigger point injections. (Id.) Dr. Hurford recommended facet injections to the cervical spine. (Id.)

Pursuant to Section 8.17, Respondent had a Utilization Review Completed regarding the need for facet injections and the need for a cervical traction unit by Dr. Anthony Rozman. (Rx. 1)

Dr. Rozman the medical records of Dr. David Raskas and Dr. Patricia Hurford. (Id.) Dr. Rozman performed a peer to peer telephone call with Dr. Hurford regarding the need for a cervical traction unit and facet injections. (Id.)

Dr. Rozman found that the need for a cervical traction unit was not medically necessary or appropriate in this case. (Id.) Dr. Rozman found that the need for Cervical Facet Injections were not medically necessary or appropriate. (Id.)

Dr. Rozman noted that the standards of care do not support treating Petitioner with a cervical traction unit or cervical facet injections. (Id.)

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

As a result of the November 27, 2013 accident, Petitioner suffered a cervical strain. Petitioner received conservative treatment and got better following trigger point injections. While at a family function on July 4, 2014 Petitioner began noticing increased neck pain after playing volleyball. Following this accident, it was recommended that Petitioner receive a cervical traction unit and cervical facet injections. The volleyball injury is an intervening accident and severs the causation from the November 27, 2013 accident.

K. Is Petitioner entitled to any prospective medical care?

Respondent submitted a Utilization Review pursuant to Section 8.17 of the Act. (Rx. 1) Said review found that the recommended cervical traction unit and the cervical facet injections were not medically necessary or appropriate. (Id.) In addition, the review cited to the standards of care in not authorizing said treatment. (Id.) The report was dated September 11, 2014.

Section 8.17 of the Act requires Petitioner to prove by a preponderance of the evidence that a variance from the standards of care used in the utilization review is necessary. 820 ILCS 305/5 (8.17)(West 2014).

That last medical record submitted by Petitioner is dated August 20, 2014. (Px. 5) Petitioner has not submitted any evidence to show that a variance with the standards is required in this matter.

THEREFORE, THE ARBITRATOR FINDS, that Petitioner has failed to meet his burden of proof to show by a preponderance of the evidence that a variance from the standards of care used in the Utilization Review of Dr. Rozman is reasonably required to cure or relieve the effects of his injury pursuant to 820 ILCS 5/305 (8.7)(West 2014).

STATE OF ILLINOIS)
) SS.
COUNTY OF ST. CLAIR)

☐ 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

MARK RHOADS,

Petitioner,

15IWCC0835

vs. NO: 14 WC 16709

COLLINSVILLE UNIT 10 SCHOOL DISTRICT,

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

Arbitrator Michael Nowak, in his February 9, 2015, Decision of the Arbitrator, found Petitioner's claimed current condition of ill-being to have been causally related to Petitioner's April 3, 2013, workplace accident. He noted Petitioner's preexisting low back pain and the radicular symptoms in his left leg were made worse by the accident. He noted also Petitioner began experiencing radicular symptoms in his right leg as well incontinence. The Commission finds Petitioner failed to establish how his complaint of incontinence relates to the April 3, 2013, accident.

On November 25, 2014, Petitioner testified that the problems he was having with bowel movements were worse after the accident than they were prior to the accident. The example of the worsened condition he provided was leakage. Petitioner expanded on his claim only to state that the leakage occurs almost every day. The arbitrator adopted Petitioner's testimony, stating

15IWCC0835

that Petitioner has a bowel incontinence problem. The Commission finds Petitioner's medical records fail to support Petitioner's testimony or the arbitrator's adoption of the same.

Petitioner treated with Dr. Tibor Kopjas on four occasions, from the date of the accident, April 3, 2014, through June 5, 2014. Irritable bowel syndrome was noted to be a problem on April 17, 2014, May 9, 2014, and June 5, 2014, but, on none of those dates did Petitioner indicate that he was experiencing incontinence. Dr. Kopjas' treatment records from April 17, 2014, and May 9, 2014, rule out incontinence as an associated symptom of Petitioner's complained-of back pain. The June 5, 2014, treatment record has Petitioner complaining of experiencing pressure in his bowels but not of pressure resulting in incontinence.

Concurrent with Petitioner treating with Dr. Kopjas was his undertaking physical therapy at Rehab Xcel. Petitioner participated in a total of thirty-one physical therapy sessions between April 15, 2014, and October 10, 2014. During that time, Petitioner complained of pain but never of irritable bowel syndrome or incontinence.

Overlapping his treatment with Dr. Kopjas and his physical therapy sessions at Rehab Xcel was Petitioner's treatment with Dr. Matthew Gornet. Petitioner was seen by Dr. Gornet on June 2, 2014, July 28, 2014, and October 27, 2014, and with physical examinations being conducted on June 2, 2014, and July 28, 2014. On no occasion did Dr. Gornet record Petitioner providing him with a history of irritable bowel syndrome or of Petitioner complaining of any symptoms of irritable bowel syndrome.

Petitioner was seen by Dr. Kaylea Boutwell on June 16, 2014, for a left L4-5 epidural steroid injection. Dr. Boutwell's records included an intake form completed by Petitioner. Pain, tingling and numbness were Petitioner's only enumerated complaints listed on the form.

Petitioner's testimony of experiencing the irritable bowel syndrome or leakage following his April 3, 2014, accident lacks specificity and a recorded history such that it cannot be deemed credible. The desired specificity would have Petitioner indicating that the leakage began on a specific date or even a specific month sometime after the accident date. Petitioner was seen by three physicians and underwent almost three dozen physical therapy sessions without complaining of leakage. He later testified that it occurred almost every day. Relying on both Petitioner's medical records and testimony, the Commission can only conclude that the leakage Petitioner testified to experiencing began sometime after the date Petitioner was last seen by a physician, October 27, 2014. No evidence, even Petitioner's own testimony, connects this condition to Petitioner's April 3, 2014, accident.

The Commission, as noted above, modifies the Decision of the Arbitrator to exclude Petitioner's complaint of incontinence as a condition causally related to his April 3, 2014, accident. The Commission, however, affirms and adopts all other findings in said Decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $403.97 per week for a period of 33-5/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this

15IWCC0835

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 $37,492.43 for medical expenses under §8(a) of the Act *save* medical expenses incurred treating Petitioner's incontinence.

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 in the amount of $11,684.46 for TTD payments made to Petitioner, 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: NOV 12 2015
KWL/mav
O: 09/21/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

15IWCC0835

RHOADS, MARK
Employee/Petitioner

Case# 14WC016709

COLLINSVILLE UNIT 10 SCHOOL DISTRICT
Employer/Respondent

On 2/9/2015, 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 0.06% 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:

1775 HUSTAVA, JOHN H
ANDREW NALEFSKI
101 ST LOUIS RD
COLLINSVILLE, IL 62234

2396 KNAPP OHL & GREEN
DAVID GREEN
6100 CENTER GROVE RD
EDWARDSVILLE, IL 62025

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)

15IWCC0835

MARK RHOADS
Employee/Petitioner

v.

COLLINSVILLE UNIT 10 SCHOOL DISTRICT
Employer/Respondent

Case # **14** WC **16709**

Consolidated cases: **none**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Belleville**, on **11/25/2014**. 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 _____

15IWCC0835

FINDINGS

On the date of accident, **4/3/2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**31,509.40**; the average weekly wage was $**605.95**.

On the date of accident, Petitioner was **49** years of age, ***married*** with **3** dependent children.

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

Respondent shall be given a credit of $**11,684.46** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**11,684.46**.

Respondent is entitled to a credit of $**106.68** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $403.97/week for 33 5/7 weeks, commencing 4/4/14 through 11/25/14, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $**11,684.46** for TTD, $**0** for TPD, and $**0** for maintenance benefits, for a total credit of $**11,684.46**.

Respondent shall pay reasonable and necessary medical services of $37,492.43, as provided in Sections 8(a) and 8.2 of the Act, including reimbursing Petitioner for out of pocket payments of $54.52. Respondent shall also pay for prospective medical services as recommended by Dr. Gornet pursuant to the fee schedule.

Respondent shall be given a for any medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

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

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

Signature of Arbitrator

1/29/15
Date

ICArbDec19(b)

FEB 9 - 2015

15IWCC0835

FINDINGS OF FACT

Petitioner, a 49 year old custodian, has worked for Respondent since 12/21/04. On 4/3/14, Petitioner was replacing florescent light bulbs in the boys' locker room. As he was descending the ladder, he had two bulbs in his left hand and was holding the ladder with his right. The bulbs started to fall from his hand, Petitioner lost his balance and fell off the last step off of the ladder, landing on his buttock and then on his back. He laid there for a while and then pulled himself to the bench. He finished his shift but did not do much other than sweeping up the broken light bulbs. Petitioner had a prior disability to his left hand as a result of an injury sustained as a fireman.

Petitioner admitted to having some prior low back injuries. He had a pulled muscle in his back in 1994. His symptoms resolved. He filed a workers compensation claim against Respondent alleging a low back injury on 5/11/09 while lifting a trash can to dump it into a dumpster. (RX 2) That case was 10-WC-29469. That case was arbitrated pursuant to Section 19(b) in front of Arbitrator Neal on 5/13/11. The claim was denied primarily because Petitioner did not seek any medical care and treatment for his back condition for almost 10 months after the injury. That Decision was affirmed by the Commission. (RX 3) In that injury Petitioner's doctors had recommended surgery. (RX 8) As a result of the 2009 accident, Petitioner had low back pain which went primarily into his left leg down to his left thigh to just below the knee area. (RX 4, p. 4-009, 4-0029) Respondent's examining physician, Dr. Petkovich, had also recommended surgery but stated that the need for surgery was not related to the alleged work accident. (RX 12) During the pendency of the litigation and the appeals, Petitioner continued working full duty. He did not receive the surgery that was recommended and basically quit treating with the doctors after the Arbitration hearing. He continued to work for Respondent without any lost time or having significant medical treatment in relation to his back until this accident of 4/3/14.

After this accident, Petitioner saw his family doctor, Dr. Kopjas the same day. He gave a consistent accident history. Dr. Kopjas noted that the Petitioner had prior low back pain which was now exacerbated and made worse with this fall. (PX 1) Dr. Kopjas noted that the low back pain now went in the left leg all the way to the foot, whereas, before it went to the thigh. Diagnosis was coccyx pain and acute sciatica. Dr. Kopjas authorized Petitioner off work. X-rays were negative for fracture. An MRI on 4/11/14 was read to reveal an L3-4 minimal disc desiccation with hyperintense signal in the left paracentral aspect which could be an annular tear; mild broad-based left paracentral foraminal disc protrusion without stenosis; at L4-5, mild disc desiccation with central disc protrusion with no stenosis. (PX 3) Petitioner started therapy at RehabXcel on 4/15/14. (PX 4)

On 4/17/14, Dr. Kopjas noted that now Petitioner's problems went down both legs and he was unable to planter flex his left foot. Dr. Kopjas continued to prescribe physical therapy, recommended pain management and medications. On 5/9/14, Dr. Kopjas noted that the Petitioner was getting worse and that therapy really was not helping, he noted that the Petitioner reported bowel incontinence problems indicating that he felt like he had to make a bowl movement all the time. Petitioner stated that he could not stand for more than 10 minutes, could not walk a full block and that his left foot was completely numb. Petitioner was referred to a neurosurgeon. (PX 1) It is noted that the Respondent did not initially authorize the pain management.

Petitioner came under the care of Dr. Matthew Gornet, a board certified orthopedic spine surgeon, on 6/2/14. He noted the history of the fall from the ladder at work. He recorded the present complaints of pain into both buttocks and bilateral legs and feet. He noted the Petitioner's prior low back symptoms. He reviewed the MRI of 4/11/14 and said that it showed a herniated disc at L3-4 and a central disc herniation at L4-5. Dr. Gornet opined that the fall aggravated the pre-existing L4-5 disc condition and stenosis and now a new disc injury was present at L3-4 and L4-5. He continued to authorize Petitioner off work and casually related his present symptoms to this fall. Dr. Gornet recommended physical therapy and epidural injections at L3-4 and L4-5. (PX 5) Petitioner underwent the L4-5 epidural injection on 6/16/14 and the L3-4 injection on 6/30/14. (PX 6) Petitioner testified that he received temporary minimal relief with the injections.

Respondent had Petitioner examined by Dr. Petkovich pursuant to §12 of the Act, on 7/27/14. This was the same examining doctor that Respondent had used in the earlier work comp. claim. Dr. Petkovich noted that Petitioner had complaints going into his bilateral groin and into his feet. He diagnosed a lumbar strain with degenerative disc disease at L3-4 and L4-5. He opined that the strain was related to the work accident but stated that the degenerative disc disease pre-existed it. He stated the accident did not aggravate or accelerate the degenerative disc disease. He opined that all the treatment up to date had been reasonable and related including the physical therapy and the epidurals. He felt the Petitioner could return to light duty work with restrictions of no lifting over 15lbs., limited bending, stooping, kneeling, and squatting to only 4 times an hour. He opined that Petitioner was not at maximum medical improvement but may reach it after he completes 4 weeks of physical therapy. He stated that Petitioner did not need a Tens Unit and would not need any further care after he completed his physical therapy. (RX 12)

Petitioner testified that Respondent has no light duty. He once again experienced difficulties in getting his therapy authorized.

On 7/28/14 Dr. Gornet indicated that Petitioner had some relief with the injections. Dr. Gornet compared the MRI of 4/11/14 to the earlier MRI of 6/22/10. He felt that the L3-4 disc had improved but the L4-5 had worsened "and now appears to be more of a central disc structural lesion." He recommended further conservative care including a complete course of aggressive physical therapy for at least 6-8 weeks followed by work hardening. He indicated if these conservative measures failed more aggressive treatment would be considered. Petitioner was to remain off work. (PX 5)

Dr. Petkovich authored a new report dated 9/21/14. He did not re-examine the Petitioner at that time. Nonetheless, he opined that the Petitioner was not in need of any further physical therapy, was not in need of work hardening, and that Petitioner could return to work at full duty as his lumbar strain had completely resolved. (RX 12)

Dr. Petkovich authored yet another report dated 11/15/14. He did not re-examine the Petitioner on this occasion either. He indicated that he had again reviewed the earlier MRIs. He reported the Petitioner told him on the exam of 7/23/14, that he had recovered completely without any residuals after the trash can incident. The Arbitrator notes this is not what Petitioner told Dr. Gornet or what he testified to at trial. Petitioner was forthright in his testimony at trial indicating he had intermittent flair

ups prior to the 4/3/14 accident. The prior symptoms, however included radiation of pain only to the calf level on his left leg. Dr. Petkovich opined that the L4-5 disc has contracted and improved itself and he felt that Petitioner had mild degenerative disc disease without any stenotic changes. He reiterated that the Petitioner was at maximum medical improvement, no further treatment was needed, and he could return to work without restrictions. (RX 12)

Petitioner's most recent visit with Dr. Gornet was on 10/27/14. At that point Dr. Gornet again recommended "aggressive physical therapy ... followed by work hardening and then a 'trial' of return to work full duty." He indicated "[t]his logical straightforward treatment plan is well thought through and is generally accepted as being appropriate care for patients who have acute low back pain." Petitioner was given light duty restrictions of 20 pounds with no repetitive bending or lifting, alternating between sitting and standing as needed.

Respondent offered no light duty, and the recommended conservative treatment has not been authorized. Petitioner wishes to have the treatment recommended by Dr. Gornet.

CONCLUSIONS OF LAW

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

The Arbitrator finds Petitioner's present condition of ill being is casually related to his accident of 4/3/14. This is based upon Petitioner's credible testimony and the medical records of Dr. Kopjas and Dr. Gornet, and the record taken as a whole. Petitioner's current complaints and symptoms are consistent with the medical records. Even though Petitioner had prior low back problems before this accident, his symptoms were primarily in his left leg down to his knee area. After this accident, his symptoms got worse. He now has radicular pain down both legs to his feet along with a bowel incontinence problem. He has been unable to perform full duty work. The Arbitrator finds the opinions of Dr. Gornet more persuasive those Dr. Petkovich.

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

Petitioner has been under a doctor's care since the day of this accident. The parties stipulated that Petitioner was entitled to benefits from 4/4/14 through 8/20/14, the last date of the physical therapy which was recommended by Dr. Petkovich on the one occasion when he actually examined Petitioner. Petitioner has remained off work since that time. Up until his last visit with Dr. Gornet on 10/27/14 Dr. Gornet had him off work all together. At that last visit Dr. Gornet placed specific light duty restrictions on Petitioner. Petitioner testified that Respondent never offered work within the restrictions and there is no contrary evidence contained in the record. Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner is entitled to TTD benefits from 4/4/14-11/25/14, a period of 33 4/7 weeks at a rate of $403.97 a week. Respondent is entitled to credit of $11,684.46 for TTD previously paid.

15IWCC0835

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

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

Dr. Gornet is recommending further conservative care at this time. As noted above, the Arbitrator finds the opinions of Dr. Gornet persuasive. Having found Petitioner's current condition of ill-being to be causally related to the accident, and based upon the record taken as a whole, the Arbitrator finds that both the treatment rendered to Petitioner to date, and the treatment recommended by Dr. Gornet are necessary, reasonable and related to this injury. Respondent shall pay the incurred expenses of $37,492.43 and shall reimburse Petitioner $54.52 which he paid out of pocket for related medical expenses. Respondent is entitled to credit for amounts previously paid, including credit of $106.68 previously paid pursuant to section 8(j) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF ST. CLAIR)

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

Raymond Lynch,

Petitioner,

vs.

NO: 14 WC 18552

15IWCC0831

Illinois Department of Transportation,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission corrects the Decision of the Arbitrator as to the time period for which the Respondent shall pay the Petitioner accrued compensation in the Order section of the Decision. The time period is incorrectly annotated as March 6, 2014 through February 19, 2010. However, the ending date should be February 19, 2015, the date of the trial in Collinsville, Illinois. Therefore, the Commission corrects the clerical error in the second paragraph of the Order section, page two of the Arbitrator's Decision to: "Respondent shall pay Petitioner compensation that has accrued from March 6, 2014 through February 19, 2015, and shall pay the remainder of the award, if any, in weekly payments."

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 2, 2015 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall pay Petitioner compensation that has accrued from March 6, 2014 through February 19, 2015, and shall pay the remainder of the award, if any, in weekly payments.

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

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

DATED: NOV 12 2015

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

TJT/ gaf
O: 9/21/15
51

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LYNCH, RAYMOND
Employee/Petitioner

Case# **14WC018552**

ILLINOIS DEPARTMENT OF TRANSPORTATION
Employer/Respondent

15IWCC0831

On 4/2/2015, 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:

1053 JOSEPH L SAMUELSON PC
5111 W MAIN ST
BELLEVILLE, IL 62226

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

3291 ASSISTANT ATTORNEY GENERAL
DIANA E WISE
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

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

1430 CENTAL MGMGT SERVICES
WORKERS' COMP MANAGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

APR 2 - 2015

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

15IWCC0831

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
NATURE AND EXTENT ONLY

Raymond Lynch
Employee/Petitioner

v.

Illinois Department of Transportation
Employer/Respondent

Case # **14** WC **18552**

Consolidated cases:

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak,** Arbitrator of the Commission, in the city of **Collinsville,** on **February 19, 2015.** By stipulation, the parties agree:

On the date of accident, **March 6, 2014,** 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 $**82,946.24**, and the average weekly wage was $**1,595.12**.

At the time of injury, Petitioner was **56** years of age, single, with **-0-** dependent children.

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

Respondent shall be given a credit of $**455.97** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**455.97**.

15IWCC0831

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

ORDER

Respondent shall pay Petitioner the sum of **$721.56**/week for a further period of **10** weeks, as provided in Section **8(d)(2)** of the Act, because the injuries sustained caused **2% loss of use of the body as a whole.**

Respondent shall pay Petitioner compensation that has accrued from **March 6, 2014** through **February 19, 2010,** 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.

Signature of Arbitrator

3/20/15
Date

APR 2 - 2015

FINDINGS OF FACT

Petitioner is a long term (30 year) employee of Respondent. He is employed as part of its highway maintenance program. On March 6, 2014, he was jump starting a road grader. To do so, he was required to prop the engine cover over his head. The cover weighed forty pounds. As he was working on the engine, the cover came free, fell forward, and struck Petitioner on the top of his head.

As a result, Petitioner was profusely bleeding, dazed, dizzy and "seeing stars". While he did not experience a complete loss of consciousness, he was unable to stand without assistance and required immediate medical attention. His supervisor helped stop the flow of blood and made arrangements for him to be taken to Anderson Hospital where he was treated in the emergency room. The physicians treated a two inch laceration with eight staples. Petitioner was told to remain off work, take ibuprofen for pain and seek additional care with his family physician, Dr. Simmering. (Pet. Ex. #1) Petitioner was seen by Dr. Simmering on March 16, 2014. At that time, the staples were removed and he was released to return to work the following day. (Pet. Ex. #2)

In all, Petitioner lost 1 3/7 weeks of work, during which he was paid proper benefits. Since returning to work on March 17, 2014, Petitioner has not sought any additional medical care. He takes no prescription medication, but does require over-the-counter pain relievers to control continued discomfort. Specifically, Petitioner testified he continues to suffer from: persistent pain and discomfort at the base of his neck; occasional headaches; and itching at the site of his scarring.

Upon observation, the arbitrator noted a 1 ½ inch raised scar on the top of Petitioner's head and an indentation in his scalp situated approximately two inches posteriorly to the scar. Both the scar and the indentation are covered by Petitioner's hair.

CONCLUSIONS OF LAW

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

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a highway maintainer at the time of the accident and that he was able to return to work in his prior capacity as a result of said injury. Petitioner continues to experience persistent pain and discomfort in his neck and occasional headaches. Because of his persistent symptoms, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 56 years old at the time of the accident. Because of Petitioner's life expectancy of 26 ½ years and the persistent symptoms , the Arbitrator therefore gives some weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes there is no evidence of an adverse effect upon his future earning capacity and the Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes Petitioner's injuries are clearly delineated with the medical records and further corroborated by his credible testimony. The Arbitrator therefore gives greater weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 2% loss of use of the body as a whole pursuant to Section 8(d)(2) of the Act.

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

James Gomez,

Petitioner,

vs. NO. 12WC024488

City of Chicago Department of Streets and Sanitation, **15IWCC0883**

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 30, 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.

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: NOV 2 5 2015
SJM/sj
o-10/22/15
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GOMEZ, JAMES
Employee/Petitioner

Case# **12WC024488**

09WC033405

CITY OF CHICAGO DEPT OF STREETS AND SANITATION
Employer/Respondent

15IWCC0883

On 3/30/2015, 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 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0154 KROL BONGIORNO & GIVEN LTD
DAN COLLINS
100 W MONROE ST SUITE 1410
CHICAGO, IL 60603

0766 HENNESSY & ROACH PC
JOSEPH ZWICK
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

STATE OF ILLINOIS)
COUNTY OF Cook) 15IWCC0883

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

James Gomez
Employee/Petitioner

Case # 12 WC 24488

v.

Consolidated cases: 09 WC 33405

City of Chicago (Dept. of Streets & San.)
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 Brian Cronin, arbitrator of the Industrial Commission, in the city of Chicago, on 10/3/2014. 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 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? 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 the respondent?
N. ☐ Is the respondent due any credit?
O. Other _____

15IWCC0883

FINDINGS

- On 5/31/2012, the respondent City of Chicago (Dept. of Streets & San.) *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.
- Petitioner's current condition of ill-being *is* causally related to the accident.
- In the year preceding the injury, Petitioner earned **$66,752.40**; the average weekly wage was **$1,283.70**.
- On the date of accident, Petitioner was **39** years of age, ***single*** with **0** dependent children.
- Petitioner ***has*** received all reasonable and necessary medical services.
- Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.
- Respondent shall be given a credit of **$44,014.63** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$44,014.63**.
- Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

- The respondent shall pay the petitioner temporary total disability benefits of $ 855.80 /week for 51-3/7 weeks, from 6/1/2012 through 5/26/2013, which is the period of temporary total disability which compensation is payable.
- The respondent shall pay petitioner permanent partial disability benefits of $695.78/week for 57.59 weeks because Petitioner sustained permanent partial disability to the extent of 11.518% pursuant to Sect. 8(d)2.

The respondent shall also pay medical bills of Advanced Occupational Medicine of $943.00 and of Dr. Konowitz of $1,667.00, and, pursuant to the stipulation by the parties, the Respondent shall pay those medical bills directly to the providers, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest of 0.10 % 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

3/27/15
Date

MAR 3 0 2015

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

15IWCC0883

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMES GOMEZ,	)	
	)	
vs.	)	No. 12 WC 24488
	)	
CITY OF CHICAGO, DEPARTMENT OF STREETS AND SANITATION	)	

Findings of Fact

Petitioner is employed by Respondent as a laborer in the Department of Streets and Sanitation. It is undisputed that he sustained injuries to his low back and right shoulder while working on May 31, 2012. Petitioner testified that he was pushing or pulling a garbage cart in an alley when the cart went into a pothole. He testified that he then experienced a throbbing pain in his back (it felt like something popped) and pain in his right shoulder (it felt like something tore).

On May 31, 2012, Respondent sent Petitioner to treat at Advanced Occupational Medicine Specialists. He was authorized off work. TTD benefits were paid as of June 1, 2012.

On June 5, 2012, Petitioner underwent an MRI of the lumbar spine. No new herniations were noted. He was diagnosed as suffering from a right shoulder strain as well as lumbar degenerative disc disease with lumbar radiculopathy.

Thereafter, Petitioner underwent a course of conservative treatment through Advanced Occupational Medicine Specialists. The company clinic returned him back to Dr. Wesley Yapor and Dr. Howard Konowitz. He continued to receive conservative care including physical therapy.

On February 14, 2013, Petitioner underwent a functional capacity evaluation ("FCE") at Accelerated Rehabilitation. At the conclusion of the test, the evaluator determined that the results were valid and that Petitioner was capable of working at the light-medium physical demand level. His job as a laborer in the Department of Streets and Sanitation is considered to be heavy duty. Petitioner continued to receive TTD benefits.

On February 25, 2013, Petitioner presented to Dr. Kern Singh for a Section 12 examination. Dr. Singh requested a copy of Petitioner's June, 2012 MRI and February 2013 FCE report before making further recommendations.

On March 5, 2013, Dr. Singh authored a Section 12 report after reviewing the above-requested information. Dr. Singh opined that Petitioner had aggravated a pre-existing condition as a result of the work injury of May 31, 2012. He felt that the Petitioner had reached maximum medical improvement and was capable of returning to work with permanent restrictions as outlined by the February 2013 FCE.

Petitioner remained under the pain management care of Dr. Konowitz. Respondent also began a course of vocational rehabilitation services for the Petitioner as recommended by Dr. Singh.

On March 29, 2013, Petitioner followed up with Dr. Konowitz for his low back pain that radiates into his left lower extremity. Dr. Konowitz recommended pain medication, Norco and Lyrica, and recommended that Petitioner utilize a home exercise program.

Petitioner participated in an exercise boot camp as recommended by Dr. Konowitz.

On May 3, 2013, he followed up with Dr. Konowitz and noted significant improvement from this home exercise activity. Dr. Konowitz recommended that Petitioner continue with the exercise program and also released him to return to full-duty work as of May 27, 2013.

Petitioner did return to work on a full duty basis on May 27, 2013. All TTD benefits were paid through May 26, 2013.

Petitioner followed up with Dr. Konowitz on June 25, 2013. He advised Dr. Konowitz that he had been back to work for one month and was functioning well. Dr. Konowitz recommended the Petitioner continue with his Norco, Valium and Lyrica medications and his home exercise program.

On December 30, 2013, Respondent secured an AMA impairment report from Dr. Singh. Dr. Singh assessed an AMA impairment rating of 19%.

Petitioner has continued to follow up with Dr. Konowitz every three months for renewal of his medications. Petitioner was last examined by Dr. Konowitz on September 17, 2014. He complained of left paracentral low back pain radiating into the left lateral thigh. Dr. Konowitz noted pain at a 4-5/10 level at rest, increasing to a 5-6/10 level with activity. Petitioner also voiced complaints to Dr. Konowitz of disruption of his sleep pattern. Dr. Konowitz has assessed Petitioner's condition of post-laminectomy syndrome and has prescribed ongoing use of Lyrica, Skelaxin and Norco medications.

At trial, Petitioner testified that he continues to suffer from low back pain that radiates down into his left lower extremity. Petitioner testified that his sleep is disrupted approximately 3-4 times per night because of his low back pain. Petitioner further noted that any type of cold or damp weather aggravates his low back condition.

Petitioner acknowledged that that he recovered 30% of a man for an accidental injury for which he underwent a two-level lumbar fusion in 2006.

Petitioner also testified that he noted throbbing pain in his right shoulder.

Conclusions of Law

In support of his decision relating to issue (F) " Is the Petitioner's current condition of ill-being causally related to the injury?", the Arbitrator finds the following:

It is undisputed that Petitioner sustained injuries to his low back and right shoulder while working on May 31, 2012.

In his report dated February 25, 2013, Dr. Singh, Respondent's Section 12 physician, noted that Petitioner had a work injury on May 31, 2012 and deferred an opinion on causation until he received additional records. In his May 5, 2013 report, Dr. Singh opined as follows: "[I]t appears that the patient sustained an aggravation of an underlying degenerative condition of his lumbar spine." Therefore, the Arbitrator finds that Petitioner's current condition of ill-being of his low back is causally related to the accident of May 31, 2012.

With regard to Petitioner's right shoulder, the Arbitrator notes that Petitioner received treatment on May 31, 2012 at Advanced Occupational Medicine Specialists. The doctor assessed him with right shoulder pain and right shoulder strain (as well as low back pain and low back strain). X-rays and MR images of his right shoulder were taken. Petitioner later received a cortisone shot in his right shoulder, which provided pain relief. On July 20, 2012, Petitioner was released to return to regular-duty work for his right shoulder injury. Based on the medical records, Petitioner's testimony and the chain of events, the Arbitrator finds that Petitioner's current condition of ill-being of his right shoulder is causally related to the accident of May 31, 2012.

In support of his decision relating 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 the following:

The Arbitrator has had an opportunity to review the medical treatment and finds it to be both reasonable and necessary. The treatment rendered was at the Respondent's clinic. Such clinic thereafter referred Petitioner to Dr. Yapor and Dr. Konowitz for further care. That ongoing care has allowed the Petitioner to continue working on a full-duty basis. No opinion was offered that said treatment was unreasonable or unnecessary. As such, the Arbitrator awards the following medical bills, pursuant to Section 8(a) and subject to Section 8.2 of the Act:

1. Advanced Occupational Medicine Specialists, $943.00 (Px.3)
2. Northwest Neurosurgical, $600.00 (Px.6)
3. Dr. Konowitz, $1,667.00 (Px.10)

In support of the his decision relating to issue (L) "What is the nature and extent of the injury?", the Arbitrator finds as follows:

Pursuant to Section 8.1b of the Act, the following criteria and factors must be considered in assessing permanent partial disability:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report 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.

1. **The reported level of impairment under the AMA Guides:** Dr. Kern Singh provided an impairment rating of Petitioner. In his December 30, 2013 report, he wrote the following:

> Mr. Gomez is a 41-year-old male, status post an L3 to L5 laminectomy with posterior spinal fusion and instrumentation and a solid arthrodesis with a subsequent hardware removal. His diagnosis is consistent with AOMSI (alteration of motion segment integrity at 2 levels, namely L3-4, L4-5 with surgery, including L3 to L5 fusion and hardware removal. He is, therefore, assigned to a class 3 based on a 2-level AOMSI. He has a PDQ score of 135 and a grade modifier of 4 on his functional assessment. Based upon an absent reflex in his Achilles tendon, the findings are consistent with a grade modifier of 2. Clinical studies do not apply; they help determine class. An adjustment score is, therefore, zero, and the patient's impairment is class 3, grade C, which is 19% impairment.

2. **The occupation of the injured employer:** Petitioner returned to the very heavy position of sanitation engineer for Respondent. Petitioner performs all of the required duties of such position.

3. **The age of the employee at the time of injury**: Petitioner was 39 years of age on the date of accident. Petitioner's work-life expectancy, *ceteris paribus*, is longer than that of a 50-year-old male.

4. **The employee's future earning capacity**: There is no evidence to indicate that Petitioner's level of earnings or earning capacity has been adversely affected by the accident at the present time.

5. **Evidence of disability corroborated by the treating medical records**: Petitioner sustained an injury to his right shoulder that was initially diagnosed as a strain. An MRI of Petitioner's right shoulder was ordered. The radiologist offered the following impression of the June 25, 2012 MR images:

1. Mild supraspinatus tendinosis, but no full-thickness tears and no retraction.
2. Mild anterior downsloping of a curved type II acromion.
3. Fraying of the superior labrum without full-thickness tears.
4. Mild bicipital tendinosis.

Petitioner later received a cortisone injection in his right shoulder, which provided pain relief. On July 20, 2012, Petitioner was released to return to regular-duty work for his right shoulder injury.

With respect to the back, Dr. Singh opined that Petitioner sustained an aggravation of a pre-existing degenerative condition of his low back. The Arbitrator notes Dr. Yapor, on July 5, 2012, issued permanent restrictions for Petitioner based upon his low back. Petitioner then began treating with Dr. Konowitz, who diagnosed him with post-laminectomy syndrome. Petitioner underwent an FCE that placed certain restrictions on him. Additionally, at Respondent's request, Petitioner began vocational rehabilitation. Later, Petitioner participated in a boot camp. On May 27, 2013, Dr. Konowitz released him to return to full-duty work.

In his September 17, 2014 chart notes, Dr. Konowitz wrote that Petitioner complains of left paracentral low back pain that radiates into the left lateral thigh. Pain score at rest are 4-5/10 and with activity 5-6/10. Dr. Konowitz also noted that Norco is still effective and providing 4-6 hours of relief per dose. Dr. Konowitz prescribes Norco, Skelaxin and Lyrica for Petitioner.

Based on the foregoing, the Arbitrator finds that as a result of the May 31, 2012 accident, Petitioner sustained a loss of use, man as a whole, for his right shoulder of 1.1518% and for his low back of 10%. The Arbitrator notes that the accident of May 31, 2012 aggravated of a pre-existing condition. of Petitioner's low back. Petitioner did not further undergo surgery following this accident. Prior to this accident, Petitioner was taking Norco and Skelaxin. Petitioner returned to full-duty work on May 27, 2013.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Larry Hallett,

Petitioner,

vs. NO: 12WC 41595

Westville Homes,

Respondent,

15IWCC0867

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causation, notice, benefit/wage rate, temporary total disability, 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 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.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $8,600.00. 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: NOV 2 4 2015
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CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

DISSENT

I respectfully dissent from the Decision of the majority. The Arbitrator found that Petitioner sustained his burden of proving a compensable accident on July 15, 2011 and causation to current conditions of ill-being of his left knee. She awarded Petitioner outstanding medical expenses and prospective medical treatment including an evaluation with Dr. Gurtler to determine the necessity of a high tibial osteotomy or a total knee replacement to address Petitioner's left knee condition. The majority agreed with the Arbitrator and affirmed and adopted her decision. In my opinion, Petitioner did not sustain his burden of proving that he suffered an accident July 15, 2011 or causal connection. I would have reversed the Decision of the Arbitrator and denied compensation.

Petitioner alleged three separate accidents causing injury to his left knee. The first occurred on June 27, 2008 when he tripped on carpet while doing drywall. His knee popped. Petitioner first saw Dr. Gurtler on September 4, 2008, who noted at that time that Petitioner may need a high tibial osteotomy down the road or even an osteochondral allograft depending on the size and nature of his osteochondral defect. Because of the instability at that time, Dr. Gurtler performed left knee ACL reconstruction and medial meniscectomy articular surface repair surgery on November 17, 2008. Petitioner returned to work with a 20 pound restriction on June 4, 2009.

Petitioner had a second accident on April 19, 2010, when he twisted his left knee and ankle after walking over a rut while carrying drywall. Petitioner was off for about two weeks after that accident. These first two accidents were consolidated and arbitrated with the instant claim but decisions relating to those accidents were not reviewed.

15IWCC0867

Petitioner alleged a third accident on July 15, 2011, which is the subject of this review. He testified "I was installing dryer vent underneath a house, and just crawled around with my knee pads on underneath there, put the dryer vent in, crawled back out and got in the truck and drove to Kankakee to get the transmission looked at on the truck, and when I got out, I couldn't walk."

After the third alleged accident Petitioner returned to Dr. Gurtler for treatment. In his deposition, Dr. Gurtler was asked whether the latest alleged accident would cause his current left knee condition. He answered: "It doesn't really make medical sense that crawling around would cause that kind of an injury. Certainly you very appropriately point out that there was a gap in treatment. I don't deny that. It's not the type of injury, crawling, that would likely do significant damage to an articular surface."

While he conceded that the crawling may have accelerated his pain, in looking at the totality of Dr. Gurtler's deposition testimony it becomes clear that he really ascribed Petitioner's current condition of ill being of his left knee and the need for prospective treatment to his initial accident/injury in 2008. He described Petitioner's left knee as sort of collapsing from the accumulation of degeneration.

Petitioner did not relate any injury or pain while he was crawling under the house. He simply described the later pain and dysfunction of his left knee when leaving his truck. Petitioner testified he had continuing symptoms and was working restricted duty ever since his initial injury even though there was a hiatus in treatment. There was no evidence whatsoever of any new pathology after the third alleged accident and it appears to me that his current condition is the result of the natural progression of the degenerative joint disease of his left knee.

I do not believe that Petitioner sustained his burden of proving a compensable accident on July 15, 2011, or that any event on that date caused or contributed to a current condition of ill-being of his left knee. I would reverse the Decision of the Arbitrator, and deny compensation. For these reasons, I respectfully dissent.

Ruth W. White

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

HALLETT, LARRY
Employee/Petitioner

Case# **11WC021545**

12WC041143
12WC041595

WESTVILLE HOMES
Employer/Respondent

15IWCC0867

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:

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

0000 RUSIN & MACIOROWSKI LTD
TERRY SCHRODER
2506 GALEN DR SUITE 108
CHAMPAIGN, IL 61821

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

STATE OF ILLINOIS)
)SS.
COUNTY OF CHAMPAIGN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

LARRY HALLETT
Employee/Petitioner

Case # 11 WC 21545
Consolidated cases: 12 WC 41143 & 12 WC 41595

v.

WESTVILLE HOMES
Employer/Respondent

15IWCC0867

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 **Urbana**, on **October 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 dates of accident, **June 27, 2008, April 19, 2010,** and **July 15, 2011,** Respondent ***was*** operating under and subject to the provisions of the Act.

On the dates of accident, **June 27, 2008, April 19, 2010,** and **July 15, 2011,** Respondent ***was*** operating under and subject to the provisions of the Act.

On each of these dates, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On each of these dates, Petitioner ***did*** sustain accidents that arose out of and in the course of employment.

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

Petitioner's current condition of ill-being ***is not*** causally related to the accident on June 27, 2008.

Petitioner's current condition of ill-being ***is not*** causally related to the accident on April 19, 2010.

Petitioner's current condition of ill-being ***is*** causally related to the accident on July 15, 2011.

In the year preceding the injury of June 27, 2008, Petitioner earned **$29,416.00**; the average weekly wage was **$588.32**.

In the year preceding the injury of April 19, 2010, Petitioner earned **$34,320.00**; the average weekly wage was **$660.00**.

In the year preceding the injury of July 15, 2011, Petitioner earned **$20,534.28**; the average weekly wage was **$570.40**.

On the date of accident, June 27, 2008, Petitioner was **47** years of age, ***married*** with **1** dependent children.

On the date of accident, April 19, 2010, Petitioner was **49** years of age, ***married*** with **1** dependent children.

On the date of accident, July 15, 2011, Petitioner was **50** years of age, ***married*** with **1** dependent children.

Respondent, as it relates to the injury of June 27, 2008, ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent, as it relates to the injury of April 19, 2010, ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent, as it relates to the injury of July 15, 2011, ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent, as it relates to the injury of June 27, 2008, shall be given a credit of **$11,486.15** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$11,486.15**.

Respondent, as it relates to the injury of April 19, 2010, shall be given a credit of **$440.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$440.00**.

Respondent, as it relates to the injury of July 15, 2011, 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, as it relates to the injury of June 27, 2008, is entitled to a credit of $0 under Section 8(j) of the Act.

Respondent, as it relates to the injury of April 19, 2010, is entitled to a credit of $0 under Section 8(j) of the Act.

Respondent, as it relates to the injury of July 15, 2011, is entitled to a credit of $0 under Section 8(j) of the Act.

ORDER

Respondent, as it relates to the injury of July 15, 2011, shall pay the outstanding medical bills from Carle Physician Group, Dr. George Gindi, and Provena USMC pursuant to the medical fee schedule, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall pay all reasonable and necessary medical services 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 all medical benefits previously paid.

Respondent, as it relates to the injury of July 15, 2011, shall pay for reasonable and necessary prospective medical services, including, but not limited to, an evaluation with Dr. Gurtler to determine the necessity of a high tibial osteotomy or a total knee replacement to address Petitioner's left knee condition.

Respondent, as it relates to the injury of June 27, 2008, shall pay Petitioner temporary total disability benefits of $392.21/week for 28 4/7 weeks, commencing November 17, 2008 through June 4, 2009, as provided in Section 8(b) of the Act.

Respondent, as it relates to the injury of April 19, 2010, shall pay Petitioner temporary total disability benefits of $440.00/week for 1 4/7 weeks, commencing April 22, 2010 through May 2, 2010, 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 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.

15IWCC0867

Arbitrator Molly Dearing

December 20, 2014
Date

JAN 5 - 2015

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

LARRY HALLETT
Employee/Petitioner

15IWCC0867

v.

Case # 11 WC 21545
Consolidated cases:
12 WC 41595, 12 WC 41143

WESTVILLE HOMES
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On June 27, 2008, Petitioner was employed by Respondent as a laborer, and he had been so employed since May 1993. On that date, Petitioner testified that he was performing drywall work. He descended a ladder with a drywall pan in his hand when he tripped over carpet, fell, and felt a pop in his left knee. He notified Respondent of the injury and presented to his family physician, Dr. Mary Gindi, three days later on June 30, 2008. PX 1. An MRI of July 18, 2008 revealed a contusion involving the medial tibial plateau and medial femoral condyle with no evidence of an articular injury, and a tear of the anterior cruciate ligament with moderate joint effusion. PX 2.

Petitioner thereafter treated with Dr. Gindi (PX 1) and Dr. Bipin Bavisha (PX 3), who referred him for treatment with Dr. Robert Gurtler, an orthopedic surgeon at Carle Physician Group. On September 4, 2008, Dr. Gurtler recommended an ACL reconstruction, but opined that "I think he very well may need something else done. He stands in a little bit of varus so he may need a high tibial osteotomy down the road or even something more formal like an osteochondral allograft depending on the size and nature of his osteochondral defect." PX 4.

Dr. Gurtler performed an ACL reconstruction and medial meniscectomy of Petitioner's left knee on November 17, 2008. PX 5. Post-operatively, Petitioner underwent physical therapy at Carle Therapy Services (PX 6) and received two corticosteroid injections. During that time, Dr. Gurtler imposed work restrictions, which Respondent accommodated, and Petitioner continued to complain of pain, instability, and swelling in his left knee. On August 13, 2009, Petitioner presented to Danny McFarlin, Dr. Gurtler's physician's assistant. A physical examination revealed good range of motion of both knees in flexion and extension, no pain on palpation of the knee, no swelling, no overlying tissue erythema, a nicely healed incision, no valgus or varus laxity, no pain with valgus or varus stressing, and negative anterior drawer testing. Petitioner was placed at maximum medical improvement and given a permanent work restriction of no lifting greater than 20 pounds while ascending or descending ladders. Mr. McFarlin noted that Petitioner will likely need a total knee replacement "[a]t some point in time". PX 4.

On April 19, 2010, Petitioner was carrying a sheet a drywall while working in his capacity as a laborer for Respondent when he stepped in a tire rut, and twisted his left knee and ankle.

On April 22, 2010, Petitioner presented to Dr. Paul Plattner of Carle Physician Group complaining of pain in his left knee. Dr. Plattner injected Petitioner's knee with Cortisone and imposed restrictions of no lifting, pulling or pushing more than ten pounds. PX 4. Petitioner testified that he remained off of work following that appointment.

On April 29, 2010, Petitioner returned to Dr. Plattner and reported doing well. A physical examination revealed functional left knee range, good stability, good muscle strength, but some mild discomfort on ambulation with a slight antalgic gait. Dr. Plattner released Petitioner to resume all activities as of May 3, 2010. On May 7, 2010, a physical examination of Petitioner's left knee showed good stability, no effusion, erythema or edema. Dr. Plattner released Petitioner from his care on that date. PX 4. Petitioner testified it was his understanding he remained under the 20-pound restriction while climbing ladders imposed by Dr. Gurtler in 2009.

Thereafter, Petitioner continued to present to Dr. George Gindi for care and treatment for non-related issues, including a general physical. RX 3.

On July 15, 2011, Petitioner testified that he crawled underneath a house to install a dryer vent in a home in his capacity for Respondent, after which his left knee became swollen and unbendable. Petitioner testified he reported the incident to Respondent that same day, and notified Respondent on July 16, 2011 that he was unable to ambulate on his left leg and required medical treatment.

On July 18, 2011, Petitioner presented to Dr. George Gindi for a follow-up appointment regarding his prescription medication, at which time he requested Dr. Gindi examine his left knee. Petitioner reported working under a house in the week prior at which time his knee began catching and popping before becoming unbendable upon arrival at the next job site. A physical examination revealed limited range of motion due to pain, and mild tenderness and swelling. PX 7. Dr. Gindi ordered a CT scan of Petitioner's left knee (PX 7), which revealed osteoarthritic changes of the left knee with narrowing of the medial joint space with osteophyte formation, some effusion of the left knee, and post surgical changes of the distal femur and proximal tibia were noted. PX 8.

Also on July 18, 2011, Petitioner presented to Dr. Plattner complaining of his left knee. Petitioner reported to Dr. Plattner that he had been crawling around in a crawlspace in the week prior. Dr. Plattner injected the knee with Marcaine and Kenalog, and encouraged Petitioner to utilize a knee brace. Petitioner also requested a referral to return to see Dr. Gurlter. PX 4.

On July 20, 2011, Petitioner returned to Dr. George Gindi, at which time he still was unable to bend his left knee. On July 27, 2011, Petitioner reported to Dr. Gindi that his knee was doing much better. On February 13, 2012, Petitioner returned to Dr. George Gindi and reported problems with his left knee, at which time they discussed Petitioner returning to see Dr. Gurtler. PX 7. An MRI of February 17, 2012 revealed an ACL repair, severe articular cartilage thinning throughout the medial compartment, cartilage fragments within the effusion and in a small Baker's cyst, subacromial marrow edema and subchrondral sclerosis on both sides of the medial joint space, prominent osteophytes consistent with advanced secondary osteoarthritis, severe cartilage thinning over the medial patellofemoral joint, and a partial meniscectomy of the medial meniscus was noted. PX 8.

Petitioner testified that between July 2011 and April 2012, his left knee hurt persistently when he worked or climbed stairs. He iced his knee after returning home from work. Petitioner testified that he has not sought continuous treatment for his left knee since July 2011 because it was his understanding that nothing could be done for his left knee absent a total knee replacement. Petitioner testified that he did not feel the need to seek additional treatment until there was a substantial change in the condition of his knee in July 2011 for which he sought treatment with Dr. Plattner. Petitioner further testified that he returned to Dr. Gurtler in 2012 because his left knee continued to bother him.

On April 5, 2012, Petitioner presented to Dr. Gurtler complaining of significant pain in the left knee. Dr. Gurtler noted that because of the meniscus damage, Petitioner's knee had collapsed four degrees into varus, which was creating pressure on the medial side of the joint and causing pain. Dr. Gurtler noted that a total knee replacement "would certainly take care of his pain," however, given Petitioner's age of 50, he wanted to avoid that procedure. Instead, Dr. Gurtler recommended a left knee arthroscopic examination, debridement of the old anterior cruciate ligament, debridement of a cyst, removal of hardware, and an opening wedge high tibial osteotomy to correct the medial collapse and bowing. Dr. Gurtler opined that "[t]his clearly is an outcome from his original injury and was, if anything, expected to happen over time because of that previous work related injury." PX 4. Petitioner testified he did not proceed with the recommended surgery at that time because he could not afford to do so.

Petitioner returned to Dr. Gurtler on November 1, 2012 complaining of continued pain in his left knee. Dr. Gurtler again noted Petitioner's left leg had tipped into varus, and he and Petitioner revisited a discussion of a total knee replacement. Dr. Gurtler again recommended a left knee opening wedge high tibial osteotomy, which he opined would remove the pressure from the medial side of Petitioner's knee and delay his need for a total knee replacement by approximately ten years. On October 7, 2013, Petitioner received another injection of Marcaine and Kenalog. PX 4.

On April 11, 2014, Petitioner underwent an examination with Dr. Joseph Monaco pursuant to Section 12 of the Act. Petitioner reported to Dr. Monaco suffering a work accident in June 2008 when he tripped over a rolled-up carpet and felt a pop in his knee. Petitioner also reported a subsequent injury in April 2010 when he stepped in a tire rut and twisted his left knee, as well as an aggravation of his left knee while crawling around in a crawl space when he felt a pop in his left knee. After reviewing Petitioner's medical records and the deposition of Dr. Gurtler, conducting a physical examination of Petitioner, and taking a history from him, Dr. Monaco opined that Petitioner is not a candidate for a high tibial osteotomy or an additional arthroscopy because of the significant degenerative changes of the patellofemoral joint and early changes involving the lateral tibiofemoral compartment. Dr. Monaco believed that any arthroscopic procedure would be temporary in nature and would not result in any significant benefit to Petitioner. Dr. Monaco opined that, if any surgical intervention was considered, a total knee replacement would be appropriate, though he acknowledged that Petitioner is not an ideal candidate for such a procedure due to his young age and obesity. RX 1.

Dr. Monaco opined that as a result of his work accident of June 27, 2008, Petitioner sustained a rupture of the anterior cruciate ligament, a tear of the degenerative medial meniscus, and an exacerbation of pre-existing degenerative changes involving the articular cartilage of the medial tibiofemoral compartment. Following surgery and persistently good stability demonstrated on physical examination, Dr. Monaco opined that Petitioner exacerbated his left knee in April 2010,

which resolved within a matter of weeks with conservative care and the use of an injection of cortisone. Dr. Monaco further opined that Petitioner continued to work regular duty for fourteen months before his work accident in July 2011, which again resulted in an exacerbation of his pre-existing condition and has persisted since that time. RX 1.

Dr. Monaco testified by way of evidence deposition on May 13, 2014 concomitantly with his report and examination of April 11, 2013. Dr. Monaco opined that Petitioner's left leg bowing, or varus, was a congenital/developmental condition that was not a result of any activity or injury. Dr. Monaco believed that Petitioner would not benefit from a high tibial osteotomy because of his rather advanced degenerative changes in the patellofemoral joint. He indicated that an osteotomy would not offer Petitioner more than days or weeks of some mild improvement, and instead opined that a total knee replacement would be the appropriate treatment. Dr. Monaco opined that Petitioner's work injury of July 2011 was a permanent aggravation of his left knee pain. RX 2.

Dr. Robert Gurtler testified by way of evidence deposition on August 6, 2013. Dr. Gurtler testified that he placed Petitioner at maximum medical improvement following his surgery of November 17, 2008 on August 13, 2009, but that Petitioner would most likely need a total knee replacement at some point in time in the future. Dr. Gurtler testified Petitioner was released with a permanent 20-pound restriction while climbing ladders. Dr. Gurtler testified that when Petitioner returned to him on April 5, 2012, Petitioner's left knee had essentially collapsed medially and was significantly bowing, for which Dr. Gurtler recommended a high tibial osteotomy to straighten the left leg and reduce pressure on the knee. Dr. Gurtler opined that the medial damage to Petitioner's left knee resultant from Petitioner's work injury in 2008 caused his left knee to become increasingly arthritic and collapse, which necessitates a high tibial osteotomy procedure. PX 12.

Dr. Gurtler was not aware that Petitioner has reported an injury of April 19, 2010 or July 15, 2011, and he was unaware that Petitioner had treated with Dr. Plattner for those accidents. After reviewing Dr. Plattner's medical records of April 22, 2010 and July 18, 2011, Dr. Gurlter testified that the crawling Petitioner reported in July 2011 was not likely to cause the significant articular damage he had to his knee, though Dr. Gurtler acknowledged that Petitioner had an increase in symptoms following the crawl space injury that now necessitates surgery, which he did not require as of May 7, 2010 when Dr. Plattner released him from care. Dr. Gurtler opined that the incidents involving Petitioner carrying drywall and crawling in a crawl space did not change the course of treatment that he believed Petitioner required as a result of his 2008 work injury, though he testified that it was "very reasonable" to conclude that Petitioner's work accident of July 15, 2011 accelerated his left knee deterioration. Dr. Gurtler testified that "I was hoping for quite a bit longer period of time than what we've had, so I guess what I'd say is I'm pleased he had a relatively asymptomatic period, but I think the die was cast in 2008 from these injuries, he eventually was going to need more surgery, either an osteotomy or a total knee replacement, and that goes back to that 2008." Dr. Gurtler testified that he would need to re-evaulate Petitioner to ascertain whether a high tibial osteotomy would still be an appropriate treatment option or whether "it's gone too far and he needs a total knee." PX 12.

At Arbitration, Petitioner testified that subsequent to June 27, 2008, his left knee has consistently been symptomatic. He testified that his treatment for his left knee has generally been limited to Dr. Gindi, Dr. Gurtler, and Dr. Plattner. Petitioner testified that he presented to Dr. Gindi for left knee problems as well as other conditions, but he did not always complain to Dr. Gindi regarding his left knee because Dr. Gurtler is his primary physician concerning his left knee.

Petitioner testified that he worked for Respondent until he was laid off before Christmas 2012. Petitioner testified that he briefly resumed work for a period of time in January 2013 before he was laid off permanently in spring 2013 when Respondent ceased doing business. He is not presently working, and he testified that he remains under Dr. Gurtler's work restriction of no lifting greater than 20 pounds while climbing ladders. Petitioner testified that he continues to experience pain in his left knee with frequent ambulation and he has difficulty walking on unstable ground.

CONCLUSIONS OF LAW

In regard to disputed issue (C) in 12 WC 41595, the Arbitrator finds that Petitioner sustained an accident that arose out of and in the course of his employment with Respondent on July 15, 2011. In so concluding, the Arbitrator notes that Petitioner was performing a task incidental to his job duties as a laborer for Respondent when he was crawling underneath a house to install a dryer vent. Thereafter, Petitioner's left knee became swollen and unbendable. Petitioner's testimony concerning his work accident of July 15, 2011 is credible, unrebutted at Arbitration, and well documented in the medical records of Dr. George Gindi and Dr. Paul Plattner. PX 4, 8.

In regard to disputed issue (E) in 12 WC 41595, the Arbitrator finds that Respondent was given timely notice of the accident. Petitioner testified that he notified Kim and Julie Johnson, owners of Respondent, on July 15, 2011 of the incident at work involving his left knee, and testified that he reported to Kim and Julie Johnson the following day that he required medical assistance regarding that incident. Petitioner's testimony was credible and unrebutted at Arbitration.

In regard to disputed issue (F) in 11 WC 21545, 12 WC 41143, and 12 WC 41595, the Arbitrator concludes that Petitioner's current condition of ill-being in his left knee is causally related to his work accident of July 15, 2011, and is unrelated to his work accidents of June 27, 2008 or April 19, 2010. Despite having two previous work accidents involving his left knee, undergoing an ACL and meniscal repair, and Dr. Gurtler indication's of September 4, 2008 that Petitioner's condition may necessitate a high tibial osteotomy or a total knee replacement in the future, the Arbitrator finds Petitioner's placement at maximum medical improvement following the first two work accidents, as well as the absence of left knee complaints to his treating physicians from May 2010 to July 2011 probative of a lack of a causal relationship between the first and second work accidents and his current condition of ill-being. Although Petitioner testified that he was continually symptomatic following his first two work accidents, he also testified that he did not feel the need to seek additional treatment until there was a substantial change in the condition of his knee in July 2011 for which he sought treatment with Dr. Plattner. The Arbitrator notes that Petitioner did not complain of left knee pain to his treating physicians from May 7, 2010 (PX 4, RX 3) until July 18, 2011, even though he had opportunities to do so while seeking treatment with Dr. George Gindi throughout 2010 and 2011 (RX 3), and worked during that fourteen-month time period. It was the work accident on July 15, 2011 that prompted Petitioner to again seek treatment with both Dr. Gindi and Dr. Plattner on the same date, and complain of recurrent left knee pain, which did not abate despite two injections, whereas Petitioner's previous left knee injury of April 19, 2010 resolved within two weeks with a single injection. While Petitioner indicated to Dr. George Gindi on July 27, 2011 that he was doing much better, Petitioner continued to have left knee complaints throughout 2012 to the present hearing, and the Arbitrator notes that Dr. Gurtler's examination of Petitioner on April 5, 2012 showed a change in Petitioner's left knee condition from his prior left knee examination of August 13, 2009 and from Dr. Plattner's examination of April 29, 2010, namely that

Petitioner's left knee had collapsed into four degrees of varus and was bowing, creating pain on the medial side of the joint. PX 4.

In finding Petitioner's current condition of ill-being casually related to his work accident of July 15, 2011, the Arbitrator finds the opinions of Dr. Monaco more persuasive and well-founded in the record than those of Dr. Gurtler, and accordingly assigns Dr. Monaco's opinions with respect to causal connection greater weight. Dr. Monaco's opinions recognize the temporary nature of Petitioner's work injury of April 19, 2010, which resolved within a matter of weeks with conservative care and the use of an injection of cortisone, as well as the worsening and persistence of Petitioner's left knee complaints following the work accident of July 15, 2011. Dr. Monaco's opinions also appreciate that Petitioner was able to work for over fourteen months after he was released to return to work following his second work accident until his third work accident on July 15, 2011.

Dr. Gurtler's opinions, on the other hand, fail to appreciate the significance of Petitioner's complaints and the treatment he necessitated following his work accident of July 15, 2011. The Arbitrator finds it significant that, until the time of his deposition, Dr. Gurtler was unaware that Petitioner had re-injured his left knee on April 19, 2010 and July 15, 2011, and sought treatment for those injuries with Dr. Plattner, which goes to the weight of Dr. Gurtler's opinions. Although Dr. Gurtler opined that Petitioner's current left knee condition and need for further surgery was related to his June 27, 2008 work accident, Dr. Gurtler acknowledged that he had hoped Petitioner could delay further surgical intervention than what he is able to do at the present time, and that it was "very reasonable" to conclude that Petitioner's work accident of July 15, 2011 accelerated his left knee deterioration. Dr. Gurtler further acknowledged that Petitioner's work injury of July 15, 2011 while crawling in the crawl space increased his symptoms that now necessitate surgery. PX 12.

Based upon the foregoing and the record in its entirety, the Arbitrator finds that Petitioner's work accident of July 15, 2011 aggravated and exacerbated his left knee condition so as to necessitate treatment, and accelerated his need for further surgical intervention. Therefore, the Arbitrator concludes that Petitioner's current condition of ill-being in his left knee is causally related to his work accident of July 15, 2011, and unrelated to his work accidents of June 27, 2008 and April 19, 2010.

In regard to disputed issue (J) and consistent with the Arbitrator's conclusions with respect to issue (F), the Arbitrator finds that the outstanding medical bills from Carle Physician Group, Dr. George Gindi, and Provena USMC (Arb. X 1, 2, 3) are causally related to Petitioner's work accident of July 15, 2011, and that said services were reasonable and necessary in Petitioner's care and treatment relative to that accident. Respondent shall pay all reasonable and necessary medical services, as provided in Sections 8(a) and 8.2 of the Act, and subject to the fee schedule. Respondent shall be given a credit for all medical benefits previously paid.

In regard to disputed issue (K), the Arbitrator notes that the dispute between the parties does not rest with whether Petitioner requires prospective medical treatment, but rather in what procedure to perform given Petitioner's left knee condition. Dr. Monaco opined that Petitioner would not benefit from a high tibial osteotomy due to the severe degenerative changes in his knee, and Dr. Gurtler opined that he must re-evaluate Petitioner to determine if he is still a candidate for the high tibial osteotomy or whether his condition at this time requires a total knee replacement. The Arbitrator finds that Petitioner is not currently at maximum medical improvement and is in need of further medical care. Moreover, the Arbitrator finds that the need for prospective medical

care is causally related to the work accident of July 15, 2011. The Arbitrator concludes that Respondent shall pay for prospective medical treatment with Dr. Gurtler, including but not limited to an evaluation to determine the need for a high tibial osteotomy or a total knee replacement to address Petitioner's left knee condition.

In regard to disputed issue (L), Petitioner seeks temporary total disability benefits from November 7, 2008 through June 4, 2009, April 22, 2010 through May 3, 2010, and December 15, 2012 through October 22, 2014. Respondent does not dispute liability for the June 27, 2008 and April 19, 2010 accidents, and asserts time frames for temporary total disability that only slightly differ from Petitioner's request. Arb. X 1, 2, 3.

The record reflects that Petitioner was released to return to work without restrictions on September 4, 2008. PX 4, 12. Dr. Gurtler testified that he did not see Petitioner subsequent to September 4, 2008 until his surgery on November 17, 2008, at which time Dr. Gurtler removed him from work (PX 12), and Petitioner similarly testified that he worked until the time of his surgery on November 17, 2008. Subsequently, Petitioner returned to work with a 20-pound weight restriction while climbing ladders, which Respondent accommodated, on June 4, 2009. PX 4. The record further reflects that Dr. Plattner placed work restrictions on Petitioner on April 22, 2010 after which he remained off of work, and Petitioner was allowed to resume all activities on May 3, 2010. PX 4. Based upon the foregoing, the Arbitrator concludes that Respondent shall pay Petitioner temporary total disability benefits from November 17, 2008 through June 4, 2009 relative to Petitioner's work accident of June 27, 2008, and temporary total disability benefits from April 22, 2010 through May 2, 2010 relative to Petitioner's work accident of April 19, 2010.

With respect to the period of temporary total disability benefits from December 15, 2012 through October 22, 2014, Petitioner testified that he remained under a permanent 20-pound weight restriction while climbing ladders imposed by Dr. Gurtler in 2009. He further testified that he was laid off in December 2012 and briefly resumed work for Respondent in January 2014 before Respondent ceased doing business in spring 2013. However, despite Petitioner's previous permanent restrictions, Petitioner sustained a second work accident on April 19, 2010 that necessitated further treatment and work restrictions by Dr. Plattner, which were lifted on May 3, 2010 when Petitioner was released to return to work full duty, and he was placed at maximum medical improvement for that injury on May 7, 2010. PX 4.

Subsequent to his third work accident of July 15, 2011, Petitioner has not proffered any notations, off work slips, or deposition testimony from Dr. Gurtler restricting Petitioner's current work status, excusing him from work, or opining that Petitioner presently remains restricted by the previous permanent work restrictions imposed on him in 2009. The Arbitrator notes that the claimant bears the responsibility of proffering evidence to support his off work status. *See Eileen Paule v. Schnucks*, 14 IWCC 485 (June 19, 2014). In the absence of any evidence of a restricted or off work status during the time period of temporary disability alleged, the Arbitrator is guided by the full duty release of Dr. Plattner of May 3, 2010. In light of the foregoing findings and the record in its entirety, the Arbitration denies temporary total disability benefits from December 15, 2012 through October 22, 2014.

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.

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

Michael Henneman,
Petitioner,
vs.
City of Chicago,
Respondent,

NO: 13WC 13045

15IWCC0870

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 17, 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: NOV 2 4 2015
MJB/bm
o-11/23/15
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HENNEMAN, MICHAEL
Employee/Petitioner

Case# **13WC013045**

CITY OF CHICAGO
Employer/Respondent

15IWCC0870

On 2/17/2015, 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:

0391 HEALY SCANLON
DAVID HUBER
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

0010 CITY OF CHICAGO
ELIZABETH MANNION
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Michael Henneman
Employee/Petitioner
v.
City of Chicago
Employer/Respondent

Case # 13 WC 13045
Arb. Ketki Steffen

15IWCC0870

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 **12-10-2014**. 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 **Nature and Extent of Petitioner's left leg injury**

FINDINGS

On the date of accident, **6-26-2012** Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**73,216.00**; the average weekly wage was $**1,408.00**.

On the date of accident, Petitioner was 31 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 $**29,720.51** 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** under Section 8(j) of the Act.

ORDER

- Respondent shall pay the petitioner the sum of $695.78 /week (maximum PPD rate)for a period of **69.875** weeks, as provided in Sections **8(e)** of the Act, because the injuries sustained caused **32.5% loss of use of his left leg.** Respondent shall pay $48,617.63

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.

Kelli Steffen
Signature of Arbitrator

2/13/15
Date

FEB 17 2015

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MICHAEL HENNEMAN,	)	
	)	
Petitioner,	)	
	)	
	)	
vs.	)	NO. 13 WC 13045
	)	Arbitrator Ketki Steffen
CITY OF CHICAGO,	)	
	)	
Respondent.	)	15IWCC0870

FACTUAL HISTORY

Petitioner testified that on June 26, 2012 he was a 32 year old, 5'11", 185 pound left handed cement laborer employed by Respondent, City of Chicago. Petitioner testified that he began working for the City of Chicago in early August 2002 and has always worked for the City as a laborer. Petitioner is a member of a labor union Local 76 Laborers. On 6/26/2012, Petitioner earned $35.20 per hour and worked 40 hour weeks. Petitioner earned $1,408 per week.

Petitioner testified that during his employment at Respondent his typical day would begin when he would punch in and then travel to a work site location in the City of Chicago. He and his crew would prepare sites for concrete pouring or pour concrete at sites which had been prepared the day before.

On June 26, 2012 Petitioner was at work. While at work, he was grading stone using"come-a-long" which is similar to a rake, but has a flat blade instead of tines. Petitioner testified that he was working at an excavation site where a Bobcat loader was pouring stone into the excavation. His job was to grade the stone and then tamp it down in preparation for a concrete pour. Petitioner testified that the excavation was one foot deep and has an uneven bottom including mud and stones. Petitioner stepped into the excavation from street level. When he did, he testified his left knee

buckled and he fell to the ground. Petitioner testified that he felt intense pain in his left knee and experienced immediate swelling. Petitioner testified that the job site was extremely loud, and he did not hear a pop from his knee, but he felt a pop at the time that he fell.

Petitioner reported the incident to his on-site Foreman, John Bardy and his General Foreman, Chris Davis. A written report was filled out and Petitioner signed it. Petitioner was instructed to report to Mercy Works, the City of Chicago's occupational health provider. Petitioner reported to Mercy Works at 32nd and Ashland in the City of Chicago on June 26, 2012, the same day of his injury. Petitioner testified that he reported to Dr. Homer Diadula, who examined him. Dr. Diadula's records are admitted as PEX #1. PEX #1, p. 4 shows that Dr. Diadula examined Petitioner, took X-Rays of the left knee, and diagnosed Petitioner with a knee sprain. Dr. Diadula recommended Petitioner take ibuprofen, elevate the leg and apply ice. Dr. Diadula gave Petitioner and elastic knee support. Dr. Diadula instructed Petitioner to continue working.

Petitioner continued working, but testified that he experienced pain and swelling in the knee and was unable to bend it or crouch while at work. Dr. Diadula's July 2, 2012 note shows that Petitioner was experiencing left knee pain, rated at 6 out of 10 and was limping. PEX #1, p.5. Dr. Diadula recommended Petitioner undergo an MRI. Petitioner had an MRI at Salt Creek Medical Imaging on July 9, 2012. PEX #1, p.5. The MRI, PEX #1 p. 6, shows that Petitioner's left knee had bone marrow edema present throughout the proximal tibia and phemoral condoles, indicating significant bone contusion. The MRI identified extensive trabecular fractures present in the proximal tibial metaphysis and moderate to large joint effusion. The MRI also identified a tear throughout the posterior horn of the lateral meniscus with middline displacement of the torn fragment. The MRI identified a complete ACL ligament tear. Petitioner returned to Dr. Diadula on July 13, 2012. Dr. Diadula referred Petitioner to Dr. Maday, an orthopedic specialist. PEX #1, p. 5.

Petitioner saw Dr. Michael Maday, an orthopedic surgeon, on July 18, 2012. PEX #2 is medical records from Midland Orthopedics Association. Dr. Maday reviewed the MRI, agreed that it identified

a complete tear of the Anterieor Crucilate Ligament (ACL) and revealed extensive bone contusions and a tear through the posterior horn of the lateral meniscus with displacement of the torn fragment. Dr. Maday recommended Petitioner undergo surgery to repair the ACL and meniscus. PEX #2 pp. 4-5. Dr. Maday restricted Petitioner from working. His last day worked was July 18, 2012.

Petitioner testified that surgery on his knee was not approved by Respondent until the end of August 2012. Dr. Maday performed surgery on August 30, 2012. PEX #2 pp. 31-37. Dr. Maday conducted a left knee arthroscopy, arthroscopic anterior cruciate ligament reconstruction with a patellar tendon autograft and performed a partial lateral meniscectomy. Dr. Maday's surgical report shows that there were multiple tears and a horizontal split in Petitioner's lateral meniscus which involved 30 to 40 % of the posterior horn of the lateral meniscus. His report shows that the tear and split extended into the anterior horn of the meniscus. Surgical examination of Petitioner's knee shows that the anterior cruciate ligament was completely torn. Dr. Maday performed an arthroscopic partial medial meniscectomy. A review of the report shows that Petitioner's surgery was extensive, and done in two phases.

The ACL reconstruction was done partially via arthroscope and partially via an open incision. The reconstruction was accomplished by removing a portion of the lateral femoral condyle and drilling holes in the tibia and femoral condyle. A notch was ground in the lateral femoral condyle arthroscopically. Dr. Maday then made a 5 cm (2in) incision in order to access the anterior tibia and patellar tendon. He then removed 1/3 of Petitioner's patellar tendon and removed a 10x10x25 mm bone plug from Petitioner's tibial and patella. The surgical report shows that Petitioner's patellar tendon was 30 mm wide. Dr. Maday removed the middle 10 mm. Once the patellar graph was prepared it was arthroscopically reintroduced into the knee in place of the anterior cruciate ligament. The bone plugs were screwed into Petitioner's tibia and femur. Surgery was concluded by closing the wound with skin staples and applying a post-operative brace. PEX #2 pp. 31-34.

After surgery, Dr. Maday continued to follow Petitioner. Dr. Maday recommended physical therapy to be conducted at Athletico. Athletico's medical records are PEX #3. Petitioner was seen for physical therapy starting approximately one month after surgery, on September 14, 2012. Petitioner attended 56 physical therapy sessions. PEX #3, p. 131. When he was discharged from physical therapy on January 28, 2013 Petitioner reported that he was still experiencing patellar tendon pain which he managed with a prescribed home exercise program and ice. Petitioner underwent a program of work conditioning at Athletico, PEX #2, p. 49. On February 1, 2013 Petitioner was evaluated to determine whether he could safely return to work. At that time, notes from Athletico show that Petitioner was very motivated but did not demonstrate an ability to safely lift at the heavy job demand of a cement laborer. Petitioner underwent 2 weeks of work conditioning 3-4 hours per day, 5 days per week. Id. Petitioner was authorized to return to work by Dr. Maday on February 26, 2013. PEX #2, pp. 23-24. At that time Dr. Maday noted that Petitioner should continue use of the brace and a patellar strap. PEX #2, p. 23.

On May 22, 2013 Petitioner returned to Dr. Maday. Dr. Maday noted that Petitioner was experiencing occasional anterior knee pain but he was working his full duties. PEX #2, p. 26. Dr. Maday noted that Petitioner was occasionally using his brace and patellar strap. He opined that Petitioner had reached maximum medical improvement as of May 22, 2013. PEX #2, p. 26.

Petitioner testified that he continues a home exercise program which he does for the benefit of reducing symptoms in his left knee. Petitioner testified that he performs heel lifts, lunges, and stretching as part of his daily routine. Petitioner testified that the home exercise program he engages in increases his stamina and he feels that it somewhat decreases his knee symptoms.

Petitioner testified that he frequently walks on uneven surfaces while at work. These surfaces include mud, rocks and excavations. Petitioner testified that he often carries heavy objects such as ADA/Wheelchair ramp assemblies. When he walks on uneven surfaces and/or carries heavy objects Petitioner experiences symptoms in his knee, including pain.

Petitioner testified that he experiences pain daily while working. He testified that crouching, pushing, pulling, climbing in and out of excavations and on and off of vehicles provokes pain and sometimes swelling in his left knee. Petitioner testified that the more work he performs, the more he feels pain in his knee. Petitioner testified that he experiences swelling approximately 2 times per week which requires him to ice the knee and elevate it. Petitioner testified that he uses the knee brace given to him by Dr. Maday. Petitioner testified that he uses the patellar strap given to him by Dr. Maday more often than he uses the brace. He testified that he takes over-the-counter pain medication including ibuprofen two to three times per week.

Petitioner testified that he avoids certain work activities when possible in order to avoid symptoms in his knee. Petitioner described placing expansion material in concrete pours which requires carrying material and kneeling or crouching for long periods of time. Petitioner testified that such activities provoke symptoms in his knee. Petitioner testified that he wears knee pads when at work when his duties require him to kneel.

Petitioner testified that he is now able to work at a slower pace than before his injury and is much more aware of how certain activities will affect his knee. Petitioner testified that he occasionally favors the left leg and avoids activities which he knows will provoke symptoms.

Petitioner testified that prior to his injury he had been athletic and enjoyed activities such as softball and running for exercise. Petitioner testified that he does not engage in athletic activities because of the condition of his knee. He does not play softball or run for recreation any more.

Dr. Brian Forsythe testified via evidence deposition taken November 4, 2014. Respondent hired Dr. Forsythe to provide an AMA permanent impairment rating using the 6th edition of "Guides to the Evaluation of Permanent Impairment". "Guides" Chapter 16 of the AMA Guide to the Evaluation of Permanent Impairment Rating is PEX #4. In formulating his report for Respondent, Dr. Forsythe testified that he examined Petitioner and reviewed some medical records pertinent to his left knee. Dr. Forsythe did not review Petitioner's MRI, but testified that he reviewed the MRI report. REX #1, p.

25. Dr. Forsythe determined that Petitioner stepped in a hole while at work and twisted his left knee, injuring it. Petitioner underwent an anterior cruciate ligament reconstruction and debridement of his lateral meniscus tear. Dr. Forsythe was aware that Petitioner underwent physical therapy. Dr. Forsythe agreed that Petitioner's medical treatment was reasonable and necessary. REX #1 p. 8.

Dr. Forsythe's report outlines his understanding of Petitioner's condition and concludes that according to his analysis of the AMA Guides to the Evaluation of Permanent Impairment, Petitioner's rating of impairment was 7%.

Dr. Forsythe testified that his understanding of Petitioner's condition was incomplete. This may be because, as Petitioner testified, Dr. Forsythe's exam of Petitioner lasted a very short time, approximately 5 minutes. Dr. Forsythe reported that Petitioner experienced intermitted swelling in his knee but did not attempt to determine how often Petitioner experienced swelling. REX #1, p. 28. Dr. Forsythe testified that he "presumed Petitioner did not avoid any work activities because he had been working full duty since February 2013." REX #1, p. 29. However, Dr. Forsythe did not attempt to determine what work activities Petitioner avoided such as crouching, or lifting while crouching, kneeling, pushing or pulling. Petitioner testified that these activities provoked symptoms in his knee and he avoided them when possible. Dr. Forsythe did not know and did not determine how often Petitioner used over-the-counter pain medication including ibuprofen other than that Petitioner occasionally used them. REX #1, p. 30. Dr. Forsythe did not know that Petitioner used over-the-counter pain medication two to three times per week. Dr. Forsythe testified that he did not know nor determine how often Petitioner utilized the patellar strap recommended by Dr. Maday or what affect it had on his symptoms. Dr. Forsythe did not ask Petitioner regarding his use of the patellar strap. Id p. 30.

Dr. Forsythe agreed that usage of a patellar strap as recommended by Dr. Maday was reasonable and necessary because patients such as Petitioner who have had 1/3 of their patellar

tendon removed during ACL reconstruction surgery experience symptoms from that removal. Id pp. 31-32.

Dr. Forsythe agreed that because of his occupation, Petitioner would experience work related symptoms more often than someone with a light occupation with light physical demands. REX #1, p. 34.

Dr. Forsythe agreed that the process of defining impairment is an imperfect one. REX # 1, p.40. He agreed that one could experience significant activity limitations or participation restrictions in the absence of demonstrable impairment as described in the AMA Guides. REX #1, p. 41. Dr. Forsythe agreed that "impairment" is but one of several determinants of disablement. REX #1, p. 42. Dr. Forsythe testified that he utilized Chapter 16 which addresses rating impairment of lower extremities.

Petitioner testified he performed his work duties at a slower pace and with more difficulty and effort. He avoids aggravating the condition of his knee. He avoids prolonged crouching crawling and climbing. Petitioner uses a patellar strap and brace prescribed by his doctor. He experiences frequent swelling of the knee which requires application of ice and use of over-the-counter medication. Nevertheless, Petitioner continues to experience significant symptoms and limitations of use of his left leg as a result of his injury and extensive surgical repair.

Petitioner testified that the condition of his knee has been fairly steady since his return to work in February 2013.

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

Petitioner testified that he was injured at work while performing his job duties. He stated that he stepped in a hole and twisted his knee, felt a popping sensation, and immediately felt pain and swelling. There were no prior pre-existing issues with his knees. He reported his injury to his employer and was seen and by Dr. Homer Diadula at Mercy Works on the same day. Dr. Diadula diagnosed a knee strain and Petitioner returned to work. He experienced severe pain when back at work and a MRI was finally and properly ordered which showed that the Petitioner had completely tore his anterior cruciate ligament and partially torn his left medial meniscus. Petitioner underwent medical treatment including extensive surgery which required both arthroscopic and open procedures to reconstruct the anterior cruciate ligament using a portion of his patellar tendon harvested by an open surgery to the knee. After surgery, Petitioner underwent physical therapy and work conditioning. Despite returning to work, Petitioner described experiencing symptoms while working despite wearing a patellar strap and brace prescribed by his surgeon.

Based on a review of the medical evidence and Petitioner's testimony, The Arbitrator finds the symptoms he described are causally related to the work accident.

O. What is the nature and extent of Petitioner's injury?

Petitioner was 32 years old at the time of his work accident was working in a physically demanding occupation as a cement laborer. He suffered a complete tear of his ACL and a partial tear of his left medial meniscus. He underwent surgery which required both arthoscopic and open procedures to reconstruct his ACT using a petallar tendon harvested by an open surgery to his knee. The medical procedures were followed by physical therapy and work conditioning. Petitioner has returned to full duty employment at his prior job position but has to make compromises in the type, manner and speed at which he can perform his job functions. Petitioner experiences frequent pain

and swelling in his knee as a result of his injury and certain activity exacerbates the symptoms in his knee. Petitioner is obliged to ice and elevate the leg when he uses is vigorously. Petitioner takes over-the-counter pain medication two to three times per week to address his symptoms. On the other hand, Petitioner is has a full duty release without restrictions and is able to perform his job duties. He is a member of a health club and is able to and likes to exercise. He also in a home exercise program to help with his symptoms and testified truthfully that the physical nature of his job provides plenty of exercise to his body. These facts are supported by Petitioner's credible testimony as well as the medical records.

Currently, Petitioner experiences difficulties with activities requiring the use of his left knee. Such pain has continued after surgical reconstruction of his anterior cruciate ligament and debridement of his torn medial meniscus. Petitioner's treating physician, Dr. Maday, describes that Petitioner experiences anterior knee pain while working. Dr. Maday prescribed Petitioner a knee brace and patellar strap. Petitioner testified that he wears the patellar strap and brace when he experiences symptoms in his knee. While he does not wear the strap or brace every day he testified that he frequently uses them. Petitioner's work activities are vigorous. He testified that as a cement laborer, he is required to walk on a construction sites including excavations, which have uneven and unstable surfaces. He testified that he is required to carry heavy objects while at work. Petitioner testified that specific activities such as those that require crouching, kneeling, or climbing in and out of vehicles provoke symptoms in his knee; he attempts to avoid these activities when possible.

In assessing the nature and extent of Petitioner injury, the Arbitrator notes that the accident occurred on June 26, 2012. Sec. 8.1b has set the following criteria for determination of permanent partial disability for accidental injuries that occur 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.

Section 8.1(b) also states, "No single 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 a physician must be examined." The term "impairment" in relation to the AMA Guides to the Evaluation of Permanent Impairment 6th edition is not synonymous with the term "disability" as it relates to the ultimate permanent partial disability award.

Upon reviewing the above criteria and evaluating the testimony, medical and other documentary evidence presented in the case, the Arbitrator finds that the Petitioner sustained a 32.5 % loss of use of the left leg. In support of her finding the Arbitrator notes that the Petitioner is of a young age and will likely have to live with his compromised physical ability throughout his long work life. He is also in a labor intensity job. The Petitioner has returned to full time, unrestricted work with no loss in current earnings. Petitioner's unrebutted testimony was that he works slower and with more effort in accomplishing his work duties. Moreover, Petitioner testified that since certain aspects of his job require movements and activity which provoke symptoms in his knee, that he avoids them when possible. Petitioner testified that crouching, lifting, walking over uneven surfaces and climbing onto and off of vehicles provokes symptoms in his knee. The Arbitrator finds that will likely somewhat

impact Petitioner's future earning capacity as he has diminished use of his right knee. The Arbitrator finds the testimony in this regard to be clear, credible and corroborated by medical evidence.

Lastly, as to the criteria of the AMA ratings, Dr. Forsythe concludes that Petitioner's impairment pursuant to his interpretation of the Guides is 7% Lower Extremity Impairment. The evidence deposition highlights Petitioner's argument that Dr. Forsythe's deposition did not account for Petitioner's medial meniscus tear. The Arbitrator also takes into account the context of Dr. Forsythe's rating and the credible testimony of Petitioner in reaching her conclusion.

Even Dr. Forsythe acknowledged that Petitioner, who has a heavy job, would experience symptoms in his knee more often than an individual with a job which required lighter physical demands. Therefore, taking into account Petitioner's young age and other factors in this favor, the Arbitrator finds that Petitioner's left knee injury resulted in a 32.5 % loss of use of the left leg. Respondent shall pay the sum of $695.78 per week for a period of 82.225 weeks. or $57,210.51 because the injuries sustained caused 32.5 % loss of use of Petitioner's left leg.

Kethi Steffen 2/18/15

Signature of Arbitrator Date

STATE OF ILLINOIS)
) SS.
COUNTY OF Mc LEAN)

☐ 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

Johann Friedmansky,
Petitioner,

vs. No. 13 WC 17656

Show Bus Public Transportation,
Respondent.

15IWCC0865

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 nature and extent 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.

Upon a review of the record as a whole, the Commission modifies the Arbitrator's award of permanent partial disability benefits, from 20% loss of use of the left foot to 15% loss of use of the left foot. The Commission bases its determination on the factors set forth in Section 8.1b of the Act, giving particular weight to: the impairment report submitted pursuant to subsection (a), indicating an impairment level of 8% of the lower left extremity; the Petitioner's age of 71 at the time of the injury; and Petitioner's status as a full-time retiree from the workforce.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner permanent partial disability benefits of $366.07 a week for a period of 25.05 weeks, for the reason that the injuries sustained caused the 15% loss of use of the left foot, as provided in Section 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.

15IWCC0865

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $7,000.00. 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: NOV 2 4 2015

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-10/21/15
jdl/ac
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FRIEDMANSKY, JOHANN
Employee/Petitioner

Case# **13WC017656**

SHOW BUS PUBLIC TRANSPORTATION
Employer/Respondent

15IWCC0865

On 3/26/2015, 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 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0564 WILLIAMS & SWEE LTD
STEVEN R WILLIAMS
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

2904 HENNESSY & ROACH PC
EMILIE MILLER
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

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

Johann Friedmasky
Employee/Petitioner

v.

Show Bus Public Transportation
Employer/Respondent

Case # 13 WC 017656

Consolidated cases: _____

15IWCC0865

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 **Bloomington, Illinois**, on **2-27-15**. 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 **1/10/13**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$34,070.46**; the average weekly wage was **$610.12**.

On the date of accident, Petitioner was **71** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$2,250.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$2,250.00**.

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

ORDER

Pursuant to stipulation of the parties, Respondent shall pay $359.00 representing an underpayment of temporary total disability benefits. The parties further stipulated that there appears to be one charge outstanding of $92.00 to Dr. Keller's office. Respondent stipulated at trial that they would pay this if it does remain unpaid.

Respondent shall pay Petitioner the sum of **$366.07**/week for a further period of **33.4** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **20% loss of use of the left foot.**

Signature of Arbitrator

3/25/15
Date

MAR 26 2015

15IWCC0865

STATEMENT OF FACTS:

On the day of accident, January 10, 2013, Petitioner was employed by Respondent as a bus driver responsible for transporting handicapped and elderly people. As of January 10, 2013 Petitioner had been employed with Respondent approximately six and a half years. Prior to his employment with Respondent, Petitioner was employed by the railroad industry for 40 years as a supervisor in customer service. Petitioner retired from the railroad in 2002.

On January 10, 2013, Petitioner slipped and fell on wet grass while walking from Respondent's office to his bus. Petitioner testified that he twisted his left foot and ankle. Petitioner also testified that prior to January 10, 2013 he had no problems with his left foot or ankle.

On January 11, 2013 Petitioner sought treatment from his family doctor, Dr. Tom Kenney. The doctor noted he fell and hurt his ankle. He had blisters. There was ecchymosis. The blisters were described as severe. (PX2) X-rays taken that same day showed minimally displaced spiral fracture of the lateral malleolus with soft tissue swelling about the lateral malleolus. (PX3)

Pursuant to Dr. Kenney's referral, Petitioner saw Dr. Brett Keller on January 15, 2013. After obtaining a history, reviewing the previously take x-ray and performing an examination, Dr. Keller diagnosed left distal fibula fracture minimally displaced with presence of fractured blisters. Petitioner was placed in a sugartong splint and taken off work with instructions to avoid strenuous activities. (PX5)

Petitioner returned to Dr. Keller on January 18, 2013. Dr. Keller noted ecchymosis, significant drainage from the blisters and positive swelling. Petitioner was placed in a short leg cast. On a return visit on January 25, 2013, the doctor noted Petitioner was using a walker. He had calf tenderness and swelling. There was tenderness of the medial deltoid ligament and tenderness. On February 20, 2013, Petitioner had tenderness to palpation of the lateral aspect of the left ankle. His weight bearing was as tolerated. Petitioner's cast was removed at that time at his request after he had partially removed it himself. Dr. Keller returned him to light duty work. (PX5)

Petitioner returned to Dr. Keller on April 4, 2013. At that time it was noted Petitioner had an antalgic gait. There was swelling laterally and tenderness in the distal fibula. There was reduced range of motion. (PX5) X-rays taken that day showed a displaced obliquely oriented distal fibular fracture. There was also callus formation which suggested healing. (PX3) Petitioner's was continued on light duty work.(PX 5)

On May 16, 2013, Dr. Keller reported that Petitioner had a significant limp and that walking becomes more difficult as the day progressed. There was tenderness of the distal fibula and tenderness of the medial malleolus. A bone stimulator was ordered. By July 11, 2013, Petitioner reported that most of his pain occurred while driving. Also noted was that Petitioner had been using a TENS unit which he felt was not providing much relief. (PX 5) X-rays taken showed a nonunited fracture of the lateral malleolus. Lucency was noted at the fracture site which was deemed to be more prominent than the previous study. (PX 3) On August 15, 2013, Petitioner complained of some pain while driving. There was tenderness of the distal fibula. There was also limited dorsal flexion and limited plantar flexion. Dr. Keller recommended continued use of the bone stimulator. (PX5)

At Respondent's request, Petitioner underwent an impairment rating assessment with Dr. Lawrence Li on January 5, 2014. On examination Dr. Li noted atrophy on the left calf as opposed to the right. There was reduced range of motion between the left and right ankle. Dr. Li gave a lower extremity impairment rating of 8%. (RX 2)

On March 6, 2014, Petitioner returned to Dr. Keller. Petitioner reported continued discomfort at the lateral ankle indicating the pain was more of an annoyance. An examination revealed mild tenderness of the distal fibula with no tenderness medially. Ankle dorseflexion was at -5 and plantarflexion was at 30. The doctor noted that x-rays taken showed distal fibula fracture with slight displacement. Dr. Keller released Petitioner from his care with instructions to advance activities slowly as tolerated. He also recommended Petitioner use Advil or Aleve over the counter for pain and swelling. (PX 5)

On September 12, 2014, Dr. Keller authored a report indicating Petitioner sustained a left distal fibula fracture. Dr. Keller stated there was a causal relationship between the injury and the work accident. The doctor also provided that Petitioner is at risk for developing post traumatic osteoarthritis of the ankle joint. He felt there was a small chance that he may require additional surgery including potentially an ankle fusion depending on his pain. (PX1)

Petitioner returned to Dr. Keller on November 6, 2014. Records show Petitioner's ankle continued to be swollen. Petitioner reported discomfort and irritation. The discomfort was described as burning or numbness in the lateral ankle. The symptoms were worsening with sitting for periods of time and driving. An examination demonstrated tenderness in the distal fibula. There was reduced range of motion of dorsal flexion and plantar function. Dr. Keller diagnosed healed left distal fracture with mild/moderate osteoarthritis of the left ankle. There was noted to be continued mild complaints of pain and that the fracture likely accelerated or irritated the osteoarthritis of the left ankle. Dr. Kelley discharged Petitioner from care with instruction to advance activities slowly as tolerated. A home exercise program was also prescribed. (PX4)

Petitioner testified that he returned to light duty for Respondent in February 2013. He continued to work light duty until he resigned in October of 2013 to pursue full retirement. Petitioner testified that he continues to experience some discomfort in his left ankle in the form of numbness and a burning sensation while sitting.

The only disputed issue in this case is the nature and extent of Petitioner's injuries.

For injuries occurring after September 1, 2011, permanent partial disability pursuant to 835 ILCS 305/8.1(b) shall be assessed using the following criteria:

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

(b) In determining the level of the 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.

Applying this standard to this claim, the Arbitrator concludes as follows:

(i): In this case, the only impairment rating offered in evidence was from Dr. Li. He determined Petitioner had an impairment of 8% of the left lower extremity. The doctor noted atrophy and reduced range of motion.

(ii): Petitioner was employed as a bus driver at the time of the accident. Although, he was able to return to work in his prior capacity, he voluntarily resigned from said employment with Respondent in October 2013. He does not intend to return to the workforce. As such, little weight is given to this factor.

(iii and iv): Petitioner is currently 73 years old. Petitioner resigned his employment with Respondent in October of 2013. As Petitioner has retired and testified he does not intend to return to the workforce, his occupation and future earning capacity is not a significant factor in assessing his disability. The Arbitrator notes Petitioner's age is a factor in assessing his disability as he is 73 years old and will not be living with his disability as long as a younger person.

(v): Petitioner was diagnosed with left distal fibula fracture minimally displaced with presence of fractured blisters. The blisters were described as severe. He treated conservatively for over a period 23 months. Petitioner last saw his treating physician, Dr. Keller, on November 6, 2014. Records show Petitioner's ankle continued to be swollen. Petitioner reported discomfort and irritation. The discomfort was described as burning or numbness in the lateral ankle. The symptoms were worsening with sitting for periods of time and driving. An examination demonstrated tenderness in the distal fibula. There was reduced range of motion of dorsal flexion and plantar function. Dr. Keller diagnosed healed left distal fracture with mild/moderate osteoarthritis of the left ankle. There was noted to be continued mild complaints of pain and that the fracture likely accelerated or irritated the osteoarthritis of the left ankle. Petitioner's complaints at arbitration were consistent with his complaints and the findings of Dr. Keller in November 2014. The Arbitrator therefore gives greater weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 20% loss of use of his left foot pursuant to §8e of the Act.

The Arbitrator notes that pursuant to stipulation of the parties, there is an underpayment of TTD benefits in the amount of$359.00. Respondent, through their attorneys, stated they would issue payment of same. Also, the parties agreed there appears to be one charge outstanding of $92.00 to Dr. Keller's office. Respondent stipulated at trial that they would pay this if it does remain unpaid.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DENA SOLOMON,

Petitioner,

15IWCC0881

vs.

NO: 13 WC 18388

COMBINED INSURANCE,

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, and temporary total disability, and being advised of the facts and law, reverses the Decision of the Arbitrator and finds that Petitioner has failed to sustain her burden of proving a current condition of ill being was caused by her work-related accident.

Findings of Fact and Conclusions of Law

1. Petitioner testified in May of 2013 she worked for Respondent as an Administrative Assistant. "After the file person retired," Petitioner was also given her responsibilities which including maintaining and moving files. They would be moved off-site in "legal boxes." On May 20, 2013, she picked up a heavy box which she estimated weighed 40 pounds and went to put it up on a filing cabinet. She felt a twinge in her right lower back. The Arbitrator noted that Petitioner gestured that she was lifting the box to shoulder level. She asked a coworker to help put the box on a cabinet.

15IWCC0881

2. Petitioner testified she completed her work day but felt "a little pain, not much, nothing." When she got home she took some Advil but did not have any really noticeable pain; it was just achy. When she woke in the morning she had severe pain. She did not go to work that day and made an appointment with Dr. Erulkar, an orthopedic surgeon at Illinois Bone & Joint, whom she saw on May 22nd.

3. Dr. Erulkar ordered an MRI and prescribed medication. That treatment did not provide any relief. Petitioner was then referred to Dr. Alleva who administered an epidural steroid injection, which had no effect. Later Dr. Erulkar referred Petitioner to Dr. Broadnax, a pain specialist. He administered facet injections and then radio frequency ablation. This treatment was minimally helpful. Dr. Broadnax also prescribed Vicodin and physical therapy. She last saw Dr. Broadnax on September 2, 2014.

4. She was currently in hydrotherapy and was to follow up with Dr. Broadnax. She was still taking Vicodin as needed. Currently, regarding her pain "it was one step forward, two steps back." In around 2000 she had two or three treatments for her back. She did not notice anything about her back from 2001 to the accident on May 20, 2013.

5. After a medical examination pursuant to Section 12 of the Act, Petitioner returned to work on September 6, 2013 even though her treating doctor had not released her. Immediately she was informed her job was eliminated and she was fired. Respondent did not offer her any job thereafter. She tried to perform volunteer administrative work for a charity, but had to leave after 20 minutes because of the pain. Her pain was in her low back and down the right leg to the knee. She tried to continue the volunteer work four or five times, but she was sent home because of the pain. She has not looked for work since.

6. Petitioner stated that sometimes the hydrotherapy helps her pain and sometimes it does not. Currently, she feels sharp piercing pain in her right lower back down the back of her right leg, with tingling in her foot.

7. On cross examination, Petitioner was shown the patient intake form she filled out at Dr. Erulkar's office. She acknowledged that the form indicated she did not have previous back problems or diagnostic tests. She also acknowledged that that statement was incorrect. She disagreed that she initially reported that the pain was in her left leg, but stated that could be correct if the medical records so indicated.

8. Petitioner agreed that Dr. Erulkar indicated she was not a surgical candidate. She did not recall that he wanted her to return to work on a limited basis, but that could be correct if the medical records so indicated. It could also be correct that Petitioner was hesitant to return to work. She also did not recall Dr. Erulkar telling her to return to work on July 8, 2013, but that could be correct if the medical records so indicated. She also agreed that she did not inform Dr. Broadnax about any previous back condition.

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9. On redirect examination, Petitioner testified that Dr. Erulkar took her off work and on July 8, 2013 indicated she was off work until further notice. Dr. Erulkar could have recommended she return to part-time with no lifting, and she was hesitant about returning to work but understood that was the best option to return to normal function. However, that did not happen.

10. The medical records show that on February 11, 2000, Petitioner presented to Dr. Cohn complaining of "somewhat diffuse low back pain for seven months;" she had previously elected not to take physical therapy prescribed. X-rays showed some mild facet arthropathy. Dr. Cohn diagnosed "chronic lumbar strain" and prescribed Vioxx. If she did not improve in two weeks he would order an MRI and consider injections.

11. On March 22, 2000, Petitioner reported she was feeling much better after five physical therapy sessions. She can climb stairs without back pain. She still felt her sacral area was "sticking out." Another six physical therapy sessions were requested.

12. Petitioner was treated over the next several years mostly for her knee, ankle, and shoulder/cervical problems. She was also treated for chronic depression.

13. On May 22, 2013, Petitioner presented to Dr. Erulkar complaining of low back pain radiating into the left leg. It started on May 20th when she was "lifting boxes and doors at her workplace and had sudden increase in low back" pain which started to worsen after she got home. She described the "pain as sharp, severe, intermittent, and worsening. She tried Vicodin without lasting relief." Dr. Erulkar noted x-rays showed lumbar degenerative disc disease. He diagnosed L5-S1 radiculopathy and axial back pain. He prescribed Medrol Dosepak, Skelaxin, ice & heat, ordered an MRI, and took her off work until further notice. The MRI showed a diffuse bulge at L3-4 narrowing the foramina.

14. On June 3, 1013, Petitioner reported progressing leg pain. Dr. Erulkar noted that Petitioner was in obvious discomfort. Dr. Erulkar indicated it was "not clear that the disc protrusion that she has is from this particular action although it obviously according to her was exacerbated by her work injury." He prescribed injections and physical therapy.

15. On July 5, 2013, Petitioner reported to Dr. Erulkar that she had some relief from an injection about seven days previously administered by Dr. Alleva. She still had back pain but denied any radiation into the legs or other leg symptoms. Dr. Erulkar recommended that Petitioner continue physical therapy but thought she could return to work on a limited basis with no lifting over five pounds. Petitioner was hesitant but understood that was her best chance of returning back to normal function.

16. On July 23, 2013, Dr. Erulkar noted her follow-up appointment with Dr. Alleva did not go well and they apparently argued about treatment options. She wanted a 2nd opinion. Dr. Erulkar diagnosed axial back pain and facet arthropathy with mild foraminal stenosis.

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Dr. Erulkar referred Petitioner to Dr. Broadnax, a pain specialist, for injections. If that was not successful he would likely start her in a work hardening program. He kept Petitioner off work until further notice.

17. On August 13, 2013, Petitioner presented to Dr. Broadnax reporting pain at 3-10/10 and began after a work-related injury three months previously. Petitioner was 40 years old, 67" and weighed 275 lbs. Dr. Broadnax noted the MRI showed bilateral neuroforaminal narrowing at L3-4, mild stenosis, and facet joint arthropathy. Dr. Broadnax diagnosed degenerative disc disease, lumbar radiculopathy, lumbar stenosis, and lumbar facet arthropathy. He would administer lumbar facet injections upon approval by Respondent.

18. Petitioner reported 50-70% relief after series of injections. On November 19, 2013, Dr. Broadnax performed radiofrequency ablation at L2-5 and he prescribed additional aquatherapy.

19. On March 25, 2014, Petitioner returned to Dr. Broadnax with different symptoms. She reported the return of low back pain but the pain was now radiating down the posterior of the right leg to the foot. Dr. Broadnax ordered a new MRI, which showed L3-4 desiccation from generalized disc bulging and facet arthropathy causing mild spinal and bilateral foraminal stenosis and mild bulge at L4-5 with facet arthropathy but without stenosis. Dr. Broadnax administered an epidural steroid injection at L5-S1.

20. Dr. Broadnax repeated another series of injections and prescribed additional physical therapy. Petitioner last saw him on September 2, 2014. At that time Petitioner still reported 80% relief from the injection and was making slow but steady progress in aquatherapy. She now reported 2-8/10 pain with current level of 3/10. Dr. Broadnax recommended continued aquatherapy.

21. On May 7, 2014, Dr. Broadnax testified by deposition that he is a pain medicine physician board certified in anesthesiology. When he first saw Petitioner she complained of back pain radiating to the back of both thighs and down part of her right leg. She reported no significant history of back pain until some sort of an accident at work three months earlier. Other than obesity she had no other significant issues regarding her back. His examination was relatively benign other than "some lower tenderness." Her MRI showed mostly age-related degenerative disc disease, mild stenosis, and fairly mild spondylosis.

22. Dr. Broadnax's initial suspicion was her facet joints, which sometimes become irritated after a fall. He attributed her pain to that accident because if he recalled correctly she reported she did not have back pain prior to the fall. He recommended lumbar facet injections which are both therapeutic and diagnostic. Her reaction to the injections indicated that her facet joints were contributing to her pain, which was confirmed in later injections.

23. Dr. Broadnax performed radiofrequency ablation on November 19th, which hopefully would provide longer lasting benefit than the injections. By January 22, 2014, he was "looking to kind of wrapping things up a little bit." Petitioner asked for additional aquatherapy and he prescribed it. He "absolutely" thought that was medically necessary.

24. Dr. Broadnax also testified that Petitioner's pain was pretty well managed but on March 25, 2014, she returned with new pain in the right back buttock going down the right leg only. She did not report any specific new injury. While the pain pattern was somewhat different it was not really dissimilar to the pain he had treated her for previously. He thought she may have injured her back in therapy. A new MRI was pretty similar to the previous one. It showed a small bulge at L4-5 that was not mentioned in the first report but her condition had not significantly changed overall. Because the new pain was not in her back but in her leg only, Dr. Broadnax concluded the facet joints were not the source of the pain. She had no significant neural deficits so surgery was not indicated. He administered transforaminal injections and prescribed physical therapy. By April 23, 2014, Petitioner was definitely feeling better. She was to follow up with him.

25. Dr. Broadnax testified that the facet problem had resolved at this stage. Her leg pain, or radiculitis, was likely from nerve irritation. He believed Petitioner could work as long as there was no heavy lifting and could take intermittent breaks and moving around for back pain. Petitioner seemed honest and earnest, and he currently had no reason to doubt her complaints.

26. On cross examination, Dr. Broadnax testified he understood Dr. Erulkar released her from treatment because he did not consider her a surgical candidate. Dr. Broadnax did not "provide any off-work recommendations" to Petitioner. All he knew was that she told him she had a fall at work, but he did not know the precise mechanism of injury.

27. Dr. Broadnax indicated the MRIs did not show acute pathology but essentially mild degenerative disc disease mostly localized around L3-4. Dr. Broadnax agreed that there can be aggravation of symptoms without aggravating underlying pathology, and that aggravation can be temporary. Her initial complaints of back pain were subjective and his examination findings were normal. The MRI findings were age-appropriate and her height and weight could be factors.

28. On redirect examination, Dr. Broadnax testified that as a pain management doctor the nature of his practice involves patients reporting the location of pain to him and the level of pain experienced. Petitioner reported improvement of pain with treatment. It was significant that even though she had preexisting degenerative disc disease she did not report symptoms until the accident. The onset of pain shows a temporal relationship between a traumatic event and symptomology of the condition.

29. Dr. Ingberman performed a medical examination of Petitioner pursuant to Section 12 of the Act on August 27, 2013, reviewed her medical records, and issued a report. She also testified by deposition on June 8, 2014. Dr. Ingberman testified she is board certified in pain management.

30. Dr. Ingberman noted that when Petitioner initially saw Dr. Erulkar she reported pain in the left side. However, later her complaints changed to the right side. The shift in pain reports indicated that "she did not have anything specific that persists on the same side and would be suggestive of something significant, so it is basically a sign that there's some inconsistencies in her presentation, in her complaints, and exaggerated presentation of disability."

31. Dr. Ingberman reviewed the records of Dr Alleva and testified that Petitioner "complained of lower back pain down the right side along the S1 dermatome but had negative straight leg raise and had many non-organic signs, which really would indicate that there is exaggerated pain behavior but nothing to correlate with her complaints."

32. Petitioner reported to Dr. Ingberman that on May 20th she was lifting a heavy box and got halfway. She put it down and asked a coworker for help. Her boss became angry with her because her request could lead to another worker's injury. Petitioner felt he did not care about her and that upset her.

33. Dr. Ingberman also testified that Petitioner did not report any previous issues with her lumbar spine. She had suffered from anxiety and depression and had treated for the conditions since age seven. Petitioner reported her current pain and depression both at 7/10. She stopped seeing a psychologist because of the inability to sit for prolonged periods. She began treating with a psychiatrist. Petitioner reported she could not tolerate physical therapy and injections provided only temporary relief. From her answers on a PDQ, it was "clear she's exaggerated many of her disabilities."

34. Petitioner's job had been 95% working on a computer or at a desk. However, since February of 2013 she was assigned significantly more work including physical tasks such as lifting and moving boxes. She complained to her boss that she was unable to handle the additional work, and the help that was promised her was never available. She felt a lot of pressure to perform.

35. Dr. Ingberman noted that on examination the only non-organic signs Petitioner exhibited were exaggerated pain behavior. The MRI showed a mild disc bulge at L3-4 with very mild foraminal narrowing without neural structure compromise or pressure on the nerve root. Petitioner "definitely had more subjective complaints and she had unremarkable examination and unremarkable MRI." Her diagnosis was "subjective lower back pain not supported by objective findings of any pathology that would cause chronic pain."

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36. Dr. Ingberman concluded that Petitioner's history, behavior, and dissatisfaction with her work environment, "placed her at the perfect position to develop chronic pain complaints without any supportive objective findings." She will continue to complain of chronic pain in spite of any treatment because she is not motivated to return to work. She could return to work at her previous job; there was "no orthopedic contraindication to lifting boxes weighing up to 25 pounds."

37. On cross examination, Dr. Ingberman testified she is not an anesthesiologist. She does not administer injections and refers patients out if they are needed. Her treatment is different than an anesthesiologist because she treats the "whole person" in a "functional approach rehabilitation *** based pain management."

38. Dr. Ingberman explained that "anesthesiologists are trained to treat patients who are asleep." They don't really interact with patients or treat the whole person. Many pain clinics simply push continuing treatment and medication. Petitioner's background "was just perfect for somebody to have chronic pain whether it's work related or non work related." The anesthesiologists do not understand the need to assess these types of factors.

39. Dr. Ingberman agreed that Petitioner worked for Respondent for four years prior to the incident. She did not know whether or not she suffered back pain, but she did have a preexisting condition.

40. On redirect examination, Dr. Ingberman testified even if a patient thinks his/her pain is real that does not indicate you should inject them. One should not perform injections for subjective complaints. "You need to make a diagnosis that is based on correlating subjective and objective data."

41. Dr. Broadnax again testified by deposition on July 14, 2014. He now testified that he did not really recall Petitioner telling him that the mechanism of her back pain was a fall. Hypothetically, the onset of pain while lifting a box would be a mechanism compatible with the symptoms he observed in Petitioner and for which he treated her. That mechanism could aggravate an underlying degenerative condition. There was nothing in his records indicating Petitioner specifically reported the nature of the accident. Petitioner had improved since he last saw her and was doing well. He still believed she needed work restrictions. He hoped that when he saw her again he could release her.

42. On cross examination, Dr. Broadnax testified that there was no indication in his records that Petitioner reported a fall. He did not recall his previous testimony that Petitioner reported to him that she was injured in a fall. He never reviewed her previous medical records. He agreed that pain complaints are subjective and he provided treatment based on Petitioner's subjective complaints.

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In finding Petitioner proved causation of a current condition of ill-being the Arbitrator noted he "closely observed petitioner's demeanor, behavior, and testimony:" and found her credible. He also found the testimony of Dr. Broadnax straightforward and Dr. Ingberman's testimony unpersuasive. He was not impressed with her criticism of anesthesia-based pain management and characterized her testimony as "largely advocatory." The Arbitrator awarded Petitioner temporary total disability benefits to the date of hearing.

The Commission does not completely accept the Arbitrator's assessment of the relative persuasiveness of the testimony of Dr. Broadnax and Dr. Ingberman. Dr. Ingberman had a legitimate point that Dr. Broadnax did not really appear to consider Petitioner's entire history in assessing Petitioner's current condition. He acknowledged that he treated Petitioner based on her subjective complaints.

The medical records are clear that Petitioner suffered from significant long-term depression for which she was treated since childhood. It is well documented that such psychological factors can substantially affect the way in which a patient perceives pain and depressive mood often exacerbates the perception of pain. Therefore, the Arbitrator could have been absolutely correct in his assessment that Petitioner was being truthful about her perception of pain even if her perception was in some way askew.

There are really no objective findings to corroborate Petitioner's subjective pain complaints. Dr. Ingberman noted non-organic and exaggerated pain behaviors and Dr. Broadnax noted that the MRI finding did not show traumatic injury and were actually consistent with age-appropriate degenerative disc disease. There is also absolutely no objective findings that would associate Petitioner's subjective complaints to her work-related accident on May 20, 2013. Once again, the Commission stresses that the MRIs showed no findings suggesting any type of traumatic injury.

Petitioner did suffer a work-related accident/injury on May 20, 2013. However, the Commission finds that she did not sustain her burden of proving that she has a current condition of ill-being that is causally related to that accident. Therefore, the Commission modifies the Decision of the Arbitrator to terminate temporary total disability benefits as of August 27, 2013, the date of Dr. Ingberman's examination and report.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $478.50 per week for a period of 14&2/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

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

15IWCC0881

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $7,000.00. 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: NOV 25 2015

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
O-10/27/15

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Marco Moreno,
Petitioner,

vs. NO. 13 WC 29197

15IWCC0869

DMS Welding & Machine,
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, causation, average weekly wage, temporary total disability, medical expenses and prospective medical expenses, and being advised of the facts and law, modifies the Decision regarding average weekly wage and temporary total disability and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Comm'n*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Commission notes that since Petitioner worked less than 52 weeks during the year preceding the accident, his average weekly wage ("AWW") would be calculated utilizing the third method set forth in §10 of the Act and as enunciated in *Sylvester v. Industrial Commission*, 197 Ill.2d 225, 230-231 (2001). Specifically, "... [w]here the employment prior to the injury extended over a period of less than 52 weeks, the method of dividing the earnings during that period by the number of weeks and parts thereof during which the employee actually earned wages shall be followed..." Along these lines, the wage statement submitted into evidence shows that during the year preceding the injury, Petitioner earned a total of $12,962.38 over the course of 24 weeks (from the week starting July 1, 2012 through the week starting June 30, 2013, and excluding the weeks from July 8, 2012 through January 12, 2013 when he did not work for Respondent). (RX2). The Commission finds that Petitioner failed to prove that he was hired or actually scheduled to work 40 hours a week, particularly during the period in question. Neither Petitioner nor his boss, Mr. Evans, testified that this was in fact his schedule, and the wage statement itself reflects hours worked ranging from 16 to 40 hours a week. Indeed, the record reflects that Petitioner worked an

average of 31.61 hours per week during the year preceding the injury (758.75 hours ÷ 24 weeks). Therefore, the Commission finds that Petitioner's average weekly would be based on full weeks and not the "weeks and parts thereof." (See *Greaney v. Industrial Commission* (2005), 358 Ill.App.3d 1002, 832 N.E.2d 331, 295 Ill.Dec. 190). Accordingly, the Commission modifies the decision of the Arbitrator and finds that Petitioner's average weekly wage was equal to $540.10 based on earnings of $12,962.38 divided by 24 weeks.

Furthermore, the Commission modifies the decision of the Arbitrator to find that Petitioner was temporarily totally disabled from October 28, 2013 through January 3, 2014, or the time Petitioner underwent physician-ordered physical therapy, for a period of 9-5/7 weeks. In his decision, the Arbitrator noted that "Petitioner has medical off work slips for (the period alleged from August 22, 2013 through October 9, 2014) and is entitled to benefits." The Commission notes that a review of the record reveals no such off work slips. Furthermore, none of the office notes or reports by the various providers contains any indication that Petitioner was taken off work by any physician during this period, other than, presumably, the time during which he participated in physical therapy. Indeed, Dr. Jones conceded during the course of his deposition that he was unable to say he took Petitioner off work. (PX6, pp.8-9). Instead, the best he could do was to say that Petitioner's work status at the time of his January 9, 2014 visit was "not currently working." (PX6, p.39). In addition, Dr. Bernardi, Respondent's §12 examining physician, testified that with respect to any work restrictions, he "... could not identify any reasons why [Petitioner] should have activity restrictions, in fact, I think they might be counterproductive. (RX1, pp.32-33). As a result, the Commission finds that Petitioner failed to prove by the preponderance of the evidence that he was restricted from work beyond the period he was participating in the physical therapy program ordered by Dr. Criste, or from October 28, 2013 through January 3, 2014.

All else is hereby affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $360.07 per week for a period of 9-5/7 weeks, as provided in §8(b) of the Act, 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 set forth in PX7 and under §8(a) of the Act, subject to the fee schedule pursuant to §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to prospective medical treatment in the form of the L5-S1 discectomy recommended by Dr. Jeffrey Jones, and Respondent shall pay the reasonable and necessary expenses associated therewith pursuant to §8(a) of the Act, subject to the fee schedule pursuant to §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.

15IWCC0869

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 $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: NOV 2 4 2015

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-10/20/15
jdl/po
68

NOTICE OF 19(b) ARBITRATOR DECISION

MORENO, MARCO
Employee/Petitioner

Case# **13WC029197**

DMS WELDING & MACHINE
Employer/Respondent

15IWCC0869

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:

1167 WOMICK LAW FIRM CHTD
CASEY VAN WINKLE
501 RUSHING DR
HERRIN, IL 62948

0000 RUSIN & MACIOROWSKI LTD
TRICIA J SHELTON
231 W MAIN ST SUITE 2E
CARBONDALE, IL 62901

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Marco Moreno
Employee/Petitioner

v.

DMS Welding & Machine
Employer/Respondent

Case # **13** WC **29197**

Consolidated cases: _____

15IWCC0869

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **10/9/14**. 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. ☒ 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, **7/1/13**, 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 $**12,962.38**; the average weekly wage was $**654.67**.

On the date of accident, Petitioner was **36** 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 $**6825.00** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**6825.00**.

Respondent is entitled to a credit of $**10,564.29** under Section 8(j) of the Act.

ORDER

Respondent shall authorize and make payment for the medical treatment recommended by Dr. Jones, including a microdiscectomy at L5-S1 level of the lumbar spine.

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

12/22/14
Date

ICArbDec19(b)

JAN 5 - 2015

MARCO MORENO v. DMS WELDING & MACHINE

IWCC# 13 WC 29197

15IWCC0869

ATTACHMENT:

FINDING OF FACTS:

Petitioner, Marco Moreno, worked for DMS Welding and Machine on July 1, 2013. Petitioner was working with a piece of metal on a table. Petitioner described the metal piece as weighing around 100 pounds. As Petitioner was moving the heavy piece of metal from the table to the floor, he noticed his back was feeling something but he continued to work.

The next morning, Petitioner went to the emergency room complaing of low back pain and testified that he told the emergency room staff that he had pain into his left leg as well.

On July 2, 2013, Petitioner also saw his family physician, Dr. Salem. He complained of back pain from the day prior and a sense of weakness in his legs.

July 6, 2013, Petitioner returned to the emergency room saying his back pain was getting worse. He was prescribed Percocet and a muscle relaxant and told to follow up with Dr. Salem.

On July 9, 2013, Petitioner called in to Dr. Salem telling them that the pain medication was not effective and he felt worse. Dr. Salem ordered an MRI and referred Petitioner to Dr. Criste, a pain specialist.

On July 22, 2013, Petitioner had an MRI at Memorial Hospital of Carbondale. It was interpreted as showing a broad-based central disc bulge/protrusion at L5-S1.

On August 22, 2013, Petitioner followed up with Dr. Christie who referred him to physical therapy and for a series of epidural steroid injections.

On October 1, 2013, Petitioner had his first epidural injection.

On October 15, 2013, Petitioner had his second epidural injection.

Between October 28, 2013 and December 11, 2013, Petitioner attended 10 out of 12 scheduled physical therapy sessions. At that time work condition was recommended.

On November 19, 2013, Petitioner was referred by Dr. Salem, to Dr. Jeffrey Jones, a neurosurgeon at the Orthopedic Institute of Southern Illinois.

January 9, 2014, Dr. Jones offered Petitioner a discectomy at L5-S1.

Petitioner was taken off work on August 27, 2013 by Dr. Salem and has been under work restrictions from that date until the date of hearing, October 9, 2014 representing 58 weeks.

Issue (C):

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

The testimony of the Petitioner is that on July 1, 2013, he was lifting a heavy piece of metal weighing around 100 pounds and felt pain in his back. This pain increased and Petitioner sought medical attention the next morning. Initially, Petitioner testified that he did not tell the emergency room or his family doctor about his work injury for fear that they would take him off work and he had to work. When Petitioner told Dr. Christie of his work injury on August 22, 2013, he described it in detail and was consistent in his explanation of the injury with every physician after that point.

Arbitrator finds that an accident did occur that arose out of and in the course of Petitioner's employment with Respondent.

Issue (F):

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

The opinions on causal connection were provided by Dr. Robert Bernardi and Dr. Jeffrey Jones.

Dr. Bernardi opines that he has three reasons that he doesn't believe that Petitioner's injury is related to his current condition.

First, Dr. Bernardi says he does not have an explanation for the Petitioner's symptoms.

Second, Dr. Bernardi says his opinion is based on the fact that the first mention of a work injury being with Dr. Christie on August 22, 2013. Petitioner testified that he didn't tell the emergency room or Dr. Salem initially because he wanted to continue to work but it just didn't get any better.

Third, Dr. Bernardi states that he finds is concerning that Petitioner had a previous episode of back problems in 2006 and 2007. Petitioner testified that he indeed had previous back complaints in 2006 and 2007 and was even offered back surgery by Dr. Kee Park. Petitioner testified that he told Dr. Park that he did not want surgery because after one epidural injection he felt much better and didn't have pain.

Dr. Bernardi also recognized that the difference in the MRI's between 2006 and 2007 and the MRI from 2013 was that there was a new broad based disc bulge at L5-S1.

Dr. Jones opines that Petitioner's current condition is causally related to the work injury of July 1, 2013.

Dr. Jones points out that Petitioner's spine on film is pristine except for L5-S1. Dr. Jones says that Petitioner has an L5-S1 disc herniation that looks acute on MRI and is consistent with the timing of the injury and the type of activity that Petitioner was engaged in when he was hurt.

Dr. Jones believes that the disc herniation at L5-S1 is acute and from the work injury based on the high frequency signal that you see in the disc on the MRI. Dr. Jones opines that the high

signal in the disc is the inflammation that shows him that the injury lines up with an injury date that the Petitioner is claiming.Arbitrator finds the opinion of Dr. Jones more persuasive and finds that Petitioner's current condition of ill-being is related to the claimed work injury.

Issue (G):

What were Petitioner's earnings?

From the wage statement (R Ex 2) the Arbitrator finds the Petitioner worked a 40 hour 5 day 8 hour work week i.e. if the Petitioner worked 24 hours in a week that would constitute 3/5s of a week, and that his total wages were $12,962.38.

In this case, Petitioner's schedule had partial weeks and full weeks. Adding the weeks and parts thereof , the Arbitrator determines he worked 19.8 weeks.Dividing $12,962.38 by 19.8 weeks the Arbitrator finds the Petitioner's AWW to be $654.67.

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?

Arbitrator finds that medical services provided to Petitioner have been reasonable and necessary and the charges for those services are the responsibility of the Respondent.

Issue (K):

Is Petitioner entitled to any prospective medical care?

Petitioner has been offered a discectomy at level L5-S1 by Dr. Jeffrey Jones.

Arbitrator finds that Respondent is responsible for Petitioner's prospective medical care.

Issue (L):

What temporary benefits are in dispute?

Temporary total disability benefits are in dispute from August 22, 2013 until October 9, 2013, representing 58 weeks.

Petitioner has medical off work slips for this period of time and is entitled to benefits.

Arbitrator finds Respondent responsible for 58 weeks of TTD.

Issue (N):

Is Respondent due any credit?

Arbitrator finds, Respondent is owed a credit of $6,825.00 for TTD already paid.

Respondent is owed a credit of $10, 564.29 for payments made on medical bills.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Charles Friend,

Petitioner,

vs. No. 13 WC 35877

State of Illinois IDOT,

15IWCC0884

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 issue of the nature and extent of Petitioner's disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission notes that the Arbitrator determined the permanency rate to be $689.97 based on an average weekly wage of $1,034.96. This is incorrect. The correct permanency rate is $620.98 ($1,034.96 x 0.6). The Commission modifies the Arbitrator's decision accordingly.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 12, 2015, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $620.98 per week for a period of 130.5 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 17.5 percent of the person as a whole and 20 percent loss of use of the left leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay all medical expenses listed in Petitioner's Exhibit 19 that were necessary and reasonably related to the accident, directly to the medical providers, pursuant to §§8(a) and 8.2 of the Act.

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

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

Pursuant to §19(f)(1) of the Act there shall be no right of appeal, as the State of Illinois is Respondent in this matter.

DATED: NOV 2 5 2015
d-11/12/2015
SM/sk
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FRIEND, CHARLES
Employee/Petitioner

Case# **13WC035877**

15IWCC0884

STATE OF ILLINOIS IDOT
Employer/Respondent

On 5/12/2015, 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 0.08% 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:

0333 SHAY & ASSOCIATES
TIMOTHY M SHAY
260 E WOOD ST
DECATUR, IL 62523

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9208

5116 ASSISTANT ATTORNEY GENERAL
GABRIEL CASEY
500 S SECOND ST
SPRINGFIELD, IL 62706

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

1430 CENTAL MGMGT SERVICES
WORKERS' COMP MANAGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

MAY 12 2015

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

15IWCC0884

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

Charles Friend
Employee/Petitioner

v.

State of Illinois, IDOT
Employer/Respondent

Case # **13** WC **35877**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Peoria**, on **April 10, 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 _____

FINDINGS

On **January 7, 2013**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**53,817.92**; the average weekly wage was $**1,034.96**.

On the date of accident, Petitioner was **45** years of age, married with **1** dependent children.

Petitioner has received all reasonable and necessary medical services.

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

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $689.97/ week for 130.5 weeks, because the injuries sustained cause the 17.5% loss of the person as a whole, as provided in Section 8(d)(2) of the Act, and 20 % loss of the left leg, as provided in Section 8 (e) of the Act.

Respondent shall pay all medical expenses listed in Petitioner's Exhibit 19 that were necessary and reasonably related to the accident, directly to the medical providers pursuant to the Medical Fee Schedule set forth in Section 8(a) and 8.2 of the Act.

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

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

D. Dlan McCarthy
Signature of Arbitrator

April 30, 2015
Date

MAY 12 2015

STATEMENT OF FACTS

Petitioner works as a highway maintainer for Respondent. On January 7, 2013, Petitioner slipped and fell on ice that had accumulated when another employee washed an ice truck in the Lincoln yard. Petitioner immediately felt pain in his left shoulder, and as the day progressed, he lost immobility in the shoulder as well.

On January 30, 2013, Petitioner presented to Dr. Christopher Rivera, his primary care physician, with complaints of left shoulder, low back, and left hip joint pain. (PX 1). Dr. Rivera diagnosed an acute left rotator cuff sprain and trapezoid muscle strain, prescribed pain medication, and ordered diagnostic imaging. Petitioner testified he waited twenty- three days to present to a physician because he kept hoping his symptoms would naturally diminish. Petitioner is left hand dominant.

Petitioner returned to Dr. Rivera on March 22, 2013 with complaints that his symptoms had not subsided. Dr. Rivera ordered a MRI and physical therapy. The March 27, 2013 MRI revealed a subacromial decompression with surgical resection of the distal clavicle, small glenohumeral joint effusion and a small amount of fluid in the subacromial/ subdeltoid bursa, and mild supraspinatus and infraspinatus tendinosis. (PX 2). Upon review of the MRI, he referred Petitioner to Dr. Stephen Huss, an orthopedic surgeon. (PX 4). Dr. Rivera treated Petitioner until November 19, 2013. (PX 1).

Petitioner underwent physical therapy at Abraham Lincoln Memorial Hospital from April 30, 2013 through May 21, 2013, to treat his neck and shoulder injury. (PX 10).

Dr. Huss treated Petitioner from August 30, 2013 through October 8, 2014. (PX 4). Upon his first visit, Dr. Huss administered a cortisone injection into Petitioner's left shoulder that provided no symptom relief. As conservative treatment had failed, Dr. Huss recommended surgery, which was performed on October **15,** 2013. Dr. Huss performed an arthroscopic surgery, diagnostic examination, and debridement of the torn labrum to the anterior shoulder. (PX 5). The post- operative diagnosis was a partial tear of the anterior and superior labrum and bursitis of the shoulder. The rotator cuff was noted to be normal. (PX 5). Dr. Huss referred Petitioner for physical therapy following surgery.

On September 23, 2013, Petitioner underwent a MRI of the left hip, as ordered by Dr. Huss due to his ongoing symptomatology. (PX 7). The MRI revealed mild osteoarthritis and labral tears. (PX 7).

Petitioner underwent physical therapy at Decatur Memorial Hospital from October 21, 2013 through November 25, 2013, to treat his shoulder injury. (PX 6).

Petitioner also received treatment from Dr. Jacob Sams, an orthopedic surgeon, at Decatur Orthopedic Center, upon referral by Dr. Huss, from October 3, 2013 through September 9, 2014 for treatment of Petitioner's left hip injury. (PX 8). Dr. Sams performed a left hip arthroscopy with debridement of the labrum and osteochondroplasty of the femoral head neck junction on November 25, 2013 to repair his left hip labral tear. (PX 9). Petitioner underwent

post- surgical physical therapy for his hip at Decatur Memorial Hospital from January 9, 2013 through March 7, 2014. (PX 12).

Dr. Huss then referred Petitioner to Dr. Robert Kraus, a neurosurgeon, for treatment for his neck and upper trapezius. (PX 13). Dr. Kraus ordered a MRI of the thoracic spine on February 27, 2014, which revealed left T10-11 degenerative charge of the facet with ligamentum flavum calcification effacing the subarachnoid space contacting and slightly deforming the thoracic cord. (PX 15). Upon examination and review of the MRI, Dr. Kraus diagnosed thoracic region myofascial pain and referred Petitioner for physical therapy for myofascial release. (PX 13).

Petitioner underwent physical therapy at Abraham Lincoln Memorial Hospital from April 1, 2014 through April 17, 2014, to treat his cervical and thoracic injuries. (PX 17).

Petitioner also treated with Dr. Paul Smucker at the Orthopedic Center of Illinois for his cervical and left upper thoracic pain, as referred by Dr. Kraus. (PX 16). A MRI of the cervical spine, as ordered by Dr. Smucker on July 1, 2014, revealed a posterior disk bulging most prominent at C6-7, C5-6, and C4-5, tiny central herniation at C3-4 narrowing the subarachnoid space anterior to the cord in the midline, degenerative changes, and a thyroglossal duct cyst dorsal to and anterior to the hyoid in the midline. Dr. Smucker performed an EMG and administered an epidural steroid injection at the C7/ T1 levels on August 5, 2014. On August 25, 2014, Petitioner returned to Dr. Smucker with complaints that the injection provided no symptom relief. Dr. Smucker recommended that Petitioner see a chiropractor, and the Petitioner testified that the treatment was not approved by the Respondent.

Petitioner testified that he still experiences dull pain where the cervical and thoracic spines meet. He also experiences a stabbing, hot pain in his trapezius that often wakes him up at night. Petitioner has tightness and pain in his upper back between his shoulder blades. Petitioner testified that cold weather irritates his shoulder, but that he performs full body stretches every morning to help ease the pain. He does work at his normal job, and he does not take any pain medications.

CONCLUSIONS OF LAW

In regard to (J), Medical, the Arbitrator finds:

Under Section 8(a) of the Illinois Workers' Compensation Act, an employer is required to provide or pay for "all the necessary first aid, medical and surgical services, and all necessary medical, surgical and hospital services thereafter incurred, limited, however, to that which is reasonably required to cure or relieve from the effects of the accidental injury. " *820 ILCS 305/8(a).*

The Evidence Deposition of Dr. James Stiehl was taken on November 19, 2014. Dr. Stiehl, an orthopedic surgeon and Respondent's Section 12 physician, opined that Petitioner's left trapezius cervical injury was causally related to the January 7, 2013 workplace accident. (RX 1, p. 25). Dr. Stiehl testified that the labrum tear of the shoulder was causally connected to the January 7, 2013 accident. (RX 1, p. 32). Dr. Stiehl also testified within a reasonable degree of medical certainty that Petitioner's anterior labral tear of the hip was causally related to Petitioner's January 7, 2013 workplace injury. (RX 1, p. 42).

Dr. Stiehl opined that the treatment, including the steroid injections, performed by Dr. Smucker, was reasonable and necessary treatment for the cervical spine injury. (RX 1, p. 24; 31). Dr. Stiehl testified that the treatment and surgery was reasonable and necessary for his shoulder condition. (RX **1,** p. 11). Dr. Stiehl opined that the treatment for the labrum tear of the hip was reasonable. The Arbitrator orders Respondent to pay all medical expenses listed in Petitioner's Exhibit 19, directly to the medical providers pursuant to the Medical Fee Schedule set forth in Section 8(a) and 8.2 of the Act and hold Petitioner harmless for any subrogation claims asserted by Petitioner's group health insurer.

With regard to issue (L), Nature and Extent, the Arbitrator finds as follows:

As the accident occurred after September **1,** 2011, the nature and extent of the injury must be determined through the five factor test.

At the request of Respondent, Dr. Stiehl performed an AMA evaluation of Petitioner on August 29, 2014. (RX 1, p. 8)

Dr. Stiehl assigned Petitioner a 4% loss of the person has a whole impairment rating for his labral tear of the shoulder and an impairment rating of 2% loss of the person as a whole for the anterior labral tear of the hip. (RX 1, p. 46). He also assigned a Petitioner an impairment rating of 2% loss of the person as a whole for Petitioner's neck injury. (RX 1, p. 46). Dr. Stiehl did not rate the Petitioner's ongoing left trapezius pain, which he said he found through palpation. (Id at 41) He said that the condition was part of his rating for the neck. (Id at 25) He also opined that the Petitioner could have ongoing pain in the trapezius. (Id at 49)

Dr. Stiehl testified that in his examination, he did not compare the injured and uninjured shoulders. (RX 1, p. 33). Dr. Stiehl did not use a goniometer in measuring Petitioner's range of motion in his shoulder or hip, despite it being the preferred method according the AMA Guidelines. (RX 1, p. 34, 42). Dr. Stiehl testified that there is not a clear- cut guide on assessing hip injuries. (RX 1, p. 42). Dr. Stiehl testified that he did not have Petitioner fill out a pain disability questionnaire for the neck. (RX I, p. 47).

The Arbitrator notes that Petitioner's[3] rated level of impairment does not necessarily

equate to permanent partial disability under the Workers' Compensation Act, but instead is a factor to be considered in making such a disability evaluation. Also, the Guides apparently do not allow for a separate rating to be given to the trapezius injury, which is the area which the Petitioner complained the most about at arbitration, and to all of his treating physicians. Despite the above deficiencies in the doctor's examination, his findings matched those of the Petitioner's treating physicians. Accordingly, the Arbitrator gives moderate weight to the impairment ratings.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, Petitioner has worked as a highway maintainer for Respondent since 2011. Petitioner's job description was introduced into evidence as Petitioner's Exhibit 20. His job is very labor intensive and includes duties such as snow control, cleaning the trucks, filling potholes, jackhammering roads, removing concrete from roadways, and shoveling rock. (PX 20). Petitioner testified that the jackhammers he uses weigh approximately one hundred pounds, and that drive shafts he is responsible for removing from the road weigh approximately sixty pounds. Petitioner's testimony that he notices symptoms when performing this heavy work is credible considering the injuries which were sustained. Therefore, the Arbitrator assigns greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 45 years old at the time of the accident, and is currently 47 years old. The Arbitrator assigns weight to this factor, as the Petitioner will have to work for a number of years with the problems and symptoms referenced above.

With regard to subsection (iv) of §8.1b(b), the Arbitrator notes that Petitioner does not have a potential for a decreased future earning capacity. Therefore, the Arbitrator assigns 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 at the time of the AMA evaluation, Dr. Stiehl testified that Petitioner's difficulty with range of motion in the left shoulder would be a permanent condition as he is at maximum medical improvement. (RX 1, p. 39). Dr. Stiehl noted an ongoing disability with respect to his shoulder condition. (RX 1, p. 42).

Dr. Stiehl testified that Petitioner had extreme pain with his upper trapezius. (RX 1, p. 41). Dr. Stiehl testified that as Petitioner is at maximum medical improvement for his neck injury, his minor pain with strenuous activity is an ongoing and permanent condition. (RX 1, p. 49).

Dr. Stiehl testified that the limitation of rotation of the hip is a permanent condition as he is at maximum medical improvement. (RX 1, p. 47).

Following surgery and physical therapy, Dr. Huss on January 13, 2014 noted slight restrictions in flexion and internal rotation of the shoulder, similar to the above findings of Dr. Stiehl.

Following hip surgery and physical therapy, the Petitioner was found to have significant decreased hip motion in external rotation and abduction, along with a slight loss of strength in external rotation. (PX 12) Dr. Sams at his final visit on March 6, 2014 noted that the Petitioner had an antalgic gait with no complaints of pain. (PX 8)

The Petitioner consistently complained of pain in the left cervical area, concentrating in the trapezius muscle, to Drs. Huss, Kraus and Smucker. (PX 4, 13 and 16)

Based on the above factors, the Arbitrator finds that the Petitioner sustained a permanent partial disability to the extent of 10% loss of use of the person as a whole for the left shoulder, 7.5 % loss of use of the person as a whole for the cervical and trapezius injuries, pursuant to §8(d)(2) of the Act, and 20 % of the left leg, pursuant to Section 8 (e) of the Act., Respondent shall pay Petitioner permanent partial disability benefits of $689.97/ week for 130.5 weeks for said award.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Luis Frausto,
Petitioner,

vs. NO: 13 WC 40782

Munie Leisure Center,
Respondent.

15IWCC0863

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causation, notice, medical expenses and prospective medical care, and being advised of the facts and law, hereby reverses the November 19, 2014 decision of Arbitrator Nowak, whose decision is attached hereto and made a part hereof. The Commission finds that Petitioner failed to prove that his carpal tunnel syndrome is causally connected to his employment with Respondent. In support of its decision on review, the Commission makes findings of fact and conclusions of law as follows.

1. Petitioner began working as a laborer in the construction department at Respondent, Munie Leisure Center, a company in the business of building and servicing in-ground swimming pools, in around 1999. He alleges a work injury, specifically carpal tunnel syndrome, which manifested on November 30, 2012 resulting from repetitive stress to his hands, wrists and fingers. This date is also the last day of his employment with Respondent.

2. After Petitioner left employment with Respondent, he promptly founded his own company, Aqua Works Pool Specialists ("Aqua Works"). Aqua Works is in the same business as Respondent. Petitioner testified that, at Aqua Works, he performed the same kind of activities as at Respondent. (Tr. 27-28).[1]

[1] Citations to the transcript pages of the hearing, Petitioner's exhibits and Respondent's exhibits are styled "Tr. ___," "PX __" and "RX __," respectively. Citations to the transcript pages of the evidence depositions of Dr. Harley Mirly and Dr. Mitchell Rotman are styled "Mirly Dep. ___" and "Rotman Dep. ___," respectively.

3. Petitioner testified that installing pools required hand intensive work. For the pool floor, a mixture of vermiculite and "Portland cement" must be spread, leveled and compacted across the bottom, using trowels gripped in both hands. A one-piece vinyl liner is then affixed over the interior of the pool. Petitioner, who is right-handed, testified that he used his right hand to apply pressure to the vermiculite/cement; he used his left hand mostly to smooth it out. He testified that the installation of vinyl liners required that he drag the vinyl liner across the pool and affix the liner into tracks at the pool's edge, using his hands to hold, grip and twist the heavy liner in the process. (Tr. 12-16, 12; PX 5).

4. Petitioner testified that the busy season for pool construction is mid-March through October or November. While employed at Respondent, Petitioner worked 50 to 55 hours per week, six days per week during the busy season. He installed 30 to 40 pools, and applied 60 to 70 liners per season. He spent about two hours per day (or 12 hours per week) troweling, and spent 11 hours per week working with vinyl liners. During the remainder of the year (the slow season), Petitioner would perform other tasks in connection with servicing pools. (Tr. 11, 13, 18-22, 37-38).

5. Petitioner testified that, while employed by Aqua Works, he installed fewer pools per busy season. He installed "five or six" pools in 2013, Aqua Works' first year in business. In 2014, he installed eight to ten pools. At the time of the hearing, Petitioner was still making his living installing pools for Aqua Works. (Tr. 27, 35-36).

6. As to his symptoms, Petitioner testified that he had begun experiencing numbness and pain in his hands, wrists and fingers in 2010, symptoms that would wake him at night. He observed that troweling activities would make the symptoms flare up. During the months of the slow season, when he was not required to work weekends, he noticed the pain would abate during these weekend breaks; however, the pain would recur when he returned to work. These symptoms allegedly continued throughout 2010, 2011 and 2012. Petitioner testified that he orally notified his immediate supervisor, Tom Greenwald, in 2010 about what he was experiencing, and he told Respondent's owner, Michael Ford, in 2011. (Tr. 20-23). These oral notifications are asserted by Petitioner as constituting notice of accident to the employer in his Request for Hearing.

7. Petitioner sought treatment for his symptoms for the first time when he visited Dr. Mirly on December 3, 2013 – more than a year after leaving employment with Respondent -- and obtained a diagnosis of bilateral carpal tunnel syndrome on that day. This was the first and only time he saw Dr. Mirly. The doctor recommended bilateral carpal tunnel release surgery, which Petitioner seeks to undergo. On the patient intake form, in the blank marked "Employer," Petitioner wrote "Munie Leisure Center (previously)." He did not identify Aqua Works as his current employer. (Tr. 25, 32-34; PX 1).

8. On December 10, 2013, "Employer's First Report of Injury" was generated by Michael Ford and is the only written notice to Respondent of Petitioner's injury in evidence. (RX 2).

After review of the record as a whole, the Commission finds Petitioner failed to prove that his current ill-being is causally connected to his employment with Munie Leisure Center. As noted above, more than a year had passed between Petitioner's last day of employment with Respondent and when he first sought treatment and obtained a diagnosis of carpal tunnel syndrome. During that intervening year, Petitioner was doing identical work for a subsequent employer – a company founded and owned by Petitioner himself. Even assuming *arguendo* that his work activities of building pools were a causative

factor in his carpal tunnel syndrome, Petitioner has not proven by a preponderance of the evidence that his carpal tunnel syndrome arose from his employment with Respondent and not with his more recent employer (i.e., himself).

The Commission's determination in this regard is supported also by the independent medical evaluation of Dr. Mitchell Rotman. Dr. Rotman examined Petitioner pursuant to Section 12 of the Act on July 7, 2014 and testified by way of evidence deposition on September 19, 2015. While Dr. Rotman agreed with Dr. Mirly that Petitioner had carpal tunnel syndrome, Dr. Rotman noted that Petitioner's carpal tunnel syndrome was "in the milder stages." (Rotman Dep. 12). In his written report, the doctor noted also "there is certainly no hurry to proceed with operative treatment considering the mild nature of his condition." (Rotman Dep. Exhibit 2). Regarding causation, Dr. Rotman stated that it would be impossible to render an opinion with a reasonable degree of medical certainty. The doctor explained that, since Petitioner's neurometric test results were "mild, in fact, borderline," and since there was no contemporaneous medical documentation that Petitioner had suffered symptoms prior to December 3, 2013, much less prior to November 30, 2012, it was not possible to determine whether Petitioner's carpal tunnel syndrome related to employment at Respondent or to his more recent employment at Aqua Works. (Rotman Dep. 12-14). Notably, Petitioner told Dr. Rotman that his symptoms started in the summer of 2012, his last summer with Respondent. (Rotman Dep. 7-8; Rotman Dep. Exhibit 2).

The Arbitrator had found credible Petitioner's testimony that his symptoms began in 2010 during his employment with Respondent. In his decision, the Arbitrator *sua sponte* fixed the date of accident (manifestation date of repetitive trauma injury) at December 3, 2013. The Arbitrator explained, "This is the date Petitioner saw Dr. Mirly and first became aware of the true nature of the injury he had suffered and the causal relation of his injury to his employment with the Respondent." (Arbitrator's Decision p. 6). In so doing, the Arbitrator was also able to find that the only written notice in evidence – the "Employer's First Report of Injury" dated December 10, 2013 proffered by Respondent -- was timely. In short, the Arbitrator modified both the date of accident and the date of notice from those originally asserted by Petitioner in order to arrive at an outcome favorable to Petitioner. (As noted above, the original date or dates of notice asserted in Petitioner's Request for Hearing were based on his alleged oral notifications to his supervisor and Respondent's owner in 2010 and 2011.) The Arbitrator modified the date of accident purportedly to conform to the evidence. However, the Arbitrator's finding actually is inconsistent with the evidence. Petitioner testified that: (1) his symptoms were so severe that they would wake him at night, beginning in 2010; (2) troweling work made his symptoms flare up; and (3) he noticed that, right after weekend breaks during the slow season, his symptoms would abate, but then return when he resumed work. In light of this testimony, it cannot reasonably be claimed that Petitioner neither understood the fact of his injury nor its causal relationship to his employment until Dr. Mirly told him so.

The Commission does not find Petitioner credible. His delay in seeking treatment, coupled with his failure to identify his current employer during his visit with Dr. Mirly, negatively color his credibility before the Commission. The evidence contained in the record makes it apparent that Petitioner's primary objective in seeing Dr. Mirly was to obtain a diagnosis precedent to filing a workers' compensation claim. Dr. Mirly's records of the December 3, 2013 visit and his deposition testimony of May 9, 2014 indicate that Petitioner had in mind the procurement of authorization for surgery via a worker's compensation claim against Munie Leisure Center at the time of that first and only visit. (Mirly Dep. 17; PX 1).

15IWCC0863

For the foregoing reasons, the Commission finds Petitioner failed to prove by a preponderance of the evidence that he sustained a compensable accident in connection with his employment with Respondent.

Benefits denied. All other issues are moot.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 19, 2014, is hereby reversed. Benefits 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: NOV 24 2015

o-10/21/15
jdl/ac
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Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

NOTICE OF 19(b) ARBITRATOR DECISION

FRAUSTO, LUIS
Employee/Petitioner

Case# **13WC040782**

MUNIE LEISURE CENTER
Employer/Respondent

15IWCC0863

On 1/26/2015, 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:

0384 NELSON & NELSON
NATHAN LANTER
420 N HIGH ST PO BOX Y
BELLEVILLE, IL 62222

0283 JELLIFFE FERREELL DOERGE ET AL
KELLY R PHELPS
108 E WALNUT ST PO BOX 406
HARRISBURG, IL 62946

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)

LUIS FRAUSTO
Employee/Petitioner

v.

MUNIE LEISURE CENTER
Employer/Respondent

Case # **13 WC 40782**

Consolidated cases: _____

15IWCC0863

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Collinsville, IL**, on **11/19/2014**. 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. ☒ 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 _____

15IWCC0863

FINDINGS

On the date of accident, **12/03/13**, 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 **$47,407.88**; the average weekly wage was **$911.69**.

On the date of accident, Petitioner was **34** years of age, **married** with **0** dependent children.

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

Respondent shall be given a credit of **$0.00** 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 reasonable and necessary medical services of $87.00, as set forth in Petitioner's Exhibit 8 as provided in Sections 8(a) and 8.2 of the Act. Respondent shall also pay for prospective medical services as recommended by Dr. Mirly pursuant to the fee schedule.

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

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

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

Signature of Arbitrator

01/09/2015
Date

ICArbDec19(b)

JAN 26 2015

FINDINGS OF FACT

On the date of hearing Petitioner was 36 years old, married, and had no dependent children. Petitioner is right-handed. He worked for Respondent for almost 13 years. Petitioner was a laborer in the construction department. His job involved building, servicing, and repairing outdoor swimming pools. The job had a busy season generally starting in March and ending in November, depending on the weather. During the busy season Petitioner worked about 50 to 55 hours per week during his six day work week. During these months they would install 30 to 40 pools. There would generally be two or three employees working on a pool. During the slow season there was work, but they did not work as many hours.

Petitioner's job duties included shaving the walls of a hole smooth with a shovel, after the hole was dug with a Bobcat. Petitioner's job also involved pouring and troweling Portland cement and vermiculite concrete to make the footing and walls of the pool. This required Petitioner to trowel Portland cement and vermiculite concrete with a hand trowel in each hand. Petitioner testified the vermiculite concrete is spongy, soft, and absorbs a lot of water. Its consistency is totally different from concrete. Troweling it required Petitioner to apply force to compact it while troweling to make sure the vermiculite concrete stayed tight. When working on the bottom of a pool, Petitioner would have to use a lot of force to make the vermiculite smooth. When making the sides of the pool, he would push the vermiculite concrete up to make it tight. Petitioner would perform the troweling an average of 2 hours per day. Petitioner identified three photographs (PX 5, p. 1-3) as showing his hand holding a trowel which was the same or similar to the trowel he used while working for the Respondent. Petitioner testified that while working for the Respondent he held and used the trowel in the manner shown in the photographs. Petitioner identified one more photograph (PX 5, p. 6) as showing the manner in which he would trowel vermiculite concrete and Portland cement along the bottom of a pool.

Petitioner's job also involved the installation of vinyl liners for the pools. During the busy season, Petitioner would install vinyl liners an average of 11 hours per week. They would install 60 to 70 vinyl liners per year. Petitioner explained each vinyl liner is the size of the pool. The liner would be drug across the pool and installation would begin by attaching the liner to the pool's edge. Petitioner would kneel and use his hands to put the liner's edge into a track that went around the pools edge. Petitioner testified he would have to grab the liner with both hands and hold it tight because it would get heavy to lift. Petitioner identified two photographs (PX 5, p. 4-5) as accurately showing the type of holding and twisting that he would do with his hands when installing the liner.

During the busy season, Petitioner's job also required Petitioner to install pool plumbing, haul equipment, dig trenches from the pool to the pump filter by hand, use a jackhammer to break concrete, and install covers using an impact drill.

Petitioner testified in 2010 he began to notice numbness in both hands, especially at night. He also experienced pain in his hands. Petitioner testified these symptoms began in 2010 and continued through 2011 and 2012. Troweling would cause the symptoms to flare up because troweling required use of more strength with his hands. Petitioner testified that he told his immediate boss Todd Greenwald about his symptoms in 2010. Petitioner further testified that he told Michael Ford, Respondent's owner, about his symptoms in 2011. When Petitioner would be away from the job for a few days or over a weekend his hands would feel better. When he returned to work, the symptoms increased.

Petitioner's last day of work for Respondent was 11/20/12. At that time he was experiencing pain and numbness in his hands. Petitioner had not sought any medical treatment for his symptoms up to that point.

After 11/30/12, Petitioner started his own company, Aqua Works Pool Specialists, building swimming pools. He didn't build as many pools as he had while working for the Respondent because he didn't have as much business. In the first year running his own business, he installed 5 to 6 pools. Petitioner testified he and another worker, and sometimes two other workers who would install a pool. Petitioner's busy season consisted of a much lower volume of work than the busy season with the Respondent. Petitioner testified he installed about 8 to 10 pools in 2014.

Petitioner contacted the office of Dr. Mirly, an orthopedic surgeon, in August 2013, but Dr. Mirly could not see him until December 2013. Petitioner testified he told Dr. Mirly when his symptoms began and about his job duties for the Respondent. Dr. Mirly's records indicate Petitioner was a 35-year-old ambidextrous male who had complaints of bilateral hand numbness with both hands hurting for about 3 years. He believed Petitioner had classic symptoms of carpal tunnel, which were consistent with his physical exam. Dr. Mirly's diagnosed bilateral carpal tunnel syndrome and recommended bilateral carpal tunnel release surgery. (PX 1, p. 4; PX 9, p. 8) Dr. Mirly's understanding of Petitioner's job duties for the Respondent included installing swimming pools that required Petitioner using his hands intensively while troweling and installing vinyl liners. (PX 9, p. 8) Dr. Mirly opined that Petitioner's job duties for the Respondent were a significant causative factor in the development of Petitioner's carpal tunnel syndrome. (PX 9, p. 9) When asked a hypothetical question which was consistent with Petitioner's testimony at the hearing, Dr. Mirly testified the facts in the hypothetical further reinforced his opinion that Petitioner's work for the Respondent was a significant contributing factor to Petitioner's development of carpal tunnel syndrome. (PX 9, p. 11-15) Dr. Mirly testified he had experience with troweling and stated the motion of Petitioner's hands while troweling was similar to that of meat cutting, which is "a classic occupation with carpal tunnel syndrome". (PX 9, p. 15) He explained use of the trowel requires a change in wrist motion with fingers being flexed forcefully. (PX 9, p. 15)

Dr. Rotman performed a Section 12 examination at Respondent's request on 07/07/14. The history taken by Dr. Rotman indicated Petitioner worked for the Respondent and he felt that his carpal tunnel symptoms came on while working. (RX 1, p. 7) Dr. Rotman notes Petitioner's symptoms started in the summer of 2012 and he had worked for the Respondent since 1999. (RX 1, p. 8) Dr. Rotman felt Petitioner did have typical complaints of carpal tunnel. (RX 1, p. 9) He performed neurometric tests using a hand-held nerve study device. (RX 1, p. 10) Dr. Rotman's diagnosis of Petitioner's condition was bilateral carpal tunnel syndrome. (RX 1, p. 12) He agreed Petitioner would benefit from carpal tunnel releases. (RX 1, p. 12) When asked if he could state, within a reasonable degree of medical certainty, whether Petitioner's job activities for the Respondent caused or contributed to cause Petitioner's carpal tunnel Dr. Rotman indicated he could not due to the lack of documentation of complaints in medical records from the time of his employment with Respondent. (RX 1, p. 13) The Arbitrator notes it is apparent that Dr. Rotman was basing his opinions on the assumption that Petitioner did not exhibit symptoms while working for Respondent. This assumption is contrary to the unrefuted testimony of the Petitioner which the Arbitrator finds credible. Dr. Rotman admited the Petitioner's job duties for the Respondent could aggravate carpal tunnel syndrome, especially during the busy season. (RX 1, p. 17) Dr. Rotman also opined that if Petitioner told his boss that he was having some numbness and tingling in both hands, it would be fair to say his job duties with the Respondent aggravated Petitioner's symptoms. (RX 1, p. 17-18) Dr. Rotman also acknowledged that if Petitioner's symptoms at the time of the section 12 exam in July 2014 were the similar to the symptoms Petitioner had while working for the Respondent, it is possible Petitioner had carpal tunnel while working for Respondent. (RX p. 20-21,)

Petitioner testified that his symptoms, which began in 2010, have never gone away completely. He further testified he did not know his hand symptoms were work related until after he saw Dr. Mirly on 12/03/13. At the time of hearing he was still having pain and numbness is his hands and wrists and wanted to undergo the

surgeries as recommended by Dr. Mirly. The Arbitrator finds the testimony of the Petitioner credible and persuasive.

The Employer's First Report of Injury is dated 12/10/13. (RX 2) It indicated Petitioner was employed by Respondent from 01/02/01 through 11/30/12 as a swimming pool installer.

CONCLUSIONS OF LAW

Issues (C&F): Did Petitioner suffer an injury that arose out of and in the course of his employment, and if so, is Petitioner's current condition of ill-being causally related to the injury?

In a repetitive trauma case, the issues of accident and causation are intertwined. *Elizabeth Boettcher v. Spectrum Property Group and First Merit Venture,* 99 I.I.C. 0961 (1999).

There is no standard threshold which a claimant must meet in order for his or her job to classify as sufficiently "repetitive" to establish causal connection. *Edward Hines Precision Components v. Indus. Comm'n*, 825 N.E.2d 773, (2d Dist. 2005). The Court expressly stated, "There is no legal requirement that a certain percentage of the workday be spent on a task in order to support a finding of repetitive trauma." *Edward Hines*, 825 N.E.2d 773 at 780, (2d Dist. 2005); *see also Dorhesca Randell v. St. Alexius Medical Center*, 13 I.W.C.C. 0135 (2013); *All Steel, Inc. v. Indus. Comm'n*, 582 N.E.2d 240 (2d Dist. 1991). Even when a claimant's work activities are varied, it has been held that "repetitive" is not defined as performing one or two monotonous tasks; rather, "repetitive" refers to the rigorous use of an extremity throughout employment, even though the tasks performed may vary. *City of Springfield v. Illinois Workers' Comp. Comm'n*, 901 N.E.2d 1066, (4th Dist. 2009).

The tasks performed by Petitioner in his work for Respondent as a Pool Installer were hand intensive both in terms of the quantity and quality of the activities performed. Petitioner performed these hand intensive tasks for Respondent for almost 13 years. The Arbitrator found Petitioner to be a credible witness. Petitioner's testimony is consistent with the medical records of Dr. Mirly. Dr. Mirly opined that Petitioner's job duties for the Respondent were a significant causative factor in the development of Petitioner's carpal tunnel syndrome. Dr. Rotman testified that if Petitioner's symptoms in July 2014 were similar to the symptoms Petitioner had while working for the Respondent, it is possible Petitioner had carpal tunnel while working for Respondent. Petitioner testified in the months before his final day of work for the Respondent on 11/30/12, Petitioner felt pain and numbness in his hands. Petitioner also testified his symptoms, after starting in 2010, have never gone away. He still has pain and numbness is his hands and wrists. Thus, Petitioner symptoms in 2014 were similar to the symptoms Petitioner had while working for the Respondent and Petitioner did have carpal tunnel while working for the Respondent. The Arbitrator finds the testimony of Petitioner with regard to the onset and progression of his symptoms to be credible. Further, the Arbitrator finds the testimony of Dr. Mirly with regard to the relationship between Petitioner's employment with Respondent persuasive.

Based upon the foregoing, and the record taken as a whole, the Arbitrator finds Petitioner suffered an injury which arouse out of and in the course of his employment with Respondent and that his current condition of ill-being is causally related to that injury.

Issue (D): What as the date of the accident?

The manifestation date in a repetitive trauma claim can be set as: **(a)** the date the employee actually became aware of the physical condition and its relation to work through medical consultation; **(b)** the date the employee requires medical treatment; **(c)** the date on which the employee can no longer perform work activities; or **(d)** when a reasonable person would have plainly recognized the injury and its relation to work. *Durand v. Industrial Commission*, 862 N.E.2d 918 (Ill. 2006), *see also Peoria County Belwood Nursing Home v. Industrial Commission*, 505 N.E.2d 1026 (Ill. 1987); *Oscar Mayer & Co. v. Industrial Commission*, 531 N.E.2d 174 (4th Dist. 1988); *Three "D" Discount Store v. Industrial Commission* 556 N.E.2d 261 (4th Dist. 1989).

In short, the courts have recognized three groups of claimants: (1) those who do not recognize that their symptoms are related to work; (2) those who have a "suspicion" that they may have a work related condition, along with a "sketchy and equivocal understanding" of the condition; and (3) those who know they have a work related condition, but diligently work through their progressive condition until it requires treatment. All three groups are given protection under the Act by virtue of the Supreme Court's ruling in *Durand*. The Supreme Court's ruling in *Durand* emphasized: "[t]he purpose behind the Workers' Compensation Act is best served by allowing compensation where an injury is gradual but linked to the employee's work," *Durand v. Indus. Comm'n*, 862 N.E.2d 918 at 925; "the 'fact of injury' is not synonymous with the 'fact of discovery'" *Id.* at 927.

Although a claimant may have complained of symptoms in the past, or even sought treatment in the past, his or her injuries have not "manifested" if there is no evidence that the claimant was aware that the injuries complained of were *related to work. Durand v. Industrial Commission*, 862 N.E.2d 918 (Ill. 2006); *Three "D" Discount Store v. Industrial Commission* 556 N.E.2d 261 (4th Dist. 1989).

The claimant in *Durand* was aware of her symptoms and even suspected that they were related to her employment; however, she was not fully aware of what injury she had suffered or the causal relation of her injury to her employment. *Durand v. Industrial Commission*, 862 N.E.2d 918 (Ill. 2006). Therefore, her injuries had not "manifested." *Id.*

The Arbitrator concludes the date of accident of this repetitive trauma claim is 12/03/13. This is the date Petitioner saw Dr. Mirly and first became aware of the true nature of the injury he had suffered and the causal relation of his injury to his employment the Respondent. The fact that this date of manifestation is subsequent to the last day Petitioner worked for Respondent is not fatal to Petitioner's claim. In *Jeff Broshears v Menard Correctional Center*, 13 IWCC 63 (2013) the Commission found that an employee who's injury manifested itself on August 18, 2010, but who had retired from his employment with the Respondent in February, 2008 was entitled to compensation. *See also, A.C. & S. v. Industrial Commission*, 304 Ill. App. 3d 875 (1999)

Issue (E): Was Timely Notice of the Accident Given To Respondent?

The Arbitrator concludes Petitioner did provide timely notice of the accident to the Respondent. Respondent's Exhibit 2, Illinois Form 45: Employer's First Report of Injury, dated 12/10/13, is well within 45 days of the 12/03/13 date of accident.

Issue (J): Medical Expenses

There was no real disagreement between Dr. Mirly and Dr. Rotman as to the appropriateness of the treatment provided. The Arbitrator concludes all of the medical treatment provided to Petitioner was reasonable and necessary and Respondent is responsible for the medical bill of Dr. Mirly in the amount of $87.00 incurred as a

result thereof. Respondent is to pay the medical bill identified in Petitioner Exhibit 2 as provided in Section 8(a) of 8.2 of the Act subject to the fee schedule.

Issue (K): Prospective Medical Care

There was likewise no real disagreement between Dr. Mirly and Dr. Rotman as to the appropriateness of the treatment recommended going forward. The Arbitrator concludes Petitioner is entitled to prospective medical care as recommended by Dr. Mirly, including bilateral carpal tunnel releases and all concurrent and subsequent related treatment. The need for this prospective care is not refuted. Dr. Mirly and Dr. Rotman both agree that the diagnosis of Petitioner's condition is bilateral carpal tunnel syndrome and that Petitioner would benefit from surgery.

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

ADAM NETH,

Petitioner,

15IWCC0877

vs. NO: 14 WC 10

SM SERVICE GROUP,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, temporary total disability, and medical expenses both current and prospective, 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 parties stipulated to employment relationship, accident, and notice. The Arbitrator found that Petitioner did not prove causation to a current condition of ill being of his right ankle. She awarded Petitioner 23&4/7 weeks of temporary total disability benefits, granted Respondent credit of $22,703.68 for temporary total disability payments and $206.64 for medical payments, denied prospective medical treatment, and did not award any permanent partial disability benefits. Petitioner did not preserve the issue of permanent partial disability because he argues he has not yet reached maximum medical improvement and seeks prospective treatment in the form of testing for complex regional pain syndrome ("CRPS") and possible treatment for that condition.

The Arbitrator awarded temporary total disability benefits to February 14, 2014, when he was released to light duty which was compatible with his current profession as a locksmith. Dr. Lin had treated Petitioner for an injury to his foot/ankle. He last saw Petitioner on February 4, 2014. At that time he noted that a bone scan was normal and his determination of whether Petitioner achieved maximum medical improvement would be determined after an assessment for possible CRPS. He recommended the assessment because MRI results could not explain Petitioner's residual subjective complaints of pain.

15IWCC0877

Petitioner was examined by Dr. Vinci on March 19, 2014 pursuant to Section 12 of the Act. He noted Petitioner walked with a very slow cadence using a cane on the right side. He stated he was unable to bear his weight on his right foot. Clinically, there appeared to be no difference between the right and left foot, though he had 4/5 strength in the right foot. Petitioner tried to guard on ankle range of motion testing and Dr. Vinci noted no grinding, cracking, or popping. Petitioner stated the ankle was tender with motion. Dr. Vinci believed the initial diagnosis of right ankle sprain was appropriate and was still appropriate. There was no clinical evidence to support a diagnosis of CRPS. He thought Petitioner suffered from symptom magnification. He noted that he observed Petitioner in the parking lot walking briskly and bearing his full weight on his right foot when getting into a car which was a different presentation than his displaying ambulation impairment during the exam.

The Commission concludes that there was no basis for suspecting Petitioner suffered from CRPS. The Commission finds that Petitioner was at maximum medical improvement as of his last visit to Dr. Lin on February 4, 2014. At that time Dr. Lin deferred his determination of whether Petitioner achieved maximum medical improvement pending a CRPS evaluation. However, the Commission concludes that such an evaluation was ultimately unnecessary as determined by Dr. Vinci in his examination. The Arbitrator was correct in denying prospective medical testing/treatment and denying permanent partial disability benefits. In addition, the Commission modifies the award of temporary total disability benefits to terminate it as of February 4, 2014, the date of Petitioner's last visit to Dr. Lin.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $709.14 per week for a period of 22 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $15,000.00. The party commencing the 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: NOV 2 4 2015

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
O-10/27/15
46

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0877

NETH, ADAM
Employee/Petitioner

Case# **14WC000010**

SM SERVICE GROUP
Employer/Respondent

On 12/12/2014, 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 0.09% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2333 WOODRUFF JOHNSON & PALERMO
DEXTER J EVANS
4234 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

0507 RUSIN & MACIOROWSKI LTD
KISA P STHANKIYA
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

15IWCC0877

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ADAM NETH
Employee/Petitioner

Case # 14 WC 00010

v.

S.M. SERVICE GROUP
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 Jessica A. Hegarty, Arbitrator of the Commission, in the city of Chicago, on September 12, 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 __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. **Other: Prospective Medical**

15IWCC0877

FINDINGS

- On August 15, 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 the Respondent.
- Petitioner's current condition of ill-being ***is not*** causally related to the accident.
- In the year preceding the injury, Petitioner earned $55,312.92; the average weekly wage was $1,063.71.
- On the date of the accident, Petitioner was 39 years of age, ***single*** with 2 child 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 $22,703.68 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for non-occupational indemnity disability benefits, for a total credit of $22,703.68.
- Respondent is entitled to a credit of $206.64 under Section 8(j) of the Act.

ORDER

1. Respondent shall pay Petitioner temporary total disability benefits of $709.14 per week from September 3, 2013 through February 14, 2014 which is the period of TTD for which compensation is payable.

2. Respondent is due credit for TTD overpayment in the amount of $6,991.66. This is equivalent to $1,518.31 for payments made from August 19, 2013, to September 3, 2013 while Petitioner continued to work for the Respondent. This also includes a credit for $5,473.35 that was paid from February 14, 2014, to March 19, 2014, when Petitioner was found to be at MMI by the Arbitrator.

3. Respondent is granted a Section 8(j) credit for 206.64 the amount previously paid by its group 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.

Signature of Arbitrator

Date: 12/11/14

DEC 12 2014

15IWCC0877

STATE OF ILLINOIS)
)SS
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ADAM NETH
Employee/Petitioner

v. Case # 14 WC 00010

SM SERVICE GROUP
Employer/Respondent

DECISION OF ARBITRATOR

FINDINGS OF FACT

The parties stipulated to: accident, whether the accident arose out of and in the course of employment and notice. (Arb.1)

Respondent disputes causal connection, prospective medical care and TTD. (Id.).

Petitioner testified that he was employed by Respondent as a locksmith for approximately two months before his alleged accident. He testified that his job duties included stringing conduit, re-keying locks, opening safes and door locks, and driving.

On August 15, 2013, Petitioner testified that he was working on a ladder when he lost his balance and fell onto the ground landing directly on his right ankle. He finished the job without seeking medical attention.

Petitioner testified he awoke the next day and experienced excruciating pain in his right foot when he attempted to get out of bed. Petitioner called the Respondent to report his injury and advise that he would not be at work that day. Petitioner testified he called his personal physician, Dr. James McCreary and told him he was "going back on narcotics". Petitioner testified that he had leftover narcotics from a prior shoulder surgery.

Petitioner reported to work on August 17, 2013. He testified that he felt he could work if he was medicated. While picking up supplies at a hardware store, he had difficulty walking and advised the Respondent that he was going to the emergency room.

August 17, 2013, Rush University Medical Center records reflect Petitioner's complaints of pain with weight bearing. The records note an accident history consistent with Petitioner's testimony at the hearing. X-rays of the ankle were negative for fracture. Petitioner was diagnosed with a

right ankle sprain/strain. His right foot and ankle was wrapped in an Ace bandage and he was instructed to follow up with an orthopedic surgeon. (PX3)

Petitioner testified that he continued to work full duty for the Respondent through September 3, 2013. He was paid his full pay during this time. He testified that he also received temporary total disability checks that he cashed.

Petitioner testified that he made an appointment with orthopedic specialist, Dr. Johnny Lin at Midwest Orthopaedics at Rush but could not get an appointment until September 3, 2013. Dr. Lin previously treated Petitioner at Midwest Orthopedics for his left shoulder.

On September 3, 2013, Dr. Lin noted Petitioner's complaints of pain, stiffness, swelling, numbness and weakness in his right foot. Petitioner demonstrated decreased range of motion and right heel pain. The doctor noted that Petitioner was taking Norco that had been previously prescribed by Dr. McCreary for Petitioner's shoulder. Dr. Lin diagnosed a right foot and heel contusion, ankle pain and a plantar fascia strain. Dr. Lin recommended the use of a walking boot, prescribed therapy and recommended a sedentary work capacity due to the level of pain reported by Petitioner. (PX2)

Petitioner testified that he called Respondent and advised of his sedentary work restrictions and was told that Respondent could not accommodate them.

Petitioner had physical therapy on September 5 and 6, 2013, but suspended therapy due to being hospitalized for an episode of pancreatitis. (PX2)

On September 23, 2013, Petitioner presented to Teren E. Hawk, APN. This was in regards to pancreatic and ankle pain. Petitioner presented for a follow up after a hospitalization for pancreatitis. He was diagnosed one week prior. In regards to his ankle injury, Petitioner reported that on August 15, 2013, he injured his right ankle. Petitioner reported that he was put on disability at work and it was recommended that he do sedentary work. The records reflect that he reported marijuana use and that he consumed one beer a day. Petitioner reported that his boss told him that no sedentary jobs were available. Petitioner reported that after finding this out he began binge drinking because he was very upset. He only had the job for 90 days. Petitioner reported that the stress was driving him nuts. Petitioner also reported that he began smoking once again due to stress. On examination, Petitioner had pain in his right ankle and was walking with a limp. Petitioner was diagnosed with pancreatitis, anxiety, well controlled GERD, and an ankle sprain. Petitioner was advised to follow up with orthopedic surgeon in October in regards to his ankle sprain.

On October 1, 2013, Dr. Lin noted Petitioner's continued complaints of pain in his right foot especially with first steps in the morning. Petitioner reported that he was using a cane for ambulation. Petitioner reported that he was not achieving any relief with physical therapy. Dr. Lin ordered an MRI of Petitioner's right foot. (PX2)

On October 8, 2013, Petitioner had an MRI of his right foot. Dr. Lin reviewed the MRI on the same day and found no evidence of fracture, the plantar fascia was found not to be ruptured and

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there was no evidence of any tendon tears. Dr. Lin's diagnosis remained unchanged: a right foot and heel contusion, ankle pain and a plantar fascia strain. Petitioner was to restart physical therapy. The doctor also recommended continued use of the walking boot. (PX2)

Petitioner underwent a course of physical therapy from October 10, 2013, to November 20, 2013. (PX2)

On November 8, 2013, Petitioner presented to his general physician, Dr. McCreary who noted Petitioner's chief complaints were pancreatitis and ankle pain. Petitioner reported marijuana use and a beer every day. Petitioner requested a refill of his medications for his ankle pain. Petitioner described his pain as aching and stabbing. The pain was moderate.

Dr. Lin prescribed work conditioning that Petitioner participated in from December 2 to December 18, 2013.

On December 19, 2013, Petitioner had a functional capacity evaluation ("FCE") that was deemed valid by the therapist. The FCE placed Petitioner at the light physical demand work level. (PX2)

On December 3, 2013, and January 14, 2014, Dr. Lin's records confirm that Petitioner continued to complain of diffuse pain on December 3, 2013, and January 14, 2014, over the anterolateral aspect of the ankle and over the ATFL and CFL in the peroneal tendons. Dr. Lin recommended a bone scan. The doctor suggested an evaluation by a pain doctor for complex regional pain syndrome ("CRPS") if the bone scan was negative. Petitioner was released to return to work within the limits of the FCE. (PX2)

On January 22, 2014, Petitioner underwent a bone scan which was negative. (PX2)

On February 4, 2014, Dr. Lin noted Petitioner's complaints of ankle and foot pain along with plantar fascia pain. Petitioner was again given a limited duty release. It was again recommended he see a pain management physician for possible CRPS. That was the last time Petitioner saw Dr. Lin. (PX2)

On March 17, 2014, Petitioner underwent an IME with Dr. Vinci. Petitioner testified that Dr. Vinci only saw him for five minutes. He testified that Dr. Vinci pushed on Petitioner's foot 2-3 times. He testified that he was honest about his pain complaints to Dr. Vinci.

Petitioner testified that Yana Blanke, his business partner, drove him to the appointment as he was medicated. Petitioner testified that he did review Dr. Vinci's report and did not believe he was faster leaving Dr. Vinci's office. When his attorney asked him why he disagreed with the statement, Petitioner testified that the reason he was walking faster leaving the office was because he was walking with paper booties on hard tile while he was at Dr. Vinci's office and when he was leaving the office he was back in his regular shoes. He testified that he never would have bore weight on his right ankle as there was an excruciating pain.

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On June 6, 2014, Dr. McCreary noted that Petitioner presented in regards to his ankle injury. Petitioner reported that he had been dismissed from workers' compensation in a letter stating that he was faking his injury. Petitioner reported that since workers' compensation would not pay he was dismissed from his orthopedic treating physician and physical therapy. Petitioner reported alcohol and marijuana use. Petitioner was using a cane to walk. Petitioner denied swelling but felt his muscles were smaller. Dr. McCreary recommended Petitioner undergo some diagnostic tests. Petitioner declined. Petitioner desired pain relief. Dr. McCreary recommended Gabapentin and Norco. Dr. McCreary limited Petitioner's Norco to 180 per month.

Petitioner testified that his right ankle on the day of trial was at a pain level of 5-6/10. At the time of trial, he was taking Capizam topically, Hydrocodone, Gabapentin, Valium, Advil Omeprazole and two sprays of antihistamine. He testified that Dr. McCreary had been prescribing him this medication throughout the duration of his work injury. He testified that his pain currently was the same as what he reported to Dr. Lin. He testified that he wanted the CRPS evaluation. He felt symptoms of tingling and numbness.

Petitioner testified that he had difficulty performing everyday tasks. He was unable to do his dishes as he could not stand on his two feet. He could not do anything that required two hands. He testified that he had two children but that it was difficult to see them. He only saw them once a year prior. He testified that he could not wear any above ankle shoes. It was difficult to put pants on. He used a cane to walk and had one with him at the time of trial. He denied being prescribed the cane.

Petitioner testified that he had one drink per week. When asked if in 2010, he reported to Dr. McCreary that he was drinking 10-12 drinks a day, Petitioner testified that he could not recall that. He testified that was how much he drank when he was in his teens. Petitioner denied taking recreational drugs. He admitted that he did smoke marijuana but had not for 90 days. He testified that he smoked marijuana one time a week. He smoked when marijuana was made available to him but he did not seek it out.

Yana Blanke

Yana Blanke testified on behalf of the Petitioner. She testified she was born on August 4, 1956. She was mutual friends with the Petitioner for the past 15 years. Petitioner lived on the second floor of their home. The home was purchased in partnership with the Petitioner. She testified that she was aware of Petitioner's August 15, 2013, work injury. Since that date, she observed Petitioner having pain going up and down stairs. Petitioner used to help cook and grill but no longer was able to help around the house. She testified that she accompanied Petitioner to his medical appointments. She went to his IME appointment in March of 2014 with Dr. Vinci. She testified that she stayed in the waiting area. She testified that he did not walk differently while he was in the waiting area versus when he was outside of Dr. Vinci's office. She testified she only observed him bear weight on his left foot. She had not seen him bear any type of weight on his right foot. She did not believe Petitioner was someone to exaggerate symptoms.

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On cross-examination, Ms. Blanke testified she had known Petitioner for a long time. Petitioner helped around the house. Petitioner occasionally helped clean. Petitioner also helped with the payment of the mortgage.

Deposition of Dr. Lin

Dr. Lin testified via evidence deposition on July 21, 2014. He testified that he was a board certified orthopedic surgeon that did not diagnose or treat CRPS. (PX1, Tr. 20) Dr. Lin testified that he could not find anything upon examination of Petitioner to be consistent with the level of pain that Petitioner reported. He testified that he never prescribed Petitioner a cane. (PX1, Tr. 29) He testified that Petitioner's X-rays and MRI films were negative. (PX1, Tr. 29) He believed there was some reduced uptake within the extremity seen on the bone scan. (PX1, Tr. 29) During the course of his physical examinations of Petitioner's foot he did not notice any changes in skin color, temperature or abnormal swelling. (PX1, Tr. 30-31). Dr. Lin testified that he made the referral for the pain management because Petitioner was not recovering as expected for the mechanism of injury. (PX1, Tr. 37) Dr. Lin testified that Petitioner could return to work as a locksmith for the Respondent based on Petitioner's light duty restrictions. (PX1, Tr. 34,36) Dr. Lin testified that Petitioner's current condition of ill-being was caused by the work accident. Dr. Lin testified that he recommended Petitioner undergo an evaluation for CRPS with a pain management specialist. (PX1, Tr. 23-4)

Deposition of Dr. Vinci

Dr. Vinci testified on behalf of the Respondent. He testified that he was board certified podiatrist (RX1, Tr.5) He testified that he did evaluate and treat CRPS patients. The doctor estimated that less than 1% of his patients are being treated for CRPS. (RX1, Tr.7) He testified that CRPS can be diagnosed based on the physical exam that is supported by diagnostic testing. (Id.) He testified that CRPS presents with symptoms of erythema, swelling and restriction in the range of motion of the extremity. (RX1, Tr.8) The diagnostic testing would be a bone scan that shows increased flow consistent with hyperemia. (Id.) Dr. Vinci testified that he examined the Petitioner on March 19, 2014, noting that Petitioner's gait during his exam was different from when he observed him through the window walking to a car after the exam. (RX1, Tr.11) Petitioner was walking much faster and with a brisk pace and was pivoting and shirting with full weight on his right lower extremity getting into a vehicle. (RX1, Tr.12) Dr. Vinci noted no biomechanical abnormality to Petitioner's foot. (RX1, Tr.13) He noticed no integumentary changes in his exam between the feet of skin color, hair growth, nails and any type of lesions. (RX1, Tr.14) He noticed no circulatory or blood flow changes. (Id.) He noticed no neurological changes. Finally, he found no musculoskeletal changes. (RX1, Tr.15) He reviewed the bone scan and found it to be negative. (RX1, Tr.42) He testified that the bone scan did not contain osseous lesions or increased blood flow. (Id.) These findings would support a CRPS diagnosis. (RX1, Tr.41-42)

After completing his physical exam and reviewing the medical records, Dr. Vinci diagnosed Petitioner with status post ankle sprain. (RX1, Tr.17) He believed Petitioner's condition had resolved and that Petitioner was at MMI. (Id.) He did not believe Petitioner had a potential

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diagnosis for CRPS. (RX1, Tr.18) His basis for his opinion was that there was no finding upon physical examination or diagnostic testing to support a CRPS diagnosis. (Id.) He opined that the X-ray would have shown some spottiness or osteoporosis should Petitioner have had CRPS. (Id.) He testified that Petitioner needed no further treatment and could return to work as a locksmith based on the FCE. (RX1, Tr.20-21)

Dr. Bach's and Dr. McCreary's Records from 2010

On July 26, 2010, Dr. James McCreary, Petitioner's noted that Petitioner presented for the first time in several years for a check-up. Dr. McCreary noted Petitioner's affect was "strange". The doctor asked Petitioner if he was using illicit drugs which Petitioner vehemently denied. Petitioner reported drinking twelve beers a day. (RX6)

On July 30, 2010, Dr. Bernard Bach performed surgery on Petitioner's left shoulder. (PX2)

On August 9, 2010, Dr. Bach noted that Petitioner:

> *[P]resented a chronicle of the medications he has taken over the course of the last 10 days with regards to narcotics, anti-inflammatory medication, and muscle relaxants. He clearly has pain issues. He has no findings to suggest nerve injury or early RSD.* (Id.)

Dr. Bach noted that he thought Petitioner may have some longstanding pain issue with respect to the left shoulder which may explain the need for an excessive amount of medication after surgery. Dr. Bach explained to Petitioner that since Petitioner was out of pain medication, the doctor would provide Petitioner with one additional pain prescription and that will be it. The doctor noted that if Petitioner needed a referral to the Pain Service he would consider making the referral. (Id.)

On August 23, 2010, Dr. Bach noted that a typical patient would not have been in pain postoperatively for as long as Petitioner had complained of pain. The doctor also noted that there was no evidence of CRPS.

On August 31, 2010, Dr. McCreary noted that Petitioner presented in tears. The doctor noted that Petitioner was "literally crying, he said he was in so much pain." The doctor noted that Petitioner had an orthopedic procedure on his left shoulder that left him in substantial pain. He reported drinking twelve beers a day. The doctor prescribed Norco, 10/325 mg, 1 tablet, every 4 hours, for Petitioner's pain. (Id.)

On September 13, 2010, Dr. Bach provided Petitioner with a referral to Rush Pain Center regarding his chronic pain and pain out of proportion. He noted that Petitioner did not appear to have RSD or CRPS.

On September 27, 2010, Dr. McCreary noted that Petitioner presented with Ringworm. Dr. McCreary noted that "his story is so confusing...[i]t's just a very chaotic story." The doctor noted that Petitioner was so upset that he was crying. Petitioner reported drinking twelve beers a day. Dr. McCreary indicated that Petitioner should consider antidepressants if something as

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benign as ringworm puts him to the point of tears. Petitioner refused. The doctor noted that Petitioner was not a stable person and recommended he see a counselor.

FINDINGS

F. Causal Relationship

The Arbitrator does not find Petitioner's current condition of ill-being related to the August 15, 2013 injury.

The Arbitrator notes that Petitioner's medical records reflect a pattern of diffuse pain complaints and pain complaints deemed disproportionate by his treating doctor's with Petitioner's right foot injury.

The Arbitrator notes Petitioner's prior left shoulder treatment in 2010 with Dr. Bach and Dr. McCreary reflects Petitioner's pain complaints that both doctors deemed disproportionate to the injury.

The Arbitrator notes that during the Arbitration hearing the Arbitrator noted that throughout the hearing, Petitioner's demeanor and affect was strange. Petitioner appeared to be over medicated. The Arbitrator did not find Petitioner to be a credible witness based on her observations at the hearing. The Arbitrator also notes inconsistencies between Petitioner's testimony regarding his alcohol use and the medical records of Dr. McCreary.

The Arbitrator finds the opinions of Dr. Vinci more persuasive than Dr. Lin. Dr. Vinci testified that he diagnosed and treated CRPS. He did not find any objective findings upon physical examination to support Petitioner's subjective complaints of pain and a CRPS diagnosis. The Arbitrator further notes, that Petitioner's treating physician, Dr. Lin did not find any objective findings upon physical examination to support a CRPS diagnosis such has changes in skin color, temperature, edema or restricted range of motion. The Arbitrator notes that Petitioner's subjective complaints of pain were not consistent with a CRPS diagnosis. Dr. Lin testified and his records reflect that Petitioner made diffuse complaints of pain. Dr. Lin denied Petitioner making complaints of pain that is consistent with CRPS such as numbness, tingling, burning or stabbing pain. Moreover, Petitioner's diagnostic tests consisting of x-rays, MRI, and bone scan were negative. The Arbitrator agrees with Dr. Vin's analysis of Petitioner's diagnostic studies in that they show no pathology for CRPS.

Based on the foregoing, the Arbitrator finds Petitioner at maximum medical improvement as of February 14, 2014, for a right ankle sprain when Dr. Lin released Petitioner with light duty restrictions that fell under his job title of a locksmith.

C. Past Medical Expenses

Petitioner provided medical bills for medical services in relation to his August 15, 2013, work accident. (PX6). Petitioner received continual treatment for his right ankle from the day after

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his work accident through February 4, 2014, at which time Dr. Lin recommended a CRPS evaluation that Respondent has denied. Dr. Lin testified that all of the Petitioner's treatment, was reasonable and necessary to treat Petitioner's right ankle work injury. Dr. Vinci also agreed that Petitioner's treatment to-date was reasonable. (RX1, 20:22 to 21:4).

Having found for the Petitioner on the issue of causation and based upon the testimony of both Dr. Lin and Dr. Vinci, the Arbitrator finds that all medical services provided to Petitioner thus far have been reasonable and necessary. Based upon the medical bill workup identified as Petitioner's Exhibit No. 6, it appears all bills have been paid up to the date of trial in this matter.

The Respondent shall receive a credit under Section 8(j) of the Act for the payment of $206.64 made by Petitioner's group insurance for medical services received relating to the work accident.

(K) Prospective Medical Care

Pursuant to the Arbitrator's finding that Petitioner achieved MMI on February 14, 2014, the Arbitrator denies prospective medical care.

(L) Temporary Total Disability

The Arbitrator finds Petitioner at MMI as of February 14, 2014. Respondent's Exhibit 5 reflects that Petitioner was paid temporary total disability benefits from August 19, 2013, through March 19, 2014.

The Arbitrator notes that Petitioner testified working and receiving his full pay until he was restricted from work by Dr. Lin on September 3, 2013. Dr. Lin released Petitioner on February 14, 2014 with light duty restrictions that fell under his job title of a locksmith.

The Arbitrator awards TTD benefits from Respondent in the amount of $709.14 per week for the time period of September 3, 2013, through February 14, 2014.

The Arbitrator awards Respondent a credit for temporary total disability benefits in the amount of $6,991.66. This is equivalent to $1,518.31 for payments made from August 19, 2013, to September 3, 2013 while Petitioner continued to work for the Respondent. This also includes a credit for $5,473.35 that was paid from February 14, 2014, to March 19, 2014, when Petitioner was released by Dr. Lin with light duty restrictions that fell under his job description of a locksmith.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

IRIS ALICEA,

Petitioner,

15IWCC0875

vs.

NO: 14 WC 30835

CHICAGO TRANSIT AUTHORITY,

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 issue of accident, and being advised of the facts and law, changes the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

As indicated above, this matter was arbitrated under §19(b) of the Act. The Arbitrator found that Petitioner failed to meet her burden of proving a compensable accident. The Commission affirms that finding. However, in the "ORDER" section of the decision, the Arbitrator included the language that "in no instance shall this award be a bar to subsequent hearing and determination of any additional amount of medical benefits or compensation for a temporary or permanent disability, if any." Because the claim was denied in its entirety, the matter will not be remanded for determination of any additional benefits and therefore the decision does bar subsequent awards. Therefore, the Commission strikes the above quoted language from the "ORDER" section of the Decision of the Arbitrator.

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IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 15, 2015 is hereby affirmed and adopted with the changes noted above.

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

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: NOV 2 4 2015

Ruth W. White

Joshua D. Luskin

RWW/dw
O-10/28/15
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Dissenting Opinion

I must respectfully dissent and would find that Petitioner has proven that she sustained accidental injuries arising out of and in the course of her employment on September 13, 2014. Petitioner testified that on the date of her injury she was operating a CTA blue line train to the O'Hare Airport station. Petitioner drove her train to the O'Hare Airport stop where she was scheduled to switch trains to operate another train that was waiting for her at the O'Hare terminal. The train that Petitioner brought in to the O'Hare Airport station was going to be operated by another rail transit operator who boarded the train at the southernmost head car, located 8 train cars away from the train car that Petitioner drove into the station.

When Petitioner began to exit the train, a passenger stopped her and asked her for directions. Petitioner used a short range radio to call her control center and ask for directions of her passenger. After asking for directions, Petitioner stepped off the train, but then realized that she left her operator keys in the train motor cab. Petitioner re-entered the train to retrieve her keys. Petitioner called the train operator on the short range radio to tell him to hold the train because she was still on board to retrieve her keys. However, at that time, the doors closed and the train began moving.

Petitioner then pulled the emergency ball to open the door and allow her to alight the train. Although pulling the emergency ball will allow the train to eventually stop, the train first slows down and starts dragging prior to stopping. While exiting the train, Petitioner tried to press the reset button in order to close the doors and allow the train to keep moving. When she exited the train, Petitioner lost her balance and fell onto the platform. Petitioner injured her right knee, right toe, and back in her fall.

Petitioner testified that her purpose in exiting the train was to be on time to operate the next train which was leaving the O'Hare terminal shortly thereafter. When she exited the moving train, her only thought was to make sure that she was in position for the next train that she needed to take out. When she pulled the emergency ball to exit the train, she knew that the train would not have been able to stop right away. Petitioner pressed the door reset button while exiting the train so as to not cause a delay for the operator who was taking out the train.

Percy Fry, the general manager of the CTA blue line, also testified in this matter. Mr. Fry testified that while there existed methods of reversing and gapping trains in the event a train operator gets stuck on a train, an individual operator cannot make the decision to reverse or gap a train. Mr. Fry testified that Petitioner was clocked in at work at the time of her injury and was not on a break. Mr. Fry testified that Petitioner was performing her work duties at the time of her injury and that she was permitted to pull the emergency door release as part of her job duties.

Although the Arbitrator properly found that whether Petitioner broke a safety rule is not relevant in this case, he nevertheless found that "Petitioner was not furthering the interests of her employer when she imperiled herself" and that her "conduct took her outside of the sphere of her employment and constituted a deviation from her actual work activities." (Arb. Dec. at 5).

The majority has affirmed the Arbitrator who found that Petitioner exposed herself to an unnecessary personal danger similar to the claimant in Dodson v. IC, 308 Ill.App.3d 572 (1999). In Dodson, the claimant had clocked out, exited her employer's building, and proceeded down several steps of the concrete sidewalk leading to the employee parking area. (Id. at 574). However, it was raining hard so she left the sidewalk and walked across a grassy slope to reach the driver's side of her car because it was the most direct route to her car door. (Id.) While walking on the sloping grassy path, the claimant fell backwards on her right foot and broke her ankle. The Commission concluded that:

> [C]laimant's injuries resulted from exposure to an increased personal risk. She chose to take a shortcut to her vehicle and walked down a grassy slope that was ostensibly wet and icy from rain. Claimant did so instead of proceeding down the unobstructed stairs and sidewalk, both of which the employer provided for employees' ingress and egress. This was a voluntary decision that unnecessarily exposed her to a danger entirely separate from her employment responsibilities. Moreover, her choice was personal in nature, designed to serve her own convenience and not the interests of employer.

(Id. at 576-7). The majority of the appellate court held that the Commission's finding that the employee voluntarily exposed herself to an unnecessary personal risk only for her own convenience was not against the manifest weight of the evidence.

The Arbitrator also cited the Commission decision of Geyer v. Aardvark Builders, 14 IWCC 901 (10/17/14). The claimant in Geyer had locked himself out of his employer's building and testified that he needed to get back inside to coordinate several jobs that were going on that day. The claimant was able to enter an indoor stairwell/hallway area of the building and proceeded to stand on the back of a chair, moved ceiling tiles out of the way, and pulled himself up and over a wall partition. He then lowered himself onto a "lookout" structure and then

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jumped down about eight feet to the floor, injuring his left foot. (Id. at 2-3). The Commission found that this situation was similar to Dodson and that the claimant "chose a very dangerous activity to try to get into the offices he had locked himself out of" and that his "job description clearly did not include breaking into Respondent's offices by using a chair to climb over a high wall, to squeeze through a very small area and to then jump down from at least eight feet above the ground." (Id. at 8).

In contrast to Dodson and Geyer, the case at bar is more similar to Gerald D. Hines Interests v. IC, 191 Ill.App.3d 913 (1989), in which the claimant was injured while trying to access a subbasement using a "hatchway" because he had locked his keys in the subbasement and had to adjust the air-conditioning unit at 5p.m. in order to avoid damage to the machinery. Instead of braking into a glass key box for extra keys or calling security or management to have the doors unlocked, Petitioner attempted to lower himself into the room by hooking an industrial mop bucket onto an electric hoist and, ultimately, he fell. (Id. at 915). The court explained that:

> The Commission found that claimant, although using needlessly dangerous entry into the subbasement, was acting consistent with what his employer had wanted him to do as part of his daily routine. The Commission rejected the argument that claimant's acts were purely personal. Thus, we reject Hines' factual argument that claimant's purpose in acting 'was not for the benefit of his employer.'

(Id. at 917). The court further noted that "[i]t has long been recognized that one of the act's objectives was to do away with defenses of contributory negligence or assumed risk. Recklessly doing something persons are employed to do which is incidental to their work differs considerably from doing something totally unconnected to the work. [Citations omitted.] It matters not how negligently the employee acted, if at the time he was injured he was still within the sphere of his employment and if the accident arose out of it. [Citations omitted.]" (Id.)

Petitioner's situation in the instant case is clearly distinguishable from Dodson and Geyer. First, Petitioner was still "clocked in" at work and not leaving for the day. Second, Petitioner re-entered the train to retrieve her "operator keys," which were necessary for her job, and not to retrieve some personal item. Third, Petitioner's motivation for exiting the moving train was not to get home quickly or to avoid the rain or for some other personal convenience but, rather, an attempt to be on time to operate the next train, which is in furtherance of Respondent's interests. Fourth, Petitioner's injury occurred on the train platform, a place she was required to be in the performance of her duties; not a place of her own choosing such as a grassy slope (Dodson) or climbing through a ceiling (Geyer). Fifth, Petitioner's job required her to regularly alight from trains. Whether Petitioner injured herself while the train was stationary or, as in this case, moving, it was still a necessary function of her job duties and clearly represents a risk incidental to her employment, unlike Geyer whose job did not require him to scale walls and jump eight feet to the ground or Dodson, in which the claimant chose a dangerous shortcut to her car after work.

Based on the above, Petitioner has proven that her actions were not purely for her own personal interest and, to the contrary, did further the interests of Respondent. Alighting from her

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train to be in position for her next train is clearly incidental to her work as a train operator and performing her job in a negligent or careless manner does not automatically remove her from the sphere of her employment nor does it mean that the accident did not arise out of employment. The comparisons to Dodson and Geyer are misplaced and those holdings were incorrectly applied to this case. Therefore, the Arbitrator's decision should be reversed on the issue of accident and benefits awarded to Petitioner.

Charles J. DeVriendt

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

15IWCC0875

ALICEA, IRIS
Employee/Petitioner

Case# **14WC030835**

CHICAGO TRANSIT AUTHORITY
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:

4564 ARGIONIS & ASSOCIATES LLC
GEORGE ARGIONIS
180 N LASALLE ST SUITE 2105
CHICAGO, IL 60601

0515 CHICAGO TRANSIT AUTHORITY
ANDREW ZASUWA
567 W LAKE ST
CHICAGO, IL 60661

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STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Iris Alicea
Employee/Petitioner

v.

Chicago Transit Authority
Employer/Respondent

Case # **14 WC 30835**

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 **October 31, 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 **September 13, 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 *was* given to Respondent.

In the year preceding the injury, Petitioner earned $**65,936.00**; the average weekly wage was $**1,268.00**.

On the date of accident, Petitioner was **47** years of age, ***single*** with **1** dependent child.

ORDER

Benefits are denied, because petitioner did not sustain an accidental injury that arose out of her employment with Respondent.

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

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

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

Milton Black

Signature of Arbitrator

January 15, 2015
Date

JAN 15 2015

FACTS

Petitioner testified that on September 13, 2014, she was employed as a train operator for Respondent. Petitioner testified that on that date she drove a train to the O'Hare terminal. Petitioner testified that once she reached the terminal, she was scheduled to switch trains and operate another train. Petitioner testified that after stopping her train in the terminal, she was approached by a customer who asked for directions. Petitioner testified that she assisted the customer by calling on her radio to control headquarters. Petitioner testified that after exiting the train car she realized that her operator keys were still on the train. Petitioner testified that she then re-boarded the train and called the operator on the radio to ask him to hold the train but that the train began

moving. Petitioner testified that she then pulled the door release ball to open the train doors so that she could step off onto the platform. Petitioner testified that while she was stepping off the train she also pressed the door reset button. Petitioner testified that she exited the train in order to catch the next train at the O'Hare terminal that she was scheduled to operate. Petitioner testified that she pressed the door reset button while exiting the train to close the doors and to not cause a train delay.

Petitioner testified that she lost her balance and fell while exiting the train, striking her right toe, right knee, and left wrist on the train platform, and twisting her back. Petitioner testified that she reported the incident to her supervisor, Saul Ayala, and sought immediate medical treatment.

Petitioner was transported to the emergency room at Resurrection Medical Center, where she complained of pain in her low back pain, right knee, and right great toe. X-rays were negative for fractures. Petitioner was diagnosed with a right knee contusion, right great toe contusion, and lumbosacral strain, and she was provided a prescription for pain medication.

Petitioner testified that she followed up with her primary care physician, Dr. Anne Franke Locatelli. Petitioner testified that Dr. Locatelli placed her on work restrictions of no lifting greater than 10 pounds, no operating heavy machinery, and no sitting or standing for more than one hour. Petitioner testified that she was referred to Dr. Mark Lorenz, an orthopedic specialist, for her lower back injury and to a podiatrist for her right toe injury.

Petitioner testified that she underwent an examination by Dr. Lorenz, who recommended physical therapy and a lumbar spine MRI as well as instructing her to stay off of work.

Petitioner testified that she remains off work due to her injury, that she continues to have pain and physical limitations, and that she requires ongoing medical treatment.

On cross examination, Respondent played a video (RX1). The video showed the actual occurrence of Petitioner pulling the door release, pushing the reset button, and stepping off the moving train. Petitioner testified that there is a rule book but that she is not aware of anything in the rule book regarding alighting from a

moving train. Petitioner testified that prior to her injury she had never alighted from a moving train. Petitioner testified that she knows not to get off a moving train. Petitioner testified that she is aware of the procedures regarding reversing crews and gapping trains.

On redirect examination, Petitioner testified that when the emergency door release is pulled, the train does not stop right away but moves slower and starts dragging.

Percy Fry, Respondent's general manager, testified. He testified that he is rail safety trained. He testified that a rulebook is given to all employees in rail operations. He testified that employees are made aware of the rule prohibiting alighting off a moving train. He testified that in his experience, he has never had an instance of an employee stepping off or alighting from a moving train. He testified that if an employee is late, there are procedures to keep the trains on schedule. He testified that one method is reversing crews, wherein train crews switch schedules. He testified that another method is gapping trains, wherein a train operator is taken by a different train, to the next stop at the Rosemont station train yard.

On cross examination, Mr. Fry testified that a supervisor, the control center, or a manager makes the decision to reverse crews and that it is done on a case by case basis. He testified that an operator would not make that decision. He testified that Petitioner was permitted to pull the door cherry under certain conditions. He testified that he didn't know what purpose Petitioner had in mind and that he only heard her testimony. He testified that based on her written report he had did have an idea of why Petitioner exited the train in the manner she chose.

On redirect, Mr. Fry testified that train operators should be aware that they should not alight from a moving train. He testified that it was likely that Petitioner was aware of the safety rule prohibiting alighting off a moving train.

ANALYSIS

The core issue of the case is whether or not Petitioner's sustained an accident that arose out of the employment.

Respondent alleges that the violation of a safety rule bars this claim. However that is not the law. See *Chadwick v. Industrial Comm.*, 179 Ill. App. 3d 715 (4th Dist. 1989), wherein an employee failed to wear a safety belt. Respondent citations include *Saunders v. Industrial Comm.*, 189 Ill. 2d 623 (2000). However, *Saunders* involved an employee 1) on the way to lunch, 2) riding double on a forklift, and 3) riding double was against the rules.

Instead of a safety rule analysis, the Arbitrator finds guidance in the case of *Dodson v. Industrial Comm.*, 308 Ill. App. 3d 572 (1999). In *Dodson* benefits were denied when an employee chose to walk down a sloping grassy path during a rainstorm, instead of a concrete sidewalk. In so doing, that employee exposed herself to an unnecessary personal danger solely for her own convenience.

The Arbitrator finds that Petitioner has overstated any possible need to stop, restart, and exit a moving passenger train. The Arbitrator finds that Petitioner voluntarily exposed herself to an unnecessary personal danger solely for her own convenience. Petitioner chose a very dangerous activity when she exposed herself, and potentially everybody on the moving train, to peril. That choice exposed Petitioner to a danger which did not arise out of her employment, as it was not peculiar or incidental thereto. See *Geyer v. Aardvark Builders,* 14 IWCC 901, 08WC30748.

Petitioner was not furthering the interests of her employer when she imperiled herself. Her job description did not include the nonemergency stopping, restarting, and exiting of the moving train. Petitioner's conduct took her outside of the sphere of her employment and constituted a deviation from her actual work activities.

The fact that Petitioner was breaking a safety rule is not relevant.

Based upon the foregoing, the Arbitrator finds that Petitioner did not sustain an accident that arose out of her employment.

The remaining issues are moot.

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

Gloria Reeves,
Petitioner,

vs.

NO: 08WC 2828

15IWCC0859

City Colleges of Chicago,
Respondent,

DECISION AND OPINION ON REVIEW

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

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

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: NOV 2 3 2015
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DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

REEVES, GLORIA
Employee/Petitioner

Case# 08WC002828

15IWCC0859

CITY COLLEGES OF CHICAGO
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:

0206 GAINES & GAINES
GEORGE L GAINES
PO BOX 6345
EVANSTON, IL 60202

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
WILLIAM A LOWRY ESQ
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

15IWCC0859

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

GLORIA REEVES,
Employee/Petitioner

Case # **08 WC 02828**

v.

Consolidated cases:

CITY COLLEGES OF CHICAGO,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **JESSICA HEGARTY**, Arbitrator of the Commission, in the city of **CHICAGO**, on **September 4, 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 **10/26/2006**, 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 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 $**66,229.28**; the average weekly wage was $**1,273.64**.

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

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

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

Respondent shall be given a credit of $**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

Denial of benefits

No benefits are awarded.

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

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

Signature of Arbitrator

11/7/14
Date

NOV 10 2014

15IWCC0859

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

GLORIA REEVES,	)	
	)	
Petitioner,	)	
	)	
v.	)	08 WC 02828
	)	
CITY COLLEGES OF CHICAGO,	)	
	)	
Respondent.	)	

ADDENDUM TO ARBITRATION DECISION

FINDINGS OF FACT

Petitioner testified that on October 26, 2006, she was working for City Colleges of Chicago as a women's basketball coach and had worked in that capacity for 15 years. Petitioner testified that on October 26, 2006, basketball practice had ended and she began to prepare a basketball rebounding machine for storage. Petitioner testified that in order for the rebounder to fit in the storage room, the rebounder would need to be tilted onto its side, due to its height. When the rebounder tilted towards the ground, it would be placed on a cart. The cart would then be wheeled into a storage room.

Petitioner testified that due to the bulk and height of the rebounder, three people were required to tilt the basketball rebounder onto its cart. Petitioner testified that one assistant would tilt the rebounder as the other two would "catch" the rebounder as it began to tilt towards its cart. Petitioner testified that as the rebounder tilted over, one of her assistants failed to catch the rebounder. As a result, Petitioner testified she was forced to catch the full weight of the whole rebounder. Petitioner testified that upon catching the full weight of the rebounder, she felt pain and a stretching sensation in her left upper extremity. Petitioner thereafter placed the rebounder in storage; completed picking up the gymnasium, and proceeded home.

Petitioner testified that she did not immediately feel any significant pain after the alleged accident; however, approximately one week after the alleged accident, she testified that she could not raise her arm, shoot a basketball, or reach with her left arm.

On November 11, 2006 Petitioner sought treatment with Dr. Wilson for a follow-up to blood labs previously undertaken for an unrelated medical condition. Petitioner complained of left arm heaviness and left breast pain, however, Dr. Wilson performed no x-ray of the left shoulder or arm. Dr. Wilson did not offer a diagnosis relative to Petitioner's left arm or breast complaints.

Petitioner testified that on November 13, 2006, approximately two-and-a-half weeks after the alleged accident, she completed a Notice of Injury claiming she injured her "left arm and left breast." The Notice of Injury indicates that the two assistants on the day of the alleged date of accident were Sadie O'Neal and Dwayne Flournoy. Neither witness offered a written statement or testified at trial.

Petitioner testified that she had several past workers' compensation claims including accidents occurring May 8, 1985 and June 5, 2002.

On January 5, 2007, Dr. Wilson evaluated Petitioner at which time she complained of right knee and left arm pain. Dr. Wilson noted knee effusion and knee crepitation, however, Dr. Wilson neither examined nor offered a diagnosis relative to Petitioner's arm complaints.

On March 16, 2007, Petitioner was involved in a motor vehicle accident in which she was t-boned on the right side. Petitioner was seen in the emergency department of St. Joseph Hospital where she complained of left shoulder, left upper arm, and right knee pain. An x-ray of Petitioner's shoulder and humerus were taken revealing no acute findings. Petitioner was discharged after being diagnosed with a right knee and left shoulder contusion.

Approximately one week after Petitioner's motor vehicle accident, Petitioner followed up with Dr. Wilson on March 24, 2007 . Petitioner complained of increased pain in the left shoulder exacerbated by exercise.

On June 19, 2007, Petitioner was seen by Dr. Hoffman complaining of knee and left shoulder pain. Petitioner was diagnosed with adhesive capsulitis of the left shoulder with rotator cuff tendonitis.

On August 21, 2007, Petitioner was seen by Dr. Hoffman for adhesive capsulitis and left shoulder rotator cuff tenderness. An x-ray was taken of Petitioner's left shoulder which was revealed to be normal with type II acromion. Petitioner was diagnosed with mild rotator cuff tendonitis to the left shoulder and was prescribed three weeks of physical therapy. Petitioner thereafter underwent 12 sessions of physical therapy at St. Joseph Hospital for treatment to her left shoulder and knee.

On August 27, 2007, Dr. Wilson evaluated Petitioner who reported that she hit her head and fell approximately three weeks prior to the exam. Petitioner was diagnosed with adhesive capsulitis of the left shoulder and osteoarthritis of the right knee.

Petitioner did not receive any form of medical treatment for any condition from August 27, 2007 through December 10, 2007, a period of three and half months.

On December 6, 2007, Petitioner slipped and fell on ice and again on January 28, 2008, Petitioner fell on ice.

On December 11, 2007, Petitioner was diagnosed with a lumbar strain and right shoulder pain relative to her December 2007 fall. After Petitioner's January 28, 2008 fall, she presented to St. Joseph Hospital where an x-ray of the left wrist revealed distal radial metaphyseal fracture with an intraarticular component. Further, a possible ruptured ligament was seen. Petitioner was provided a cast for the left wrist.

Petitioner followed up with Drs. Wilson and Hoffman relative to her left wrist condition from January, 2008 until August 11, 2008. Petitioner did not seek treatment for her left shoulder, arm (excluding her wrist), or neck from August 27, 2007 until May 8, 2010, a period of two years, eight months.

On May 8, 2010, Petitioner was involved in another motor vehicle accident. Petitioner presented to St. Joseph Hospital where an x-ray of Petitioner's cervical spine was obtained. The x-ray revealed severe degenerative changes of the lower cervical spine and some degenerative arthritis of the facet joints.

Petitioner followed up with Dr. Wilson on June 3, 2010 relative to her May 8, 2010 motor vehicle accident. Dr. Wilson diagnosed Petitioner with paresthesias of the bilateral upper extremities status post motor vehicle accident with cervical spine muscle spasms and severe osteoarthritis of cervical spine. Petitioner was again seen by Dr. Wilson on July 6, 2010 where Petitioner indicated that she had been working-out to build muscle mass.

Petitioner was seen by Dr. Arculeo D.C. on November 18, 2010, citing pain in her right arm, left arm, thoracic region and cervical region. Petitioner provided a previous medical history of a broken wrist in January of 2008 with over use of the left wrist.

Petitioner appears to have been involved in another motor vehicle accident in July 2010 where she was rear-ended. At that time, however, Petitioner did not provide a history of her alleged October 26, 2006 work injury. Petitioner was diagnosed with cerviobrachial

syndrome, cervical disc displacement, carpal tunnel syndrome, disorders of the thoracic region, sciatica, lumbar degeneration, degenerative joint disease, and lower leg joint pain.

Petitioner continued to follow up with Dr. Arculeo D.C. and was treated with physical therapy from January 10, 2011 until August 11, 2011. Petitioner noted on March 24, 2011 her hobbies included weight lifting and swimming.

From March 28, 2011 to August 8, 2011 Petitioner received trigger point injections to the right shoulder, upper back, and low back approximately every third day.

On August 2, 2011, Petitioner was re-evaluated. Petitioner indicated that her current state of ill-being was caused by a previous sports injury, slip and falls, and motor vehicle accident in July 2010. After August 2, 2011, Petitioner continued to see Dr. Arculeo D.C. and began to see Dr. Guelich.

Petitioner was seen by Dr. Giannoulias on July 29, 2013, for an evaluation pursuant to Section 12 of the Act. Dr. Giannoulias indicated that Petitioner's current left shoulder symptomology is secondary to Petitioner's cervical spine degenerative disease. He also opined that Petitioner's current left shoulder condition does not have any pathology. Further, Dr. Giannoulias opined Petitioner likely sustained a contusion to her left arm and shoulder after the October 26, 2006, accident and would have reached maximum medical improvement by March of 2007 or approximately six months after the alleged accident. Lastly, Dr. Giannoulias opined Petitioner's current symptoms are secondary to the severe degenerative disc disease of her cervical spine which is unrelated to Petitioner's alleged October 26, 2006 injury.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT FOR RESPONDENT?

Petitioner alleges she sustained an injury to her left shoulder and neck arising out of and in the course of her employment on October 26, 2006. Specifically, Petitioner alleges that she was in the process of dismantling a basketball rebounding machine for placement on its cart when she was injured. Petitioner testified that one of the two assistants failed to catch the rebounder as it tilted, causing Petitioner to bear the weight of the entire rebounder. The assistant's failure to catch the rebounder as it was tilting allegedly caused Petitioner's to catch the full weight of the rebounder, causing her work related accident. The credible evidence of record suggests that Petitioner's left shoulder and neck injury did not arise out of and in the course of her employment.

Petitioner testified that after her alleged work related accident, she completed an incident report. The Arbitrator notes that relative to Petitioner's 1985 and 2002 claims, she either reported the injury the day of, or the day after the accident. However, in the claim in question, Petitioner waited a period of 18 days before filing an accident report.

Petitioner testified on both direct and cross examination that she "caught" the rebounder with outstretched hands at waist level. Petitioner's description of the mechanism of injury is inconsistent with the written mechanism of injury memorialized in Petitioner's notice of injury. In Petitioner's notice of injury, she claimed the rebounder allegedly struck her left arm and left breast. Given Petitioner "caught" the rebounder with hands outstretched at waist level, with the palms facing upwards, Petitioner failed to make reference how the basketball rebounding rebounder struck her left breast and caused pain in her left arm. The narrative provided by Petitioner at the time of trial and the narrative provided by Petitioner in her notice of injury are inconsistent.

Although Petitioner claims she sustained injuries on October 26, 2006, Petitioner's first instance of treatment following the alleged work injury was November 11, 2006. The Arbitrator notes that although this is the first instance of treatment after the alleged accident, treatment was not relative to a work related injury occurring October 26, 2006. Petitioner made reference to an injury that caused her pain in her left arm, left shoulder, and left breast, however, gave no narrative of any work related accident occurring on October 26, 2006. In fact, the primary purpose for Petitioner's visit was to review past blood labs related to Petitioner's hyperlipidemia –not Petitioner's arm, shoulder, and breast complaints. Dr. Wilson did not render a diagnosis relative to Petitioner's arm, shoulder, and breast complaint, leading to the reasonable inference that he must have found Petitioner's pain complaints to be so unexceptional as to not warrant any radiological imaging.

Petitioner's first instance of seeking medical treatment specifically for complaints of left upper extremity pain occurred on January 5, 2007, when she presented to Dr. Wilson. Although Petitioner complained of knee pain and left upper extremity pain, Petitioner provided a history of an injury occurring September 2006. Petitioner did not provide any history of an injury occurring October 26, 2006. Although Petitioner's knee was examined, Dr. Wilson failed to undertake any examination of Petitioner's left arm, left shoulder, or left breast. Further, no radiological images were ordered of Petitioner's upper extremities on that date. Dr. Wilson diagnosed Petitioner with osteoarthritis and effusion to the left knee and left shoulder pain. Dr. Wilson instructed Petitioner to apply ice to her shoulder at the end of the day.

Given the fact Petitioner waited two-and-half weeks before providing any notice of injury, provided inconsistent narratives of the alleged accident, and did not receive a diagnosis relative to her complaints until two-and-half months after the date of the alleged accident, the Arbitrator finds Petitioner has failed to prove she sustained an injury to her left shoulder, left arm, left breast, and neck arising out of and in the course of her employment for Respondent on October 26, 2006. Therefore, all benefits are denied.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

Assuming Petitioner had sustained her burden with respect to accident, the Arbitrator would deny benefits based on a failure to prove causal connection.

LEFT SHOULDER

In support of this finding, the Arbitrator notes Petitioner first sought medical treatment for her upper extremity pain, not on November 11, 2006, but instead on January 5, 2007. Petitioner's visit of November 11, 2006, was for treatment of Petitioner's hyperlipidemia, not Petitioner's upper extremity complaints. Petitioner indicated she suffered an injury to her left arm and breast, however, did not indicate that it was work related. Though Petitioner made arm and breast complaints, she did not make any neck complaints. Further, Dr. Wilson failed to examine Petitioner's arm, neck, shoulder, or order x-rays of those respective body parts.

Though Petitioner was seen on January 5, 2007 citing complaints to her left arm, Petitioner's left arm was not examined. Further, no diagnosis was rendered relative to Petitioner's left arm complaints. The Arbitrator notes the first instance of any radiological imaging was obtained when Petitioner was involved in a motor vehicle accident on March 16, 2007, when Petitioner's car was t-boned on the right side of the vehicle, the trauma of which caused Petitioner to go to St. Joseph Hospital complaining of pain in the left shoulder, left upper arm, and the right knee. The Arbitrator notes Petitioner had no recollection of this accident at the time of trial. Petitioner failed to cite any October 26, 2006, work related injury when providing her medical history on March 16, 2007. For the first time since the alleged date of accident, an x-ray was taken of Petitioner's left shoulder and humerus as memorialized in Respondent's Exhibit No. 1. The x-rays revealed no acute radiographic findings. Petitioner was diagnosed with a contusion to the right knee and left shoulder.

Following Petitioner's motor vehicle accident on March 16, 2007, Petitioner was seen by Dr. Wilson on March 24, 2007. The Arbitrator notes in that exam, Petitioner indicated for the first time that she was seeking treatment relative to a work accident that

occurred in September 2006. Petitioner was referred to an orthopedist which Petitioner never visited.

On June 19, 2007, Petitioner was seen by Dr. Hoffman. The Arbitrator notes Petitioner complained of left shoulder pain and knee pain after an incident in which she was erecting a basketball net in November of 2006. Dr. Hoffman also noted Petitioner's March 2007 automobile accident. Dr. Hoffman diagnosed Petitioner with left shoulder adhesive capsulitis with rotator cuff tendonitis and administered an injection to the left shoulder.

Petitioner returned to Dr. Hoffman on August 21, 2007 citing a 75% improvement in pain. A left shoulder x-ray of Petitioner was found to be within normal limits. Petitioner was diagnosed with mild chronic rotator cuff tendonitis of the left shoulder. Petitioner appears to have sustained a fall after she hit her head under her home's porch around August 27, 2007, however, appeared to receive only medication for treatment.

Petitioner did not receive any medical treatment for any condition from August 27, 2007 until December 11, 2007, a period of three and half months.

Petitioner was treated on December 11, 2007, by Dr. Wilson for an alleged work related accident of December 6, 2007. Petitioner claimed she slipped and fell on ice while entering a Chicago Public School training facility. Chicago Public Schools ("CPS") is not a party in the present matter. Petitioner was diagnosed with a lumbar strain and right shoulder pain.

In addition to Petitioner falling on December 6, 2007, Petitioner also slipped and fell on ice on January 28, 2008, while working for CPS. On January 28, 2008 Petitioner was initially seen by St. Joseph Hospital, after an x-ray revealing a distal radial metaphyseal fracture with an intraarticular component. Further, a ruptured ligament was seen due to the widening of the scapholunate. Petitioner subsequently followed up with Dr. Hoffman that same day. Dr. Hoffman diagnosed Petitioner with an intraarticular Colles fracture of the left wrist.

Petitioner subsequently received treatment relative to the injuries she sustained pursuant to her fall, however received no treatment for her left upper extremity, specifically her left arm, shoulder, and neck until May 8, 2010, when she was involved in another motor vehicle accident. Notwithstanding Petitioner's slip and fall in December of 2007 and January of 2008, Petitioner did not receive any medical treatment to her left arm, left shoulder, breast, or neck from August 27, 2007 until May 8, 2010 a period of two years, eight months.

The Arbitrator notes Petitioner was subsequently seen by Drs. Wilson, Arculeo D.C., Guelich and Peak Performance after March 28, 2011. Given the long periods of non-treatment, the Arbitrator finds the records after March 28, 2011 not pertinent to the alleged work related accident of October 26, 2006.

Lastly, Petitioner was seen on July 29, 2013, by Dr. Giannoulias for a Section 12 examination. Dr. Giannoulias opined Petitioner's current physical condition relative to her left shoulder is that she does not have any pathology. Dr. Giannoulias further indicated Petitioner had full range of motion with no rotator cuff pathology. Additionally, Dr. Giannoulias indicated that Petitioner's current state of ill-being is not related to the October 26, 2006 injury but instead derived from her cervical spine degenerative disease. Relying on the history provided by Petitioner, Dr. Giannoulias indicated Petitioner likely sustained a left shoulder and arm contusion on the alleged date of accident. Dr. Giannoulias opined Petitioner would have reached maximum medical improvement in approximately six months or March 2007.

NECK

Petitioner's first instance of treatment after the alleged date of accident was November 11, 2006. This treatment was not pursuant to any shoulder or neck complaints, but instead for Petitioner's hyperlipidemia. Petitioner neither complained of neck pain, nor did Dr. Wilson examine Petitioner's neck. No x-ray of the neck was done.

Petitioner was seen on January 5, 2007, citing an accident occurring in September of 2006. Petitioner failed to give any history of a work related accident occurring October 26, 2012. Petitioner did not make any neck complaints nor was Petitioner's neck examined. Petitioner was seen again by Dr. Wilson on March 24, 2007, May 24, 2007, August 27, 2007, December 11, 2007, February 18, 2008, and May 20, 2008. At no time did Petitioner make any neck complaints or receive treatment for any neck condition.

Further, Petitioner was seen by Dr. Hoffman on June 19, 2007, August 21, 2007, January 19, 2008, March 11, 2008, April 22, 2008, and May 6, 2008. At no time did Petitioner make any neck complaints or receive treatment for any neck condition.

The first instance Petitioner made any neck complaints was June 3, 2010, when she was seen by Dr. Wilson. The elapsed time between the alleged date of accident and the time Petitioner made her first neck complaint was three years, seven months. In fact, at the time Petitioner made her first neck complaint, she had been involved in two motor vehicle accidents, one of which she had been rear-ended, had been treated for hitting her head and subsequent fall, and had received treatment for two instances in which slipped and fell on ice. Furthermore, Petitioner's first instance of making any neck complaints was less than one month after her May 6, 2010, motor vehicle accident.

Lastly, Petitioner was seen by Dr. Giannoulias on July 29, 2013, for an evaluation pursuant to Section 12 of the Act. Dr. Giannoulias opined that Petitioner's neck condition is purely degenerative in nature. Given the fact Dr. Giannoulias relied on Petitioner's provided narrative of accident, Dr. Giannoulias opined Petitioner suffered at most, a contusion to her left arm and shoulder. Dr. Giannoulias also indicated that Petitioner's current symptoms are secondary to the severe degenerative disc disease of her cervical spine which is unrelated to Petitioner's alleged October 26, 2006 injury.

The Arbitrator notes that Petitioner testified that she had difficulty driving long periods without suffering from a cramping neck pain. Further, Petitioner testified that she could no longer lift weights or shoot a basketball. This testimony is inconsistent with the record. The Arbitrator notes on July 6, 2010 when seen by Dr. Wilson, Petitioner revealed that she had been working out to build muscle mass. Further, when Petitioner was seen on March 24, 2011 by Peak Performance, Petitioner indicated that her hobbies included weight lifting, swimming and sports. Petitioner's inability to exercise or drive without pain is not derived from an October 26, 2006, accident but is instead derived from Petitioner's severe degenerative disc disease of the cervical spine.

Petitioner waited a period of three years, seven months before making any neck complaints. Further, Petitioner's first neck complaint was approximately one month after an automobile accident where it was noted she had severe osteoarthritis of the cervical spine. Dr. Giannoulias indicated that Petitioner's current neck symptoms are derived from Petitioner's severe degenerative disc disease of the cervical spine which is unrelated to Petitioner's alleged October 26, 2006, injury. Petitioner's current condition of ill-being is not causally related to her alleged injury and therefore, all benefits are denied.

With respect to nature and extent, based on the Arbitrator's prior findings, all benefits are denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

David Whalen,
Petitioner,

vs. NO: 08 WC 4798

Freeman United Coal Mining Company,
Respondent.

15IWCC0838

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 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.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $16,000.00. 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: NOV 18 2015
o10/21/15
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0838

WHALEN, DAVID
Employee/Petitioner

Case# **08WC004798**

FREEMAN UNITED COAL MINING COMPANY
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:

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

15IWCC0838

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 WHALEN
Employee/Petitioner

Case # **08** WC **4798**

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/Exposure, Causation and Sections 1(d)-f of the Occupational Disease Act**

15IWCC0838

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 conditions of ill-being of mild obstructive airway disease, chronic bronchitis, and asthma ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$62,062.42**; the average weekly wage was **$1,193.51**.

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

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

Respondent ***has*** 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 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.

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 WHALEN,
Employee/Petitioner

v. Case #08 WC 004798

FREEMAN UNITED COAL MINING COMPANY
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner was 59 years old at the time of Arbitration. He graduated from high school and has an associate degree in coal mining science. After high school, Petitioner worked for the Office of Attorney General as a mail clerk for approximately a year and a half before he went to work for Respondent in the Crown II mine in 1976. He worked in coal mining for 31.25 years with the first 18 years being underground. Petitioner testified that in addition to coal dust, he was regularly exposed to silica dust, roof bolting glue fumes, diesel fumes, Trowel, and smoke from coal fires. His first job classification in the mine was laborer. After one year as a laborer, he successfully bid to repairman trainee and worked as a repairman for the remainder of the 18 years underground. As a repairman, Petitioner performed work on various machinery, as well as performing cable splices, cutting and welding. In that position, Petitioner testified that he was exposed to cable fires involving an immense amount of smoke. He testified that he was exposed to an extreme amount of dust working around the face where coal is cut, and he described the cutting performed in his repairman position as dirty because it involved exposure to coal dust and rust.

Petitioner then bid on the surface. He worked in the coal preparation plant where the coal comes up from underground, put into a water bath to be cleaned, separated, dried, and returned to the belt before going to the silo for loading. Petitioner testified that the plant "was full of dust" during operation, and involved exposures to rust and Trowel-on fumes while performing maintenance. He described the fumes as strong that it "takes your breath away". Petitioner also ran the gob truck, which he described as a dusty environment. Petitioner testified that all of his jobs have involved manual labor.

Petitioner's last day of employment with Respondent was August 29, 2007 at Respondent's Crown II mine. He was 51 at the time and his job classification was plant maintenance. Petitioner testified that he was exposed to and breathed coal dust on that day. He testified that August 29, 2007 was his last day mining coal because the mine closed, and he testified that he thereafter decided to end his mining career because he felt unable to return to mining due to his breathing difficulties. Petitioner testified that but for the mine closure, he would have reported for his next shift at the coal mine. After the mine closure, he completed a panel form listing jobs that he was ready, willing and able to be recalled to for employment at other coal mines. Petitioner could not remember what classifications he agreed to be recalled to, but he believed them to be surface plant jobs, which he testified would be very difficult to obtain because Respondent had already subcontracted those jobs out at its Crown III mine. Petitioner testified that signing up for the panel was just a formality with

no reasonable expectation of getting a job. Petitioner testified that if he were offered a job in the coal mine today he would not take it due to his breathing difficulties and because he feels unable to perform the job duties of a coal miner. He testified that as of the date of the mine closure, there were no other mines to seek employment with, but if he had felt healthy enough, he would have worked for other mines. Petitioner received a full "30 and out" pension effective November 1, 2007, which severed all of his recall rights.

Thereafter, Petitioner went to work at St. John's Hospital on December 6, 2007 in Springfield, Illinois as a security officer and he is presently employed in that position. He earns $11.22 per hour as a security officer. Petitioner completed a respiratory screening questionnaire when he went to work at St. John's Hospital. Petitioner reported on the questionnaire that he suffered no shortness of breath, and he testified that he may not have been experiencing shortness of breath on that date. PX 16. He testified that his present employer is aware that he has some breathing difficulties and could not wear a respirator prior to him being hired. Petitioner's job requires a lot of walking as he performs daily rounds of the 14-floor facility. Petitioner testified that walks on average three and a half to four miles per day, which causes difficulty with shortness of breath at various times.

Petitioner testified that he first noticed breathing problems at work within the first four to five years. He experienced shortness of breath, coughing, headaches, and clogged nasal passages. Petitioner testified that he has discussed his breathing difficulties with his primary physician, Dr. Rollett, and how those difficulties relate to his work environment.

Petitioner testified that he can presently walk 30 yards on level ground before becoming short of breath, and climb 10 to 12 steps before he had to stop and rest. From the first time he noticed breathing problems until he left the mine, his symptoms worsened, though he stated that they have stabilized. Petitioner uses Nasonex, Albuterol three to four times per day, and Advair once daily for symptom control. He testified that his breathing difficulties require that he take things slow and he "doesn't push myself too hard." Petitioner is unable to run, and instead walks briskly. He testified that he does not hunt and fish like he used to, and he presently plays golf less than he used to due to his breathing difficulties. Petitioner has never smoked.

An agreement between Respondent and United Mine Workers regarding standard hourly and daily wage rates was admitted as Petitioner's Exhibit 20. Pursuant to that agreement, Petitioner would be at grade 4 and earning $28.36 per hour. PX 20. Petitioner acknowledged that Respondent ceased to exist on September 1, 2007, that Respondent does not operate any additional mines, and that no one is presently working under that agreement.

Dr. Glennon Paul is the medical director of St. John's Respiratory Therapy and Clinical Assistant Professor of Medicine at SIU Medical School. He is a senior physician at the Central Illinois Allergy and Respiratory Clinic, which specializes in allergy and pulmonary diseases and take care of patients with respiratory diseases, critical care, allergic diseases and some internal medicine problems. Dr. Paul is not a B-reader. Dr. Paul 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. While he examines coal miners, a majority of his examinations are performed at the request of coal companies. PX 1.

Dr. Paul examined Petitioner on August 25, 2008 at the request of Petitioner's counsel. Petitioner reported to Dr. Paul symptoms of coughing and wheezing at bedtime, worsened with upper respiratory tract infections. Petitioner further reported diagnoses of bronchitis in the winter, never smoking, and a diagnosis of asthma as a child. Petitioner did not relate taking any breathing medications. Petitioner did not inform Dr. Paul that he left coal mining due to breathing problems or upon the recommendation of a physician. Petitioner did not relate to Dr. Paul any problems in performing the last duties of his job in the mine. PX 1.

Dr. Paul found Petitioner's physical examination to be normal. Upon review of Petitioner's chest x-ray, though he was unsure of its date, Dr. Paul found that Petitioner had fibrosis of the lower and mid lung zones. Dr. Paul also had Dr. Smith's B-reading available to him for review, which he took into consideration when making his final conclusions. Dr. Paul testified that in this area, coal workers' pneumoconiosis most commonly occurs first in the lower lung zones. Dr. Paul testified that the baseline spirometry showed a mild obstructive airway disease, and the methacholine challenge drop of seven percent would be compatible with bronchitis. PX 1.

Dr. Paul testified that Petitioner has coal workers' pneumoconiosis, bronchitis and obstructive lung disease, all of which were caused by exposure to coal dust. Based on these diagnoses, Petitioner could not have any further exposure to the environment of a coal miner without endangering his health. Dr. Paul testified that by definition, if one has coal workers' pneumoconiosis, he would necessarily have some impairment in the function of the lung at the site of the scarring regardless of whether the impairment can be measured by spirometry. Dr. Paul testified that Petitioner is not capable of working in a coal mine. PX 1.

Dr. Paul testified that the majority of individuals who have pneumoconiosis, such as that diagnosed in Petitioner, will not see a progression in their disease once they cease exposure. Dr. Paul acknowledged that pneumoconiosis may not progress even with continued exposure. Dr. Paul testified that obstructive lung disease means that the elasticity is gone and some of the small airways of the lungs are destroyed, which may result in holes or blebs. Obstructive lung disease is progressive, and it can progress through a series of centrilobular, panlobular, and all the way to bolus emphysema. PX 1.

In a supplemental deposition on September 30, 2013, Dr. Paul testified that in addition to coal workers' pneumoconiosis and bronchitis, Petitioner's occupational exposures exacerbated his asthma, for which Petitioner could not return to coal mining employment without endangering his health. Dr. Paul testified that Petitioner's bronchitis will remain with him for life. PX 9, 12.

Dr. Henry K. Smith, board certified radiologist and NIOSH B-reader, interpreted Petitioner's chest x-ray of September 9, 2004 as positive for pneumoconiosis, profusion 1/0 with P/S opacities in the middle and lower lung zones bilaterally. Dr. Smith made an identical interpretation of the chest x-ray dated October 13, 2005, October 4, 2006, and November 2, 2007, with the exception that he saw S/P opacities on the November 2007 x-ray. Dr. Smith interpreted chest x-ray of April 1, 2006 as positive for pneumoconiosis, profusion 1/0 with P/S opacities in all lung zones. He interpreted the chest x-ray of November 20, 2008 as positive for pneumoconiosis, category 1/1 with P/P opacities in all lung zones. Dr. Smith also interpreted a CT scan dated November 20, 2008, and noted that CT was consistent with coal workers' pneumoconiosis in which there were small opacities primary P, secondary P in the upper, mid and lower zones bilaterally with profusion 1/0. PX 3.

Dr. Michael Alexander, board certified radiologist and B-reader, interpreted Petitioner's chest x-ray of September 9, 2004 as positive for pneumoconiosis, profusion 1/0 with P/P opacities in the right upper and mid lung zones. He made an identical interpretation of the chest x-ray dated October 3, 2005. He interpreted the chest x-rays of October 4, 2006 and November 2, 2007 as positive for pneumoconiosis, profusion 1/0 with P/P opacities in bilateral upper and right mid lung zones. Dr. Alexander interpreted the chest x-ray of November 20, 2008 as positive for pneumoconiosis, profusion 1/0 with P/P opacities in all lung zones. PX 4.

Petitioner underwent a chest x-ray at NIOSH on May 7, 2007, and NIOSH determined that same showed no definite evidence of pneumoconiosis. PX 5, RX 3. Also on May 7, 2007 Petitioner underwent baseline spirometry testing, and were interpreted by NIOSH as being abnormally low. A letter from the Department of Health and Human Services to Petitioner dated July 10, 2007 indicates that an obstructive abnormality indicates that air is exhaled from the lungs more slowly than normal, which can be seen in certain lung conditions such as asthma, bronchitis, or emphysema. PX 5.

Dr. John Rollet, Petitioner's primary care physician since 2003, testified by way of evidence deposition on November 8, 2012. Dr. Rollet is board certified in family medicine, and he has practiced in that field in Chatham, Illinois for 25 years. Dr. Rollet testified that, in his opinion, Petitioner has an obstructive ventilatory defect that was caused, aggravated, and exacerbated by Petitioner's work as a coal miner. Dr. Rollet testified that Petitioner would be at risk of having his disease worsen if he was exposed to environmental coal mine dust. PX 2.

Petitioner initially presented to Dr. Rollet on February 4, 2003 with a primary complaint of heart palpitations. Dr. Rollet took a history from Petitioner, and he denied asthma, wheezing, chronic or frequent cough, lung or bronchial infections. A physical examination of his chest revealed his lungs to be clear. On February 19, 2003, Petitioner's complaint was again palpitations and costochondritis. His palpitations were improving with Inderal. A physical examination of the chest revealed his lungs to be clear. Dr. Rollet's assessment was costochondritis, insomnia, and GERD. On March 21, 2003, Dr. Rollet assessed Petitioner with GERD, and gastritis on April 28, 2003, July 21, 2003, and October 29, 2003. On those dates, Petitioner's lungs were clear on examination. PX 2.

Petitioner presented to Prairie Cardiovascular on November 17, 2003. A review of systems revealed no chronic cough. An examination of Petitioner's chest on September 14, 2004, March 24, 2005, May 23, 2005, June 20, 2005, July 7, 2005, October 5, 2005, April 7, 2006, and April 16, 2006 revealed no rales, wheezes, rub or rhonchi. Dr. Rollet's assessment on April 16, 2006 included GERD. Dr. Rollet saw Petitioner on February 21, 2007 at which time a physical examination of the chest revealed his lungs to be clear and he was assessed with gastroenteritis. Dr. Rollett testified that prior to February 21, 2007, Petitioner had never related a complaint of cough. Upon Petitioner's original visit in February 2003, Petitioner related suffering from shortness of breath, but did not complaint of shortness of breath thereafter. PX 2.

On September 12, 2007, Dr. Rollet diagnosed Petitioner with GERD, allergic rhinitis and hypertension. Dr. Rollet noted that the complaints of rhinitis were seasonal for Petitioner which were characteristic of that disease process. Petitioner was seen on February 20, 2008, at which time no rales, wheeze, rub or rhonchi were present on physical examination of the chest. Dr. Rollet's assessment was Barrett's esophagitis, which is significant inflammation of the esophagus, probably

an extension of the reflux and was likely caused by his GERD, and can also be associated with cough. PX 2.

Petitioner was seen on April 7, 2010 for asthma and COPD. Dr. Rollet testified that Petitioner had failed his screening for coal workers' pneumoconiosis in February 2008 when he applied for a job, and that the problem listed was based upon Petitioner's history and not Dr. Rollet's diagnosis. Petitioner denied any symptoms to support a diagnosis of asthma or COPD. Dr. Rollet had a copy of a report from Dr. Paul to Petitioner's counsel dated August 25, 2008. Dr. Rollet relied on that report in making the diagnosis of asthma. Dr. Rollet himself did not make that diagnosis. Prior to Petitioner's last date in the coal mine in August 2007, Dr. Rollet did not have anything in his records on which he could base a diagnosis of an obstruction. Dr. Rollet testified that he never made a referral for Petitioner for pulmonary workup by anyone. He treated Petitioner for pulmonary disease beginning on April 7, 2010, and that was the first time that he had treated him for asthma. PX 2.

Dr., a board certified occupational medicine physician, testified at Arbitration by way of evidence deposition on August 13, 2014. Dr. Bansal is the Medical Director of Occupational Medicine at Alegent Creighton Health Systems, and his practice is involved in the diagnosis and treatment of work related injuries and exposures. Dr. Bansal performs pre-placement physical exams to determine if an individual is qualified to do a certain job. Dr. Bansal examined Petitioner on October 30, 2007 and spirometry was performed on behalf of St. John's Hospital to ascertain Petitioner's pulmonary capacity to perform work at the hospital. Dr. Bansal's physical examination conducted on that date revealed no abnormality, and Petitioner did not complain to Dr. Bansal of cough or sputum. Dr. Bansal testified that the spirometry interpretation he took of Petitioner accurately reflected Petitioner's pulmonary function on the day it was taken. Dr. Bansal testified that according to the American Thoracic Society and the European Respiratory Society, the second best forced vital capacity has to be within 200 milliliters of the best forced vital capacity to be valid. For Petitioner's testing, the variability in FVC was 9.7% or 320 milliliters. Dr. Bansal testified that this would exceed the variability limit that is imposed by the American Thoracic Society and the European Respiratory Society. PX 13.

Dr. Bansal testified that, assuming Petitioner's employment prior to the hospital was as a coal miner for 31 years with approximately 18 years being underground, the obstructive ventilatory defect depicted in his testing was caused in part or aggravated and made worse by Petitioner's exposure as a coal miner. Dr. Bansal testified that in light of the obstructive ventilatory defect represented by his testing, Petitioner could not continue coal mining exposure without presenting a risk of increased potential for progression of his obstructive disease. Dr. Bansal opined that in light of the obstructive defect depicted in Petitioner's spirometry, he would carry a diagnosis of COPD and chronic bronchitis. PX 13. The medical report of Dr. Bansal, was admitted into evidence, and stated that "testing indicates moderate obstruction as well as low vital capacity, possibly from a concomitant restrictive defect." As a result of Dr. Bansal's testing, he recommended that Petitioner not wear a respirator. PX 7.

Dr. Jerome F. Wiot reviewed chest x-rays of Petitioner at the request of counsel for Respondent. 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 started. Dr. Wiot was board certified in radiology in 1959 and he typically reads 50 or 60 films per day. RX 1.

Dr. Wiot reviewed Petitioner's chest x-rays dated September 9, 2004, October 13, 2005, October 4, 2006, April 7, 2006, and November 2, 2007. Dr. Wiot testified that all films were quality 1, with the exception of the study of October 13, 2005, which was quality 2 due to underexposure. Dr. Wiot interpreted all the films as showing no evidence of coal workers' pneumoconiosis. Dr. Wiot reviewed a report of Dr. Henry K. Smith after he completed his B-readings. Dr. Smith noted that there were S and P size opacities in the bases of the lungs, which Dr. Wiot testified is inconsistent with the presentation of coal workers' pneumoconiosis. He testified that coal workers' pneumoconiosis invariably begins in the upper lung fields, most often on the right, and only with progression does it move into the mid and lower zones. Dr. Wiot also testified that the prime opacity seen with pneumoconiosis is a round opacity, and Dr. Smith found the primary opacity to be an S opacity, which is an irregular opacity. RX 1.

Dr. Wiot testified that the scarring of coal workers' pneumoconiosis is permanent. He testified that by definition, an individual suffering from coal workers' pneumoconiosis, he would have impairment in the function of their lungs at the site of the scar tissue, even though the impairment may not be measured by pulmonary function testing. Dr. Wiot acknowledged that the only treatment for coal workers' pneumoconiosis by removing the affected individual from further coal dust exposure, though he stated that most of the time coal workers' pneumoconiosis will not progress after exposure ceases. RX 1.

For determining radiographically significant coal workers' pneumoconiosis, Dr. Wiot prefers not to have medical records of the individual, and he prefers not to know anything about the individual when reading a x-ray. "I don't want to know about his pulmonary function. I don't want to know that he was only exposed two years as opposed to 30 years." Dr. Wiot testified that if he reads a chest x-ray as positive and there has been adequate coal mine exposure to support the radiographic changes, any entries and treatment records of clear lungs on physical examination mean "nothing", and pulmonary function testing "means nothing". Dr. Wiot stated that an individual can suffer from coal workers' pneumoconiosis yet still have a normal physical examination of the chest, normal pulmonary function testing, normal arterial blood gas testing. RX 1.

Dr. Jeff Selby examined Petitioner on November 20, 2008 at the request of Respondent's counsel. Dr. Selby has been board certified in internal medicine and pulmonary disease since 1980 and 1984, respectively. Dr. Selby has been a B-reader since 1985. Dr. Selby performs general pulmonary work and a small percentage of his practice dedicated to occupational lung disease. He treats patients with lung disease daily, and Dr. Selby has occasion to see individuals who have the disease process coal workers' pneumoconiosis. RX 2.

Upon presentation to Dr. Selby, Petitioner's chief complaint was shortness of breath, which he indicated had been present for approximately 10 years. Petitioner indicated he was presently employed at St. John's Hospital as a security guard. The job required walking, and he related that he had lost 25 pounds in that job and during that time his shortness of breath had improved. Petitioner's medications were for GERD and Rhinocort for allergic rhinitis. Petitioner had also taken Albuterol, a bronchodilator, to treat asthma exacerbations. Dr. Selby testified that the rhinitis and sinusitis can cause cough. In Dr. Selby's review of systems, Petitioner denied any problems with

cough. He reported to Dr. Selby that his GERD was significant, especially if he did not take his medication. Dr. Selby's physical examination of Petitioner's chest was completely normal. Dr. Selby testified that based on the review of systems, physical examination and history from Petitioner, he did not suffer from chronic bronchitis. With regard to the laboratory testing, his oxygen saturation was 98%, which is normal. RX 2.

Dr. Selby interpreted Petitioner's chest x-ray of November 20, 2008. He graded the film as quality 2 because of underinflation. He testified that underinflation can effect a final interpretation of the x-ray in that a severely underinflated film can mimic extra lung markings, especially in the bases that can be interpreted as pneumoconiosis. Underinflation accentuates the pulmonary vasculature of the lung which can be misinterpreted for opacities consistent with pneumoconiosis. Dr. Selby's interpretation of the chest film was negative for pneumoconiosis or any other pulmonary disease. Dr. Selby read Petitioner's chest x-rays dated September 9, 2014, October 13, 2005, April 7, 2006, and November 2, 2007, which were all of diagnostic quality, as negative for coal workers' pneumoconiosis. Dr. Selby also reviewed chest x-ray of October 4, 2006 as negative. Dr. Selby testified that a high resolution CT scan was performed on Petitioner, which he stated is of value in determining pulmonary disease as it can show considerably more detail and in three dimensions. Dr. Selby's report included an interpretation of the CT scan by Dr. Anthony Perkins, a board certified radiologist, who found no evidence of coal workers' pneumoconiosis, which was consistent with Dr. Perkins' interpretation. Dr. Selby testified that for a person to have coal workers' pneumoconiosis, there must be a tissue reaction to the coal mine dust in the lungs, or scarring. Dr. Selby testified that the scarring of coal workers' pneumoconiosis cannot perform the function of normal healthy lung tissue. By definition, if a person has pneumoconiosis, he would necessarily have impairment in the function of his lung at the very site of the scarring, regardless of whether that impairment could be measured by spirometry. Dr. Selby testified that removal from any further exposure to coal dust is the only treatment for coal workers' pneumoconiosis, as there is no cure. In the vast majority of cases, category 1 coal workers' pneumoconiosis will not progress without additional exposure. RX 2.

Dr. Selby testified that in regard to the spirometry that was performed as part of his examination, Petitioner's numbers pre-bronchodilator were all normal. There was a low, but clinically insignificant change post-bronchodilator, though the findings were still within normal limits. Petitioner's lung volumes were measured and were normal. Those values negated the presence of an obstruction or restriction for Petitioner. The diffusion capacity was performed and it was also normal at 85% of predicted. After it was adjusted for alveolar volume, the percent of predicted was again even the higher normal value of 105%. Dr. Selby's overall interpretation of the spirometry was normal without change post bronchodilator, normal lung volumes and normal diffusion capacity. Dr. Selby testified that the predicted of FEV_1/FVC ratio for Petitioner was 70% so anything above that would be normal. The ratio on Dr. Paul's testing was 71% which was normal. Dr. Selby reviewed spirometry performed on Petitioner on December 28, 2007. Dr. Selby noted that it could not be said that the testing was valid. The report on its face did not reveal validity based upon the FVC maneuvers varying by 9.7% or 320 mL. Dr. Selby noted that the American Thoracic Society guidelines require the best and second best efforts to be within 200 mL or five percent. Diagnoses and limitations attendant thereto should not be based on spirometry that is not confirmed as valid. RX 2.

Petitioner also underwent exercise testing as part of Dr. Selby's examination, which he described as the gold standard for determination of cardiopulmonary ability. His exercise testing

was maximal and revealed that Petitioner did not have any pulmonary disease limiting his exercise. Dr. Selby testified that the exercise testing did not reveal a pulmonary cause for Petitioner's complaint of shortness of breath and essentially ruled it out. Dr. Selby testified that based upon the exercise testing performed, from a pulmonary standpoint, Petitioner would be capable of heavy manual labor. Dr. Selby did not perform a methacholine challenge, though he acknowledged that the same is a more sensitive test for ascertaining reactivity in the airways when an individual has a normal or near normal FEV1. RX 2.

Dr. Selby concluded that Petitioner does not suffer from coal workers' pneumoconiosis, and that he possesses the respiratory or pulmonary capacity to perform his former position in the mine. Dr. Selby testified that while Petitioner may have an element of asthma based on his history, he found no physical findings consistent with asthma. The pulmonary function testing tended to show that he did not have asthma because there was an insufficient post bronchodilator response. RX 2.

Dr. Cristopher Meyer interpreted the chest x-ray of November 20, 2008. He found the film to be quality 3, underexposed, mottle and limited by body habitus. Dr. Meyer found the chest x-ray to be normal with no radiographic findings of coal workers' pneumoconiosis. Subsequent to preparing his ILO B-reading form, Dr. Meyer reviewed the interpretation by Dr. Michael S. Alexander of the same film. Dr. Meyer did not agree with Dr. Alexander's findings. The quality of the examination was limited secondary to obesity and underexposure, and there were no fine nodular opacities. RX 4.

Delores Gonzalez performed a functional assessment of Petitioner at his counsel's request on January 23, 2013, and she testified by way of evidence deposition on March 29, 2013. Ms. Gonzalez is a vocational rehabilitation counselor. She performs vocational assessments at the request of injured employees, plaintiffs, defendants, employers and third party administrators. In addition to her private practice, she is a clinical educator for Southern Illinois University of Carbondale and Maryville University where she trains master degree level students how to be vocational rehabilitation counselors. Ms. Gonzalez has performed vocational assessments at the request of Petitioner's counsel for approximately 20 years. PX 8.

Prior to her interview, Ms. Gonzalez was provided medical records by counsel. Her report contained a social history, educational history, client interview, activities of daily living, vocational history and her summary of the medical records. Ms. Gonzalez conducted vocational testing and a transferability of skills analysis. Ms. Gonzalez testified that Petitioner did not have transferable skills outside the mining industry. Ms. Gonzalez testified that Petitioner's associate degree in applied science in mine technology was 35 years prior, and due to the advancements in technology, his education does not equip him with skills readily transferrable to other industries. Ms. Gonzalez testified that his job as a security guard was within his residual functional capacity, based upon Dr. Rollett's recommendations, and as such, she did not conduct a labor market survey. Ms. Gonzalez testified that based upon her review of Dr. Rollett's records, Petitioner can perform light, unskilled jobs, and from a functional standpoint, his job as a security guard falls within that category. If she were to conduct a labor market survey, she would be looking for sedentary and light jobs at entry level that would start within $8.50 to $10.50 an hour. PX 8.

Ms. Gonzalez testified that Petitioner reported to her that he had retired and she was unaware that Respondent's mine had closed. Ms. Gonzalez testified that assuming there were other individuals that were laid off from the mine about the same time as Petitioner, she would anticipate

that their transferrable skills would be similar to Petitioner's. Most would not have any transferrable skills outside of mining. Ms. Gonzalez was aware that Petitioner obtained his current employment approximately four months after he left the mine, but she did not have any information about his job search. Ms. Gonzalez did not know whether, absent the diagnoses enumerated for Petitioner, he would earn more than $800.00 per week. Irrespective of his diagnosis, Ms. Gonzalez could not opine that Petitioner could earn greater than $800.00 per week given his age and transferable skills. PX 8.

EVIDENTIARY RULING

At Arbitration, Respondent's counsel objected to admission of Petitioner's Exhibit No. 12 on the basis of a lack of good cause for a continuance granted to the Petitioner from the June 2013 Springfield Call. At that time, Petitioner requested that this matter be continued to obtain further rebuttal evidence from his physician. At a hearing on Respondent's objection to a continuance based on good cause on June 17, 2013, Petitioner's counsel argued that because Respondent's counsel left before the deposition of Dr. Paul was completed, Petitioner's counsel needed additional time to complete said deposition. On June 17, 2013, Arbitrator Zanotti allowed Petitioner's motion to continue to allow for the completion of the deposition of Dr. Paul, which had begun on November 21, 2011. Arb. X 6. Subsequent to the continuance granted in June 2013, Petitioner's counsel obtained a report from Dr. Paul dated August 12, 2013. Said report was the subject of Dr. Paul's deposition taken on September 30, 2013, and offered as Petitioner's Exhibit No. 12. Based upon the Arbitrator's review of the deposition transcript and the record in its entirety, the Arbitrator admits Petitioner's Exhibit No. 12 over Respondent's objection.

CONCLUSIONS OF LAW

In regard to the 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 finds that Petitioner does not suffer from coal workers' pneumoconiosis. In so concluding, the Arbitrator relies upon the findings of NIOSH that Petitioner's x-ray of May 7, 2007, three months prior to the mine closure, did not reveal any definite evidence of coal workers' pneumoconiosis. RX 3. The Arbitrator relies on the opinions of the physician of NIOSH, as NIOSH is the governmental agency responsible for administering the health surveillance program for the benefit of coal miners (PX 1, 5), NIOSH is not a party to this action, and the x-ray was taken and reviewed for reasons independent of litigation. As such, the Arbitrator places greater weight on the reading and conclusion of the NIOSH B-reader than the physicians and/or B-readers hired by either party of this claim.

While Dr. Wiot opined that Petitioner does not suffer from coal workers' pneumoconiosis, the Arbitrator does not place evidentiary weight on Dr. Wiot's opinions. The Commission has noted that Dr. Wiot "has been in practice almost fifty years and could not remember examining a set of x-rays for petitioners' or plaintiffs' attorneys. The overwhelming majority of his work is for insurance companies, respondents, and employers, " *Lefler v. Freeman Coal Company*, 8 IWCC 1097, *6 (September 25, 2008), which goes to the weight of his opinions.

Further, in reviewing the readings performed by Dr. Smith, the Arbitrator notes that Dr. Smith noted opacities in all lung zones on the chest x-ray of April 1, 2006, but only found opacities in the bilateral middle and lower lung zones on the x-rays of October 4, 2006 and November 2, 2007. PX 3. As such, what Dr. Smith found to be opacities of pneumoconiosis on the April 2006 film would have had to disappear from the upper lung zones on subsequent x-rays, according to his findings, which is inconsistent with the permanent nature of the scarring of pneumoconiosis that is without a cure.

The Arbitrator finds that Petitioner suffers from mild obstructive airway disease. This diagnosis is supported by the baseline spirometry testing administered by NIOSH on May 7, 2007, three months prior to ceasing employment with Respondent. NIOSH indicated that Petitioner's results were interpreted as abnormally low, and stated that an obstructive abnormality indicates that air is exhaled from the lungs more slowly than normal, as can be seen in lung conditions such as asthma, bronchitis, or emphysema. PX 5. The diagnosis of mild airway obstruction is further supported by the pulmonary function testing performed by Dr. Bansal on December 28, 2007, which showed a variability in FVC was 9.7% or 320 milliliters and exceeded the variability limit imposed by the American Thoracic Society and the European Respiratory Society for valid testing. PX 13. The Arbitrator places the greatest weight on the testing performed at the direction of NIOSH on May 7, 2007 and by Dr. Bansal, both of which were performed for reasons independent to the present claim. The testing performed by both NIOSH and Dr. Bansal is corroborated by Dr. Paul's testing and opinions. PX 1, 9, 12. While Dr. Selby testified that his testing revealed no abnormality, the Arbitrator notes that Dr. Paul, upon review of Dr. Selby's testing, interpreted Dr. Selby's results as indicative of obstructive lung disease. PX 12. The Arbitrator finds Dr. Paul's opinions more persuasive than that of Dr. Selby, given that Dr. Paul's opinions are consistent with the testing performed by NIOSH and Dr. Bansal, whereas Dr. Selby's opinion that Petitioner does not suffer from an obstructive lung disease place them at odds with the findings of NIOSH, Dr. Bansal and Dr. Paul, and in that respect, stands alone.

The Arbitrator finds that Petitioner suffers from chronic bronchitis and asthma. Dr. Paul diagnosed Petitioner with both conditions, and the Arbitrator finds it significant that NIOSH found Petitioner's pulmonary function testing of May 7, 2007 may be consistent with chronic bronchitis, asthma, and emphysema. Dr. Bansal also testified that Petitioner's presentation to him was consistent with chronic bronchitis, and the Arbitrator notes that Dr. Selby opined in his report of November 20, 2008 that Petitioner "had asthma as a child and continues to have asthma that is relatively well controlled." Dr. Selby testified that asthma could explain why Petitioner performed just above the lower limit of normal on his examination while he performed below the normal limit on other testing. Dr. Selby also testified that asthma waxes and wanes, and a patient with asthma may have perfectly normal physical findings on one day while abnormal the next. The Arbitrator finds it noteworthy that despite acknowledging that a methacholine challenge is more sensitive test for ascertaining reactivity in the airways when an individual has a normal or near normal FEV1, Dr. Selby did not perform one as part of his examination, and stated that one reason he did not do so was because "it's very time-consuming to add on to an already long day." RX 2.

Based upon the foregoing and the record in its entirety, the Arbitrator concludes that Petitioner suffers from mild obstructive airway disease, chronic bronchitis and asthma that arises out of and in the course of his employment with Respondent.

In regard to disputed issue (F), the Arbitrator finds that Petitioner's current conditions of ill-being of mild obstructive airway disease, chronic bronchitis, and asthma are causally related to his exposures while mining coal for Respondent. In so concluding, the Arbitrator notes that Petitioner's testing physician, Dr. Rollet, opined that given the findings of the CDC pulmonary function testing administered by NIOSH on May 7, 2007 that revealed mild airway obstruction, Petitioner's obstructive defect was caused or aggravated by his employment as a coal miner. PX 18. Dr. Rollett's opinions are corroborated by the testimony of both Dr. Paul and Dr. Selby, who concur that exposures in a coalmine, such as roof bolting glues, other adhesives, spray paints, and diesel fumes, can cause and/or aggravate asthma. PX 1, RX 2. While Dr. Selby testified that chronic industrial bronchitis "virtually never causes significant, long-lasting obstructive lung disease and goes away within a few weeks of removal from the source" (RX 2), Dr. Selby's opinion in that regard is contradicted by the pulmonary function testing performed by Dr. Paul almost exactly one year after the mine closure that indicated a methacholine challenge drop of 7% compatible with bronchitis (PX 1, 17), Dr. Bansal's testing which showed abnormal pulmonary function four months after Respondent's mine closed (PX 13), as well as by Dr. Selby's own testing more than a year after the mine closed that revealed a drop in FEV1 to 84% of predicted and a diffusion capacity 85% of predicted diffusion capacity revealed by his own testing performed more than a year after the mine closed. RX 2. Because Dr. Selby's opinions are called into question by other evidence in the record, the Arbitrator does not afford his causation opinions significant weight, and instead, the Arbitrator places greater weight on the opinions of Dr. Paul.

Based upon the foregoing and the record in its entirety, and in accordance with the opinions of Drs. Rollett, Paul and Bansal, the Arbitrator concludes that Petitioner's current conditions of mild obstructive airway disease, chronic bronchitis, and asthma were caused, contributed to, and/or aggravated by Petitioner's coal mining exposures.

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).

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 305/8(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", and a claimant must show that but for his injury, he would have continued mining coal. *Id.*

In this case, Petitioner last mined coal on August 29, 2007. Petitioner testified that he would have continued to work for Respondent as a coal miner but for the mine closure. Although he testified that he decided to end his mining career due to his breathing difficulties, he acknowledged that he would have reported for his shift the next day but for the mine closure. Furthermore, Petitioner did not report to Dr. Paul that he left coal mining due to respiratory problems or that he was unable to perform the duties of his last position in the mine. PX 1. Dr. Rollet testified that prior to ceasing his mine employment, Petitioner had not been diagnosed with any chronic lung disease, he had not received any medical treatment from Dr. Rollet for breathing problems, and there were no physical findings during any of Dr. Rollet's lung examinations of Petitioner. PX 2. In light of the foregoing, Petitioner has failed to prove that, but for his injuries, he would have been in full performance of his duties as a coal miner, and as such, Petitioner is not entitled to a wage differential award pursuant to Section 8(d)1.

The Arbitrator finds that Petitioner has proven disablement in accordance with Section 1(e) of the Act, and is permanently and partially disabled under Section 8(d)2. In so concluding, the Arbitrator finds significant the opinion of Dr. Rollet that, given the findings of the CDC pulmonary function testing administered by NIOSH on May 7, 2007, further coal mine exposure would increase Petitioner's risk of progression of his obstruction. PX 18. Dr. Paul similarly opined that Petitioner's bronchitis was a permanent condition, and in light of his obstructive disease, bronchitis, and asthma, that he could not have any further exposure to the environment of a coal mine without endangering his health. PX 1, 9, 12. Dr. Selby acknowledged that an individual with asthma or obstructive lung problems should avoid such an environment. RX 2. Because the medical evidence indicates that Petitioner cannot return to mining without risking the progression or aggravation of his conditions of obstructive airway disease, bronchitis and asthma, the Arbitrator concludes that he has proven disablement within the meaning of the Act. Petitioner credibly testified that he suffers with shortness of breath with exertion and frequent coughing for which he takes Nasonex, Albuterol three to four times per day, and Advair. Based upon the foregoing and the record in its entirety, the Arbitrator concludes that Petitioner is permanently and partially disabled to the extent of 5% of the person.

In regard to the issue of timely disablement pursuant to Section 1(f) of the Act, Petitioner's last injurious exposure occurred on August 29, 2007. His pulmonary abnormalities were discovered during pulmonary function testing administered by NIOSH on May 7, 2007, and those results were conveyed to Petitioner by way of a letter dated July 10, 2007. PX 5. Petitioner filed his present claim on January 30, 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.

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BARRALES, ARNOLD Case# **06WC041557**

Employee/Petitioner

DOMINICK'S FINER FOODS

Employer/Respondent

On 11/10/2015, 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 0.34% 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:

2053 TAMVAKIS LAW
HELEN BLOCH
53 W JACKSON BLVD SUITE 601
CHICAGO, IL 60604

0560 WIEDNER & McAULIFFE LTD
MARGARET G McGARRY
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ARNOLD BARRALES
Employee/Petitioner

v.

DOMINICK'S FINER FOODS
Employer/Respondent

Case # **06** WC **41557**

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 cities of **Chicago and Wheaton**, on **1/6/15 and 5/23/15**. 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 **Permanent total disability**

FINDINGS

On **4/7/2006**, 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 not*** sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned $**43,659.20**; the average weekly wage was $**839.60**.

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

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

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

Respondent shall be given a credit of $ for TTD, $ for TPD, $ for maintenance, and $**6499.98** for other benefits, for a total credit of $**6499.98**.

Respondent is entitled to a credit of $**2838.98** under Section 8(j) of the Act.

ORDER

Because the Petitioner failed to prove that he sustained accidental injuries which arose out of and in the course of the petitioner's employment with the respondent, and failed to prove a causal relationship between his current condition of ill-being and his employment with the respondent, 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.

Signature of Arbitrator

10/2215
Date

NOV 10 2015

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ARNOLD BARRALES,	)	
Employee/Petitioner,	)	
	)	**Case No. 06 WC 41557**
v.	)	
DOMINICK'S FINER FOODS,	)	
Employer/Respondent.	)	

ADDENDUM TO THE DECISION OF THE ARBITRATOR

An Application for Adjustment of Claim was filed in this matter on September 25, 2006 with Petitioner seeking relief from the Respondent, under the Illinois Workers' Compensation Act.

On January 6, 2015, this matter was heard by Arbitrator Jessica A. Hegarty in Chicago, Illinois. To allow Respondent an opportunity to produce a witness, this matter was bifurcated and continued to May 22, 2015 in Wheaton, Illinois.

Petitioner alleges that he sustained repetitive injuries to his right arm, neck and back that manifested on April 7, 2006. Respondent disputes accident, causal connection, liability for unpaid medical bills, TTD and the nature and extent of Petitioner's alleged injury. Petitioner claims total disability. (Arb. 1).

FACTS OF THE CASE

The Petitioner, a right-handed, 65-year-old man, was hired by the Respondent in 1991 as a meat manager, a position he held until 1993, when he accepted a position as a retail meat cutter.

From 1993 through 2003, the Petitioner, who lives in New Lenox, Illinois, worked as a retail meat cutter at the Respondent's store in Crestwood, Illinois. In 2003, the Petitioner was transferred from the Crestwood location to a store located on the west side of Chicago. The Petitioner testified that this location required a long car trip from his house and was in a "dangerous" part of the city. The Petitioner worked at the Crestwood store from 2003 through 2006.

According to a job description Respondent provided to the Section 12 examining doctors, Petitioner's job was classified as "heavy" and he was required to stand throughout his shift. (R. 1, Exhibit 3)
Petitioner testified that his job duties required him to lift 40 boxes of meat that each weighed 60-80 pounds off of a pallet. He would then stack these boxes in his work area. Once stacked, the boxes reached over 5 feet in length and took up about 20-30 feet of space in the cooler. Arnold performed his job each day in refrigerated conditions. His workspace remained cold so that the meat and poultry he needed to cut would not get spoiled. He testified that he worked in an "ice box" with the cold blowing on his neck all day long in 32-40 degree temperatures.

According to his testimony, Petitioner would use a box cutter with his right arm to open the boxes that contained the meat. He would "grab" his meat hook with his right hand to lift pork loins that weighed up to 74 pounds. He would then carry the meat with his right arm and put it on the table. He would next turn on the saw and push through the meat using his right arm. On the table he would use his butcher knife, which he had to steady with force with his right arm, to trim the meat. While cutting the meat he had to keep a "firm grip" on the handle of the knife using his right arm so that he could cut through the meat and not cut himself. He used a scraper to cut away the excess fat and bone dust so that the meat would "look more presentable." Afterward, he put the meat on trays and stacked the trays on a rack until they were full. Then, the racks went to the wrapping station.

On April 7, 2006, the Petitioner was advised by his manager, Nigel Cartharn, that he was being transferred to the Respondent's location on the north side of Chicago, at Division and Clybourne. The Petitioner testified that this location was further from his home. The Petitioner did not report to the new location at Division and Clybourne and has not worked for the Respondent since April 7, 2006.

On September 25, 2006, the Petitioner filed an Application for Adjustment of Claim alleging that he sustained injuries to his right arm, neck, and back while working on April 7, 2006.

Medical Records Prior to April 7, 2006

On February 12, 1998, the Petitioner presented to Dr. K. Holmes of Advocate South Suburban Hospital with complaints of "right upper extremity pain and stiffness He has had some problems on and off for the last two years but seems to be increasing over time with pain mostly circumferentially around the right elbow and inability to straighten the right elbow." (PX 2). Petitioner also reported "some discomfort and pain in the right neck and shoulder over the last couple of weeks as well. The symptoms seem to be aggravated by repetitive movements of the arms at work." (Id.). An EMG/NCV test was performed to rule out right cervical radiculopathy, right brachial plexopathy, tight carpal tunnel syndrome and right ulnar neuropathy. (Id.). The study was interpreted as normal. (Id.). X-rays of the right elbow and cervical spine were taken. (Id.). The right elbow x-rays revealed diffuse degenerative changes throughout the right elbow with prominent hypertrophy at the coronoid and olecranon process and

osteophytes arising from the radial head. The cervical x-rays revealed normal cervical lordosis and degenerative changes at C5-C6 with disc space narrowing and osteophyte formation. The posterior osteophytes were noted to impinge on the neural foramina on the right at C5-6 and on the left at C6-7. (Id.).

The Petitioner presented to orthopedic surgeon, Dr. Mark Chang, on February 26, 1998 with complaints of neck pain radiating into both shoulders but progressive right shoulder pain and loss of motion for approximately two years. (Id.). Upon examination, Dr. Chang diagnosed the Petitioner with "severe right elbow osteoarthritis" as well as "C5-C6 spondylolisthesis with probable right C6 radiculopathy". (Id.). Dr. Chang opined that the Petitioner's elbow condition was due to severe arthritis and that while the arthritis had caused a lot of spurring and a bony blockage to full extension and flexion, his range of motion was within functional limits. The Petitioner was released to return to work as of March 8, 1998 with restrictions. (Id.).

On March 26, 1998, the Petitioner returned to Dr. Chang for a reevaluation. The Petitioner complained of the inability to straighten his right elbow, which Dr. Chang advised was due to the extent of the arthritis. The Petitioner was advised to continue light duty work. When the Petitioner returned two months later, on May 21, 1998, he reported improvement in his right elbow pain. He continued to note stiffness in the neck and upper back area on the right side. Dr. Chang recommended continued work restrictions and a re-evaluation in two months.

The Petitioner returned to Dr. Chang every two months through December 1998 with regard to the right elbow. On December 17, 1998, Dr. Chang discussed the possibility of right elbow reconstructive surgery; however, Dr. Chang noted that such surgical treatment was reserved for cases of severe pain, which the Petitioner was not having. Rather, Dr. Chang indicated that the Petitioner's symptoms involved stiffness which was responding to medication. Dr. Chang recommended the use of Naprosyn and a continuation of work restrictions for one year. (PX 2).

One year later, on December 23, 1999, the Petitioner returned to Dr. Chang. He reported that his right elbow "was doing about the same". (Id.). Dr. Chang issued permanent restrictions "for his lifting limit" and instructed Petitioner to return on an "as needed basis." . (PX 2).

The Petitioner returned to Dr. Chang on July 20, 2000. He reported that he had been working full duty without issue. The right elbow range of motion remained limited; however, his symptoms had not worsened since increasing his work load. Dr. Chang opined that it was safe for the Petitioner to resume full duty and released the Petitioner from treatment. (PX 2).

Treatment after April 7, 2006

On April 8, 2006, the Petitioner presented to Nowobilska Medical Practice, the office of his primary care physician, where he was seen by Dr. Piotrowski. The record lists the "Reason for Consultation" as "check- up." (RX 4 p.54). .The Petitioner was diagnosed

with chronic uncontrolled hypertension, for which he was given medication and was referred for a stress test and myocardial perfusion scan. The Petitioner's second diagnosis was listed as "other unspecified back disorder" for which he was referred to a pain clinic. ;It was noted that Petitioner had been seeing orthopedic specialist, Dr. Change, for years or months in relation to right elbow pain. The Petitioner was noted to be thinking about surgery and was going to follow up with an orthopedic in that regard. He was advised to return for a re-evaluation in regard to his hypertension in three weeks. (RX 4 p.55).

The Petitioner presented to Dr. Ebby Jido of the Pain Management Center at Advocate Christ Medical Center on April 27, 2006. Upon presentation, the Petitioner completed a Patient History in which he indicated that he had been experiencing a gradual onset of pain since 1994 due to illness. Dr. Jido reported that the Petitioner complained of low back and right lower extremity pain, for which he had treated with Dr. Chang approximately six years earlier. Dr. Jido recommended a lumbar MRI scan and indicated that the Petitioner would be scheduled for a series of epidural steroid injections in the future. (PX 8). The April 27, 2006 report does not contain any mention of neck or upper extremity pain.

On April 28, 2006, the Petitioner underwent a lumbar MRI scan. The MRI revealed degenerative changes of the lumbar spine, most notably at the L4-5 level. The Petitioner then returned to the Pain Center on May 1, 2006. Upon presentation after the lumbar MRI scan had been completed, the Petitioner reported that his pain was worse in his shoulders and neck. He described constant pain in his neck radiating down his shoulders bilaterally, which affected his ability to work and function. It was recommended that the Petitioner undergo a series of trigger point injections over his bilateral trapezius muscles and along the deltoids. (PX 8). The first series of those injections was provided that day. (PX 8).

The Petitioner returned to the office of his primary care physician on May 6, 2006 at which point he was seen by Dr. Piprowski. It was noted that the Petitioner had undergone a cardiac stress test on April 29, 2006 and had been diagnosed with emphysema. It was also noted that his hypertension had improved with the use of medication. Finally, Dr. Piprowski indicated that the Petitioner had undergone "shots" at the pain clinic, the results of which the Petitioner reported begin very happy with. It was indicated that the Petitioner was scheduled for an orthopedic exam two weeks later for the right elbow. In the interim, Dr. Piprowski authorized the Petitioner to remain off of work. (RX 4 p.58).

Throughout the remainder of May 2006, the Petitioner continued to undergo treatment with his primary care physician's office for numerous unrelated conditions, including kidney cysts and emphysema, as well as for a sleep apnea study. (RX 4). The second set of trigger point injections for myofascial pain was performed at the Pain Center on June 7, 2006. (PX 8). The Petitioner reported good relief with the injections and a third set was scheduled for July 2006.

On June 20, 2006, the Petitioner returned to Dr. Mark Chang. Dr. Chang indicated that he had treated the Petitioner in the past for right elbow pain secondary to severe osteoarthritis and that the Petitioner had a history or neck and lower back pain. Upon presentation, the Petitioner reported that he had to "quit working" because of neck and right elbow pain and stress. The Petitioner reported symptoms in his right elbow, neck, and low back, with the pain most severe in his right elbow. T. (PX 2).

Upon examination, Dr. Chang noted mild tenderness in the mid to lower cervical spine into the right trapezial area, with decreased rotation to the right and a negative Spurlings test. The Petitioner had severe tenderness around the right elbow and limited range of motion due to pain. A neurologic examination of the upper extremities was normal. An examination of the low back showed mild tenderness and normal neurologic findings. X-rays of the right elbow were taken which revealed severe osteoarthritis. Dr. Chang discussed a possible right elbow reconstructive surgery and referred the Petitioner to Dr. Daniel Mass for an evaluation. (PX 2).

The Petitioner presented to the Pain Center on July 5, 2006 for the final set of trigger point injections. He reported good relief with the prior set of injections and was performing stretching exercises are recommended for this myofascial pain. Trigger point injections were provided over the bilateral trapezius muscles and the Petitioner was advised to return as needed. (PX 8).

On July 18, 2006, the Petitioner returned to Dr. Chang. The Petitioner reported that he was "doing ok" and that he was applying for "medical retirement." Dr. Chang opined that he did not think it was "safe" for the Petitioner to work as a meat cutter and that the Petitioner therefore qualified for "disability." Because the Petitioner's symptoms were stable, however, Dr. Chang did not order any treatment, but rather recommended observation only. The Petitioner was advised regarding activity modification and was released on an as needed basis. (PX 2; RX 3 p.8).

The Petitioner returned to Dr. Chang on September 19, 2006. He noted pain in the neck and upper back, which had been helped with "exercises" and anti-inflammatory medications. When the Petitioner retuned to Dr. Chang on October 24, 2006, it was noted that he had received authorization for an evaluation with Dr. Mass with regard to the right elbow. Dr. Chang noted that neck treatment would be held until the Petitioner had completed treatment for the right elbow. (PX 2; RX 3 p.6).

When the Petitioner retuned to Dr. Chang on November 28, 2006, he had yet to see Dr. Mass. (PX 2; RX 3 p.5). The Petitioner reported no change in his condition and Dr. Chang opined that the Petitioner remained disabled because of "arthritis in the right elbow and because of his neck pain." The Petitioner was authorized off of work until he could be evaluated by Dr. Mass and was advised to return to Dr. Chang in six weeks. (PX 2; RX 3 p.5).

On December 13, 2006, the Petitioner presented to the emergency room at Advocate South Suburban Hospital after having tripped down the stairs at home. The Petitioner was subsequently diagnosed with an angulated fracture of the right small finger, for

which he underwent an open reduction and internal fixation on December 19, 2006. (PX 10). The Petitioner testified that after surgery, his right hand was casted and he underwent physical therapy.

The Petitioner returned to Dr. Chang on March 6, 2007. (PX 2; RX 3 p.4). It was noted that the Petitioner had recently come out of the cast for the right hand injury. He reported that his right elbow and neck pain remained unchanged and was non-responsive to ibuprofen. Dr. Chang recommended Naprosyn and opined that the Petitioner could not return to work, especially in light of his finger fracture. Continued observation was recommended and the Petitioner was advised to return in two months. (PX 2; RX 3 p.4).

On May 8, 2007, the Petitioner returned to Dr. Chang. It was noted that the Petitioner had seen Dr. Mass and that Dr. Mass recommended that the Petitioner hold off on right elbow surgery for as long as possible. The Petitioner noted some difficulty with his neck; however, Dr. Chang noted that the Petitioner was tolerating the symptoms well and no treatment was needed. The Petitioner again was noted to be seeking "medical retirement." It was recommended that he follow up in two months. (PX 2; RX 3 p.3). At the time of his deposition, Dr. Chang admitted that the Petitioner had never been evaluated by Dr. Mass. (PX 1 p.86-89).

The Petitioner returned to Dr. Chang on July 27, 2007 as recommended. The Petitioner reported the same neck and right elbow pain. Dr. Chang opined that the Petitioner could not work as a meat cutter, but that he could tolerate daily physical demands. Dr. Chang noted that the Petitioner could work light duty if available. Because, however, light duty was allegedly unavailable, Dr. Chang opined that the Petitioner qualified for "disability benefits." The Petitioner was told to return in two months. No active treatment recommendations were made. (PX 2; RX 3 p.32).

Five months later, on December 15, 2007, the Petitioner returned to Dr. Chang for a follow up evaluation. The Petitioner reported doing "about the same" with pain in the neck and bilateral arms, which he was tolerating. No active treatment recommendations were made. Dr. Chang recommended continued observation and advised the Petitioner to return in two months. (PX 2; RX 3 p.31).

In March of 2008, the Petitioner underwent various cardiac tests at the request of his primary care physician. (RX 4). The medical records from the primary care physician's office, Nowobilska Medical Practice, indicate that the Petitioner underwent a lower extremity EMG/NCV test on April 2, 2008 at the request of Dr. Nowobilska. The EMG/NCV test was normal, with no evidence of neuropathy or radiculopathy in the bilateral lower extremities. (RX 3 p.36-42).

Following the EMG/NCV test, the Petitioner continued unrelated cardiac treatment in April and May 2008. The Petitioner returned to Dr. Chang on May 27, 2008, after a five month hiatus. (PX 2; RX 3 p.33). At that time, the Petitioner noted some neck, bilateral arm, and right elbow pain which was managed with medication. No active treatment

recommendations were made. Dr. Chang recommended continued use of medication and a follow up in two months. (PX 2; RX 3 p.33).

Two months later, on July 22, 2008, the Petitioner returned to Dr. Chang. (PX 2). The Petitioner reported the same degree of neck and right elbow pain, as well as low back pain. This is the first notation of low back pain contained in the medical records of Dr. Chang since 2006. No active treatment recommendations were made. Dr. Chang renewed the Petitioner's medications and released him to return on an as needed basis. (PX 2).

The Petitioner followed up with Dr. Chang on September 9, 2008 with reports of the "same neck pain, lower back pain, right shoulder pain, and right elbow pain." Dr. Chang opined that the Petitioner's function was "very limited;" however, his condition had not worsened. No active treatment recommendations were made. Dr. Chang noted that the Petitioner remained "disabled" and advised him to return in two months. (PX 2).

The Petitioner testified that he was able to participate and drive in a 135 mile motorcycle trip fundraiser in the fall of 2008. The Petitioner also testified that in the fall of 2008, he began receiving a pension from the United Food and Commercial Workers International Union.

On December 9, 2008, and March 17, 2009, the Petitioner returned to Dr. Chang. Each office visit note indicates that the Petitioner was "doing about the same" with the same neck, lower back, and right elbow pain. It was noted that the Petitioner was managing the symptoms with the use of Naprosyn and Lortab. (PX 2). No further treatment was recommended.

The Petitioner underwent a lumbar MRI scan on July 9, 2009 at the request of Dr. Chang. The lumbar MRI revealed: mild foraminal narrowing at L3-4; moderate central canal and neuroforaminal narrowing at L4-5; and, mild to moderate neuroforaminal stenosis at L5-S1, left greater than right. (PX 2).

After the lumbar MRI scan was completed, the Petitioner presented to Dr. Chang on July 14, 2009. Dr. Chang noted that the MRI revealed L4-5 moderate disc degeneration and stenosis. The Petitioner was therefore referred to a pain clinic for injection treatment. (PX 2).

Per Dr. Chang's referral, the Petitioner presented to Dr. Nicholas Angelopoulos for a pain management consultation on July 16, 2009. The Petitioner complained of low back pain radiating down his legs bilaterally. The Petitioner was diagnosed with L4-5 and L5-S1 spinal stenosis, left greater than right; lumbar facet joint arthropathy; and probable cervical degenerative disc disease and facet arthropathy. It was recommended that the Petitioner undergo lumbar epidural steroid injections bilaterally at L4, L5, and possibly S1. (PX 2).

The first lumbar epidural steroid injection was provided on July 21, 2009. After that initial injection, the Petitioner returned to Dr. Angelopoulos on August 3, 2009

reporting "fairly good" improvement in his lumbar pain. Accordingly, Dr. Angelopoulos provided a second injection on August 3, 2009. (PX 2).
After the second injection, the Petitioner presented to Dr. Chang on August 25, 2009. It was noted that he was going for the third injection later that day; however, the Petitioner reported to Dr. Chang that he still had the same lower back and left leg pain as he had before the first two injections. Dr. Chang noted that the plan was to wait to see how the Petitioner responded to the third injection and noted that physical therapy could be an option. (PX 2).

When the Petitioner presented to Dr. Angelopoulos later that same day, August 25, 2009, he reported significant improvement in his low back and leg pain after the second injection. At that time, a third injection was given. (PX 2).

After the third injection, the Petitioner did not return to Dr. Chang until November 3, 2009. At that time, the Petitioner reported low back pain and the "same problems with his neck and elbows;" but the symptoms were manageable. The Petitioner reported medication did help with the low back pain, but indicated that he had been thinking "more and more about the possibility of surgery." The Petitioner wanted to wait until after the holidays. Therefore, Dr. Chang recommended that he return in two months. (PX 2). The specific type of surgery recommended is not discussed in the record of Dr. Chang.

On March 5, 2010, Dr. Chang performed L4-5 and L5-S1 bilateral laminotomies, partial facetectomies, and decompressions. (PX 10). Post-operatively, the Petitioner returned to Dr. Chang on April 27, 2010 with complaints of continued low back and right leg pain. Dr. Chang advised that due to the "long chronicity" of the Petitioner's nerve compression, he would likely require more time to recover. The Petitioner was advised to return in six weeks at which point an updated MRI would be considered if his symptoms continued.

Surveillance was conducted of the Petitioner on July 3, 2010 and July 4, 2010. (RX 10, RX 9). A corresponding video was entered into evidence which contained 285 minutes of footage of the Petitioner over the two day period. During this period of time, the Petitioner was observed: smoking cigarettes; walking; bending at the waist; driving his vehicle; operating and riding on a motorcycle; cranking the throttle of the motorcycle; kneeling down on his left and right elbows to change the oil in the motorcycle; using various ratchets and tools with his right hand while working on the motorcycle; washing the motorcycle; pushing a lawn mower; operating riding lawn mower; lifting patio furniture; and, carrying bags of mulch. (RX 10).

On July 12, 2010, the Petitioner underwent an independent medical examination with Dr. Paul Papierski. (RX 1). Upon presentation, the Petitioner reported a gradual onset of pain in his right elbow since approximately May 1998. He reported that he had been diagnosed with arthritis and that he had "aches all over his body." (PX 1 p.9-10). Following a physical examination and a review of medical records from 1998 through 2010, Dr. Papierski diagnosed right elbow osteoarthritis. Dr. Papierski opined that the condition was degenerative in nature and was not causally related to the Petitioner's

employment. The doctor testified that the literature in the field of hand and upper extremity orthopedic surgery does not support that there are any general work activities that would result in the development of elbow arthritis. (RX 1, p.18-19). In support of his opinion, Dr. Papierski explained that the x-rays he reviewed which were taken of the Petitioner's right elbow in February of 1998 revealed the same findings as those taken in June of 2010. The Petitioner's right elbow condition had not progressed while he worked full duty from 2000 through 2006. (RX 1 p.20).

Six months after his last evaluation with Dr. Chang, the Petitioner underwent an MRI of the lumbar spine on October 19, 2010. The MRI revealed: intervertebral post-surgical changes at L5; a small left lateral disk protrusion at L5-S1 encroaching on the left S1 nerve root; degenerative changes with moderate central canal stenosis at L4-5 with moderate right greater than left foraminal narrowing. (PX 2).

After the lumbar MRI scan, the Petitioner was evaluated by Dr. Chang on October 26, 2010. The Petitioner had not been seen by Dr. Chang since April 27, 2010. It was noted that the MRI revealed instability at the L4-5 level. Because the Petitioner remained symptomatic, Dr. Chang recommended an L4-5 revision laminectomy, decompression, and fusion. (PX 2).

The Petitioner underwent an independent medical examination with Dr. Gunnar Andersson on November 9, 2010. (RX 2). Upon presentation, the Petitioner complained of pain in the neck with radiation into the right elbow as well as pain in the lower back radiating into the right leg and paresthesia in the bilateral lower extremities. (RX 2, p.7). Dr. Andersson noted that the Petitioner had undergone lumbar laminectomies in March 2010. Upon examination, the Petitioner demonstrated no tenderness in any area of his back. Dr. Andersson noted normal range of motion of the cervical spine with normal upper body strength and reflexes. There was decreased range of motion of the lumbar spine, negative straight leg raising tests, absent lower extremity reflexes, and normal lower extremity strength. (RX 2 p.10). Dr. Andersson noted that the Petitioner complained of sensory changes in the right lower extremity which affected the whole lower extremity in a stocking-like fashion. Dr. Andersson testified that the complaints of sensory changes in the entire right leg in a stocking-like fashion exist sometimes in diabetic neuropathy, but do not fit with any known spinal conditions. (RX 2, p.10).

In conjunction with his examination, Dr. Andersson reviewed medical treatment records from 1998 through 2010. These records included diagnostic test results, including the April 2, 2008 lower extremity EMG/NCV test, the July 7, 2010 cervical MRI scan, the July 9, 2009 and October 19, 2010 lumbar MRI scans, and the April 28, 2006 lumbar MRI report. (RX 2, p.12-23). Based on the medical records and his examination of the Petitioner, Dr. Andersson opined that the Petitioner's cervical and lumbar degenerative conditions were not caused or accelerated by his employment. (RX 2, p.25-27).

Dr. Andersson noted the April 28, 2006 lumbar MRI findings were different from those in the July 9, 2009 lumbar MRI scan. The EMG/NCV test done on April 2, 2008 revealed normal findings with no evidence of any lower extremity neuropathy at that time. (RX 2, p.21-22). The subsequent MRI, taken on July 9, 2009, revealed a

progression of the degeneration since 2006. Specifically, the 2009 MRI showed the progression of the degenerative process with L4-5 spondylolisthesis that was not present in the April 28, 2006 MRI. (RX 2, p.15-16). Dr. Andersson testified that these findings in the July 9, 2009 lumbar MRI scan, as well as those in the July 7, 2010 cervical MRI scan, were consistent with the normal progression of the degenerative process of the spine for a patient in his 60's. (RX 2, p.23). Specifically, Dr. Andersson opined that the pathology in the lumbar and cervical MRI scans were chronic responses to the degenerative process. (RX 2, p.24, 26-28).

On November 12, 2010, Dr. Chang performed an L4-5 revision laminectomy, lysis of adhesions, partial facetectomy, foraminotomy, and posteriolateral fusion. (PX 10). Post-operatively, the Petitioner presented to Dr. Chang on November 30, 2010. He reported improvement in his low back and leg pain following surgery. Activity restrictions were discussed and the Petitioner was advised to return in four weeks. (PX 2).

The Petitioner retuned on January 4, 2011 with decreasing pain in the low back and legs. X-rays revealed early fusing of the bone. The Petitioner was advised to increase activity at home and was referred for physical therapy. When the Petitioner returned to Dr. Chang on February 15, 2011, it was noted that he was making improvements in therapy.

Six months after the fusion, at the May 17, 2011 evaluation with Dr. Chang, it was noted that the Petitioner was doing so well that Dr. Chang considered him "fully healed in terms of the back." At that point, however, the Petitioner reported neck pain, particularly aggravated by laying down. (PX 2). Dr. Chang recommended that the Petitioner return to the pain clinic for injections for the cervical spine.

On May 24, 2011, the Petitioner returned to Dr. Angelopoulos for cervical injections. (PX 2). The Petitioner reported pain in his neck bilaterally which had increased steadily over time and which interfered with most of his daily activities. (PX 2). The Petitioner reported that the neck pain was aggravated with lying down. (PX 2). Upon review of a cervical MRI scan, Dr. Angelopoulos diagnosed cervical degenerative disc disease with stenosis and cervical spondylosis without myelopathy. Dr. Angelopoulos provided a cervical interlaminar epidural steroid injection at C6-7. (PX 2). The Petitioner was advised to return in two weeks.

The Petitioner returned to Dr. Angelopoulos on June 7, 2011 at which point he reported a few days of improvement in his symptoms following the first injection. The second cervical injection was performed and the Petitioner was advised to return for a third injection in two weeks. Dr. Angelopoulos noted that he would also consider facet injections at that time.

On June 27, 2011, the Petitioner returned to Dr. Angelopoulos. He noted only a few days of improvement following the second injection. Therefore, Dr. Angelopoulos did not perform the third cervical steroid injection. It was recommended that the Petitioner consider returning to Dr. Angelopoulos for facet injections. (PX 2).

The Petitioner returned to Dr. Chang on July 5, 2011.Dr. Chang noted that overall the Petitioner was "managing." He continued to report some back pain and leg numbness as well as neck pain. The cervical injections had not provided significant relief and therefore, Dr. Chang did not recommend facet injections, stating they were "not worth the risk." (PX 2). Dr. Chang recommended continued observation and a return visit in two months. (PX 2).

Two months later, on September 6, 2011, the Petitioner returned to Dr. Chang. He reported continued neck pain and in regard to the low back, the Petitioner reported some radiating pain that he was able to manage. Dr. Chang noted that the Petitioner was unable to take narcotic pain medication and therefore was managing with Naprosyn. (PX 2). It was recommended that he return in two months.

The Petitioner returned on November 8, 2011 for his one year post-operative evaluation in regard to the lumbar fusion. The Petitioner reported doing "very well" with minimal discomfort in the legs and low back. Dr. Chang indicated that the Petitioner was functioning "very well" and x-rays taken revealed a successful fusion. A physical examination revealed good range of motion and stable neurological function. Dr. Chang advised the Petitioner that he did not require any set restrictions in regard to his low back. Further, the Petitioner was advised that no additional follow up visits were necessary in regard to the lumbar spine. (PX 2).

After being released from treatment without restrictions for the low back on November 8, 2011, the Petitioner retuned to Dr. Chang on March 22, 2012. At that time, he reported persistent low back and leg pain and it was noted that his function was "very limited." The Petitioner advised that he was only able to tolerate activities for a few minutes at a time and that he continued to require pain medication. A physical examination at that time revealed limited range of motion and diffuse tenderness in the low back. Dr. Chang indicated that he "validated that he [the Petitioner] remains completely disabled." The Petitioner was advised to return in three months. (PX 2). There was no mention of cervical pain or right elbow pain and there were no active treatment recommendations.

Dr. Chang's evidence deposition was taken on April 18, 2012.

Petitioner returned to Dr. Chang on June 21, 2012. The June 21, 2012 office visit report is identical to that of March 22, 2012. The Petitioner reported persistent lower back and leg pain. Dr. Chang noted that the Petitioner had "very limited" function and was only able to tolerate activity for a few minutes at a time. Again, Dr. Chang opined that the Petitioner remained completely disabled and recommended that he return in three months. There was no mention of cervical pain or right elbow pain. There were no active treatment recommendations.

The Petitioner followed up with Dr. Chang on September 20, 2012, December 20, 2012, and March 21, 2013. Each of the corresponding office visit notes are identical to those from March 22, 2012 and June 21, 2012. The Petitioner reported persistent lower back and leg pain. Dr. Chang noted that the Petitioner had "very limited" function and was

only able to tolerate activity for a few minutes at a time. Dr. Chang opined that the Petitioner remained completely disabled and recommended that he return for a reevaluation between three and six months later. There was no mention of cervical pain or right elbow pain contained in the records between November 8, 2011 and March 21, 2013 and there are no active treatment recommendations.

On September 17, 2013, the Petitioner presented for re-evaluation. (PX 3). He reported persistent neck, low back, and leg pain. Again, Dr. Chang noted that the Petitioner had "very limited" function and was only able to tolerate activity for a few minutes at a time. Examination revealed moderate diffuse tenderness in the neck and low back and limited range of motion in the low back. Dr. Chang opined that the Petitioner remained completely disabled and recommended that he return in four months. (PX 3).

The Petitioner returned to Dr. Chang on January 14, 2014. At that time, the Petitioner reported increased neck and right arm pain over the past few weeks. The Petitioner did not recall any specific injury or event that caused the aggravation in his symptoms. He reported that the pain was worse than his usual "chronic lower neck pain" and that it was associated with some numbness and weakness in the right hand. (PX 3). Upon examination, Dr. Chang noted moderate tenderness in the lower cervical spine extending into the right trapezial area. Neurological examination revealed mild weakness in the right wrist and elbow and decreased sensation. Dr. Chang opined that given the development of neurological symptoms in the right arm, the Petitioner likely aggravated his underlying degenerative cervical condition. The Petitioner was referred for an updated cervical MRI scan. (PX 3).

On January 17, 2014, a cervical MRI scan was performed. The scan revealed: C6-7 disc bulge and boney degenerative changes with more focal protrusion into the neural foramen causing moderate central spinal canal and severe foraminal stenosis; C5-6 changes with moderate spinal canal stenosis on the left and moderate to severe foraminal stenosis of the right; C3-4 changes causing mild central canal and moderate to mildly severe foraminal stenosis and a superimposed central annular tear; C4-5 mild to moderate stenosis; and C2-3 mild foraminal stenosis. The report notes that the 2014 findings were progressed from the 2010 cervical MRI findings. (PX 3).

Following the MRI scan, the Petitioner returned to Dr. Chang on January 21, 2014. Dr. Chang reviewed the MRI and noted worsening C5-6 and C6-7 disc herniations and severe stenosis. Because the Petitioner remained "severely symptomatic" and had failed conservative treatment, Dr. Chang recommended a C5-6 and C6-7 anterior discectomy and fusion. (PX 3).

On February 21, 2014, Dr. Chang performed an anterior discectomy and fusion at C5-6 and C6-7. (PX 10). Post-operatively, the Petitioner returned to Dr. Chang on March 6, 2014. The Petitioner reported improvement in his cervical and arm pain following surgery. Neurologically, the Petitioner was stable and x-rays revealed good placement of the instrumentation. The Petitioner was advised to return in two weeks for a reevaluation. (PX 3).

When the Petitioner returned on March 20, 2014, he again reported improvement. Dr. Chang allowed him to discontinue the use of the neck brace and released him to drive locally. The Petitioner was referred for physical therapy. On April 17, 2014, the Petitioner returned, again reporting improvement in his cervical and arm pain following surgery. There was improved range of motion of the neck and good strength in the upper extremities. Dr. Chang noted that the Petitioner was making progress in physical therapy and that his neurologic examination was stable. The Petitioner was advised to continue physical therapy and return in two months to discuss "activity status." (PX 3).

When the Petitioner retuned to Dr. Chang on June 19, 2014, he reported persistent low back pain and right leg pain. Dr. Chang noted that the Petitioner had "very little" function and was unable to tolerate activity for more than a few minutes at a time. It was noted, however, that the Petitioner's neck was "doing better." Examination revealed diffuse tenderness in the low back and limited range of motion; however, the Petitioner remained neurologically stable. Dr. Chang opined that the Petitioner remained "completely disabled" and recommended that he return in three months. (PX 3).

On September 2, 2014, the Petitioner returned to Dr. Chang with complaints of increased low back and bilateral leg pain over the past few weeks. The Petitioner did not recall any specific injury or event that aggravated his symptoms; however, he reported that his symptoms were worse than his "usual chronic lower back pain." An examination revealed limited range of motion of the lumbar spine and moderate tenderness. The Petitioner demonstrated mild weakness in both legs and decreased pinprick sensation. A straight leg rise test was negative bilaterally. X-rays of the lumbar spine reveled good position of the hardware and no new instability.

Following the examination, Dr. Chang opined that the Petitioner aggravated his underlying degenerative lumbar condition. Because it had been four years since his fusion surgery, Dr. Chang recommended that the Petitioner obtain a new MRI scan. The Petitioner, however, wished to "hold off" on the lumbar MRI at that time. Dr. Chang renewed the Petitioner's medications and recommended that he follow up in three months. (PX 3).

The Petitioner returned to Dr. Chang on December 2, 2014. He was noted to be "doing the same" overall. Dr. Chang noted persistent lower back and left leg pain, neck pain, and right elbow pain. Again, it was noted that the Petitioner's function was "very limited" and that he was unable to tolerate activity for more than a few minutes. An examination was limited to the lower back and was noted to reveal diffuse tenderness and limited range of motion. Dr. Chang opined that the Petitioner remained "completely disabled" and recommended that he return in three months.

Most recently, the Petitioner was seen by Dr. Chang on March 3, 2015. The corresponding record indicates that the Petitioner complained of increasing low back and leg pain. Accordingly, Dr. Chang referred the Petitioner for a lumbar MRI scan. (PX 2).

Dr. Chang Deposition

The evidence deposition of Dr. Chang was taken on April 18, 2012. (PX 1). Dr. Chang testified that the Petitioner had made good progress following the lumbar surgery and had good relief of the low back and leg symptoms. (PX 1, p.50-51). Dr. Chang testified that in relation to the low back, the Petitioner had some "mild limitations" but that he did not have "severe limitations." (PX 1, p.61). Specifically, Dr. Chang recommended twenty to thirty five pound lifting limitations. (PX 1, p.61).

Dr. Chang testified that the Petitioner's most problematic condition was the right elbow. (PX 1, p.52). Although the doctor was not recommending any active treatment for the right elbow, he testified that the Petitioner had restrictions from lifting over ten pounds, lifting overhead, and from using any mechanized, or vibratory tools. (PX 1, p.106). In regard to the cervical spine, Dr. Chang testified that the Petitioner had some neck pain; however, the condition did not require surgery or active treatment as there were no neurological issues. (PX 1, p.52).

Surveillance

Surveillance was conducted of the Petitioner on October 4, 2013 and October 7, 2013. (RX 6, RX 5). A corresponding video was entered into evidence which contained approximately 130 minutes of footage of the Petitioner over the two day period from October 4, 2013 and October 7, 2013. During this period of time, the Petitioner was observed: walking; driving a vehicle; using a hand-held leaf-blower with his right arm; smoking cigarettes; bending at the waist; shopping at various stores; and carrying boxes of groceries. (RX 6).

Surveillance was again conducted of the Petitioner on October 10, 2013. (RX 8, RX 7). A corresponding video was entered into evidence which contained approximately 90 minutes of footage of the Petitioner. During this period of time, the Petitioner was observed: walking; bending at the waist; smoking cigarettes; operating a hand-held leaf blower with the left and right arm; moving motorcycles; and, working on cars involving bending at the waist while working under the hood and laying on the ground while working underneath a vehicle itself, over a seven hour period. (RX 8).

The Petitioner testified at trial that as a requirement for the continuation of Social Security Disability benefits, he continues to see Dr. Chang every two to three months.

CONCLUSIONS OF LAW

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

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

Based on the totality of the credible evidence, the Arbitrator finds, as a matter of fact and conclusion of law, that the Petitioner failed to prove that he sustained accidental injuries which arose out of and in the course of the Petitioner's employment with the Respondent and failed to prove a causal relationship between his current condition of ill-being and his employment with the Respondent.
The Arbitrator notes that the nature of Petitioner's job might, initially, lend itself to the assumption that Petitioner's injuries with respect to the right elbow and neck are job related but an examination of the medical records and expert testimony does not support such an assumption.

The Arbitrator adopts the opinions of Dr. Paul Papierski and Dr. Gunnar Andersson in regard to the causation of the Petitioner's right elbow, cervical, and lumbar degenerative conditions. Both doctors, who are specialists in their respective areas of orthopedic surgery, testified that the conditions were due to the natural degenerative arthritic process, and not to the Petitioner's employment. Both doctors' opinions in that regard are supported by the medical records in evidence.

With regard to the right elbow condition, following a physical examination and a review of medical records from 1998 through 2010, Dr. Papierski opined that the condition was degenerative in nature and was not causally related to the Petitioner's employment. The doctor, a board certified surgeon specializing in upper extremity treatment, testified that the literature in the field of hand and upper extremity orthopedic surgery does not support that there are any general work activities that result in the development of elbow arthritis. (RX 1, p.18-19).

In the specific instance of the Petitioner, Dr. Papierski explained that the right elbow x-rays he reviewed which were taken in February of 1998 revealed the same degenerative findings as those which he reviewed that were taken in June of 2010. The Petitioner's right elbow degenerative had not changed or progressed despite his full duty employment between 2000 and 2006, nor had the condition progressed from 2006 through 2010 while the Petitioner was off of work. (RX 1, p.20).

Dr. Gunnar Andersson testified regarding both the cervical and lumbar conditions. Dr. Andersson opined that the cervical and lumbar conditions were degenerative conditions which naturally progress over time, a process that is unrelated to employment.

Dr. Andersson cited the diagnostic test results from 2006, 2008, and 2009, in support of his opinion with regard to the Petitioner's lumbar condition. Dr. Chang testified that in 2006, the Petitioner had no evidence of lumbar neuropathy or neurologic problems. An April 2, 2008 EMG/NCV confirmed no evidence of lower extremity neuropathy or radiculopathy in 2008. Then, in July 2009, three years after the Petitioner stopped working, an MRI showed a change in the lumbar condition. Specifically, Dr. Andersson testified that the July 2009 lumbar MRI revealed a progression of the degenerative process with L4-5 spondylolisthesis that was not present in the April 28, 2006 MRI. (RX 2, p.15-16).

Dr. Andersson testified that this change was evidence of the degenerative progression of the Petitioner's condition. Dr. Andersson pointed out the fact that the Petitioner had not worked from 2006 through the 2010 IME, and yet the conditions had progressed. Thus, the Petitioner's employment was not a causative factor in the progression of the degenerative process.

In 2010, Dr. Chang recommended lumbar surgery. Dr. Chang opined that surgery was necessary due to the Petitioner's "long chronicity of nerve compression" which had begun years before the decision to have surgery in 2010, four years after he stopped working. (p. 100). At that time of his deposition, however, Dr. Chang testified that the Petitioner had no low back neurologic problems in 2006. Dr. Andersson opined that any neuropathy or radiculopathy developed after the 2008 EMG/NCV. Dr. Chang admitted that he was unaware that an EMG/NCV test had been taken on April 2, 2008 and that the EMG/NCV had revealed no evidence of lower extremity neuropathy or radiculopathy. He testified that the negative lower extremity EMG/NCV in 2008 could change his opinion as to when the Petitioner's radicular symptoms began. (102).

Dr. Andersson's opinion regarding the cervical condition is also supported by the medical evidence. Dr. Chang testified that when the Petitioner presented in 2006, the condition for which restrictions were given was the right elbow arthritis. From 2006 through 2009, he did not recommend any active treatment for the Petitioner's low back or cervical spine, testifying that neither area had any "neurological problems." The symptoms noted from 2006 through 2008 were related to the right elbow and the neck, and aside from an evaluation with Dr. Mass for the elbow and anti-inflammatory medication, the neck and right elbow required no active treatment. Dr. Chang continuously noted in the records that the conditions [right elbow and cervical spine] had not worsened and the Petitioner's symptoms remained "the same" as were noted in 2006- when there were no neurologic issues and no active treatment was recommended.

Dr. Andersson testified that the Petitioner's July 7, 2010 cervical MRI scan results were consistent with the normal progression of a degenerative process of the spine for a patient in his 60's. (RX 2, p.23). Even up to the time of his deposition in 2012, Dr. Chang was not recommending any cervical treatment. At the time of the deposition in 2012, Dr. Chang testified that the Petitioner had some neck pain; however, he had no neurologic symptoms and cervical surgery was not recommended. (PX 1, p.51).

It was not until January 14, 2014, eight years after he stopped working that the Petitioner presented to Dr. Chang noting a worsening of his "usual" chronic neck pain. (PX 3). Dr. Chang noted a change in his condition, which progressed to include upper extremity neurologic symptoms. Due to the change in the Petitioner's condition, Dr. Chang recommended surgery. Dr. Chang opined that given the recent development of neurologic symptoms, the Petitioner had aggravated the underlying degenerative condition. The Petitioner was referred for a cervical MRI scan.

Dr. Andersson's opinion regarding the nature progressive nature of the Petitioner's degenerative condition was confirmed with the January 17, 2014 cervical MRI scan. The cervical MRI scan taken January 17, 2014 was compared to that taken on July 7, 2010.

The radiology report notes that the 2014 MRI revealed progression of the cervical changes since the 2010 MRI. (PX 3). Thus, per the natural progression of the degenerative condition, during the period of time between 2010 and 2014, while the Petitioner was not working, his cervical condition had advanced.

Based on the above, the Arbitrator finds that the Petitioner failed to prove that he sustained accidental injuries which arose out of and in the course of the Petitioner's employment with the Respondent and failed to prove a causal relationship between his current condition of ill-being and his employment with the Respondent.

Because the Petitioner did not sustain an accident arising out of the course of his employment, and given that the Petitioner's condition of ill-being is not casually related to his employment, the Arbitrator denies all benefits, including temporary total disability and medical benefits.

O. Is the Petitioner permanently totally disabled as a result of the alleged work injury?

As noted above, the Arbitrator finds that the Petitioner failed to prove a causal relationship between his current condition of ill-being and his employment with the Respondent. As such, the Arbitrator finds, as a matter of fact and a conclusion of law, that the Petitioner is not permanently totally disabled as the result of his employment with the Respondent.

The Arbitrator notes that irrespective of the findings regarding accident and causal connection, the records do not support a finding of permanent total disability. Based on Dr. Chang's deposition testimony, and supported by Petitioner's activity level exhibited in the surveillance footage, the Petitioner is not permanently totally disabled. While activity limitations may be recommended, any current need for restrictions is due to the progressive nature of the degenerative conditions and is not related to the Petitioner's employment, which ended nine years ago. Further, the activity limitations recommended do not render the Petitioner medically unable to work in any capacity.

Dr. Chang testified that when the Petitioner presented in June of 2006, he complained of neck, low back, and right elbow pain. The doctor testified that neck and right elbow pain were the predominant issues that had caused the Petitioner to stop working in 2006. (PX 1, p.33) At the time of his deposition, Dr. Chang testified that the Petitioner's right elbow condition was the cause for "disability" in 2006. Specifically, between 2006 and 2008, the doctor did not find any neurologic problems with the upper extremities or the low back; but, because of the right elbow pain, Dr. Chang opined that the Petitioner qualified for disability. (PX 1, p.36). While Dr. Chang's medical records indication that the Petitioner had "very limited function" and remained "disabled," at the time of his deposition, Dr. Chang testified that the Petitioner could have worked light duty in regard to the right elbow. Specifically, the Petitioner could have used the right arm for between ten and fifteen pounds of lifting, and had no specific restrictions in regard to the left arm. (PX 1, p.105). The ability of the Petitioner to function in this regard is supported with the surveillance video footage in evidence.

In regard to the Petitioner's more recent level of function, Dr. Change testified that in 2012 at the time of the deposition, the Petitioner was also capable of using the right arm in a light duty capacity, with activity modifications recommended including no use of vibratory tools, no use of mechanized tools, no overhead lifting with the right arm, and no lifting over ten pounds. (PX 1, p.106). Dr. Chang testified that in with regard to the low back, the Petitioner had some "mild restrictions," but not "severe limitations." Specifically, Dr. Chang testified that the Petitioner should limit lifting to somewhere between twenty and thirty-five pounds. (PX 1, p.61). Again, per the surveillance footage entered into evidence, the Petitioner is capable of performing all of these activities seemingly without issue.

Based on Dr. Chang's testimony, as supported by the surveillance footage, the Arbitrator finds that the Petitioner is not permanently totally disabled. Any current need for activity restrictions is due to the progressive nature of the degenerative conditions and not the Petitioner's employment with Respondent, which ended nine years before the time of trial.

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CIFONIE, RENEE Case# **09WC043377**
Employee/Petitioner

ELGIN MENTAL HEALTH CENTER
Employer/Respondent

On 11/10/2015, 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 0.34% 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:

1067 ANKIN LAW OFFICE LLC
JOSHUA E RUDOLFI
162 W GRAND AVE
CHICAGO, IL 60654

5204 ASSISTANT ATTORNEY GENERAL
CHRISTOPHER FLETCHER
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

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

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

NOV 10 2015

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

Renee Cifonie
Employee/Petitioner

v.

Elgin Mental Health Center
Employer/Respondent

Case # **09** WC **43377**

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 **Brian Cronin**, Arbitrator of the Commission, in the city of **Elgin**, on **May 4, 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

FINDINGS

On **March 9, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned an average weekly wage of **$892.00**.

On the date of accident, Petitioner was **31** years of age, ***married*** with **0** dependent children.

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

Respondent paid a medical bill in the amount of **$192.97** to Sherman Family Healthcare; there is a **$0.00** balance for this provider.

Respondent paid a medical bill in the amount of **$191.35** to "Greater E."

ORDER

Respondent shall pay Petitioner an amount equal to the outstanding charges from Elgin Physical Health Center in the amount of $1,178.00, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

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

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

Signature of Arbitrator

November 10, 2015
Date

NOV 10 2015

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

Renee Cifonie
Employee/Petitioner

Case # **09 WC 43377**

v.

Elgin Mental Health Center,
Employers/Respondents

I. FINDINGS OF FACT

This action was pursued under the Illinois Workers' Compensation Act (the "Act") by the Petitioner and sought relief from the Respondent-employer Elgin Mental Health Center for Petitioner's work-related accident on March 9, 2007. On May 4, 2015, a hearing was held before Arbitrator Cronin in Chicago, Illinois. The Illinois Attorney General filed an appearance on behalf of the Elgin Mental Health Center and participated in the proceedings. Petitioner's Exhibits 1-2 were entered into evidence. Respondent's Exhibit 1, a statement of all payments made by the State of Illinois in the Petitioner's case was also entered into evidence.

Petitioner testified that she is currently employed at Elgin Mental Health Center and has been employed there for 16 years. Currently, Petitioner is an activity therapist who runs group meetings and activities for therapeutic purposes. Petitioner starts her day at 8:00 a.m. and drives to her job.

Petitioner testified that she was working on March 9, 2007. When she got out of her car that morning after she had arrived at work, she slipped on a sheet of ice in the parking lot. Petitioner fell on her right buttock and right leg. Petitioner reported what had happened to her supervisor. She was sent to Sherman Family Health Center. The doctor did not take her off work at that time. Petitioner had pain in her buttock and the sciatic area.

Petitioner underwent physical therapy at Elgin Physical Health Center. Petitioner testified that she was discharged from Elgin Physical Health Center.

Petitioner's medical records reveal that on the day of the accident, she had a steady gait and was in no acute distress upon physical examination. (Px #1) Petitioner's pain was noted to be 3/10 at that time and the diagnosis was coccyx contusion. On March 16, 2007, Petitioner was feeling much better than the prior week, but was still sore in the right leg, right buttock and middle back. A history of back problems was noted at that time. (Px #1) Petitioner was not at that time in any distress. Petitioner indicated it made her sore to sit and walk.

On March 12, 2007, Petitioner sought treatment at the Elgin Physical Health Center and was given a diagnosis of lumbosacral strain/sprain and right sciatica. (Px #2) Over-the-counter Ibuprofen was recommended at that time. More importantly, on March 30, 2007, the doctor noted that Petitioner was 90-95%t improved since she first fell. Petitioner felt good and had only a little soreness at times. The orthopedic tests to her lumbar spine were all negative. The doctor prescribed a home exercise program and gave lifting/bending precautions. The doctor found Petitioner to be at MMI and discharged her from active care. (Px #2)

Respondent paid a total of $384.32 towards Petitioner's medical bills. The Payee for the check in the amount of $192.97 is "Sherman," and the Payee for the check in the amount of $191.35 is "Greater E." (Rx #1)

Petitioner testified that her buttock and leg pain have improved. When she has pain, Petitioner testified, she takes Tylenol and Aleve. Petitioner testified that she did not miss any time from work as a result of the accident.

Petitioner testified that before the accident, she treated for arthritis of her lower back but did not treat for right buttock and right leg symptoms.

On cross-examination, Petitioner testified that she could not recall the last time she took Tylenol or Aleve for her buttock pain, but knew that it is infrequent and when she has exerted herself physically. Petitioner did not recall what year it was that she participated in maintenance physical therapy for her buttock pain. It would have been 2010. She then believed that she treated for buttock pain in 2012-2015. She treated once a week for maintenance at another facility and treated three times a week for a while. Also, Petitioner testified, she treated for arthritis in her low back with another provider.

Petitioner testified that when she went to Sherman Family Healthcare on March 9, 2007, she was told she had a tailbone bruise. (Px #1) Then, when she returned to Sherman Family Healthcare on March 16, 2007, she told them she felt much better. (Px #1)

The doctors never prescribed anything other than over-the-counter medication for her.

Petitioner was encouraged to go to Elgin Physical Health Center.

At that time, she participated in dance, exercise in the gym and walking.

But now, she walks, swims, lifts weights and does the Zumba class. She does not have a personal trainer.

II. CONCLUSIONS OF LAW

In support of his decision with regard to issue (F) "Is Petitioner's current condition of ill-being causally related to the injury?", the Arbitrator finds the following facts:

The Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that any current condition of ill-being of her right buttock, right leg or coccyx is causally related to her work accident.

We are now more than eight years post accident. Although Petitioner testified that her buttock and leg pain have improved, she could not recall exactly when she last treated for her combination of work-related buttock symptoms and unrelated back symptoms.

Petitioner did not recall when she last took Tylenol or Aleve for buttock pain.

The medical records that Petitioner submitted into evidence show that she was discharged from active care at Elgin Physical Health Center on March 30, 2007. On that date, which was three weeks post accident, the doctor wrote that she was 90-95% improved since she first fell at work and was "overall feeling good only a little soreness @ times." Moreover, the doctor wrote that the orthopedic tests to the lumbar spine are all negative.

Petitioner did not offer a causation opinion into evidence. Furthermore, there is no documentary evidence that Petitioner has treated for her right buttock, right leg or coccyx since March 30, 2007. Petitioner testified that she currently participates in exercise activities such as weight training, swimming, and Zumba.

In support of his decision with regard to issue (J) "Were all 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 the following facts:

While he has found that Petitioner failed to meet her burden of proof that any current condition of ill-being of her right buttock, right leg or coccyx is causally related to the accident, the Arbitrator finds that the medical services rendered by Elgin Physical Health Center were reasonable and necessary. Petitioner's Exhibit #2 includes a photocopy of a check for the medical records and bills for Renee Cifonie. Such check is dated October 23, 2009. Yet, the PATIENT LEDGER contained in Px #2 is from "01-01-01 – 03-04-10." Such ledger shows an Insurance Balance of $1,178.00. Respondent did not raise an objection to Px #2.

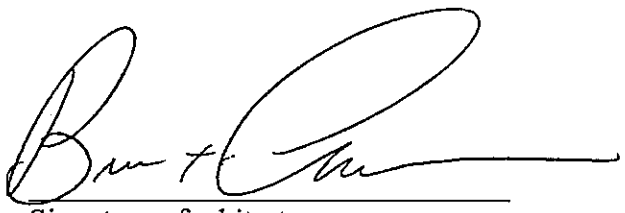
There is no evidence that since March 4, 2010, Respondent has paid any of the bills of Elgin Physical Health Center or that Elgin Physical Health Center has written off these bills.

Therefore, the Arbitrator finds that Respondent is liable for the outstanding charges from Elgin Physical Health Center in the amount of $1,178.00, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

The Arbitrator notes that Respondent paid a total of $384.32 towards Petitioner's medical bills. The Payee for the check in the amount of $192.97 is "Sherman," and the Payee for the check in the amount of $191.35 is "Greater E."

In support of his decision with regard to issue (L) "What is the nature and extent of the injury?", the Arbitrator finds the following facts:

As the Arbitrator has found that any current condition of ill-being of Petitioner's right buttock, right leg and coccyx is not causally related to the accident of March 9, 2007, the Arbitrator finds that the issue of the nature and extent of the injury is moot.



Signature of arbitrator

11-10-15

Date

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

VERA, NASARIA
Employee/Petitioner

Case# **10WC037298**

SCARLATO & SONS AND ILLINOIS STATE TREASURER AS EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

On 11/10/2015, 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 0.34% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2731 SALVATO & O'TOOLE
DAVID FROYLAN
53 W JACKSON BLVD SUITE 1750
CHICAGO, IL 60604

0000 SCARLATO & SONS
REALTY & DEVELOPMENT CORP
2795 WASHINGTON BLVD
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4987 ASSISTANT ATTORNEY GENERAL
LAURA HARTIN
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STATE OF ILLINOIS)
)SS.
COUNTY OF **COOK**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Nasaria Vera
Employee/Petitioner

Case # 10 WC 37298

v.

Consolidated cases: **D/N/A**

Scarlato & Sons and the Illinois State Treasurer, as ex-officio custodian of the Injured Workers' Benefit Fund,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **October 26, 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? [Petitioner did not claim any such benefits – see Arb Exh 1]
☐ 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 **insurance compliance/automatic coverage**

FINDINGS

On **September 8, 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 left index finger and left middle finger condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**15,600**; the average weekly wage was $**300**.

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $18,604.90, per the Medical Fee Schedule, as provided in Sections 8(a) and 8.2 of the Act. PX 9-11.

Respondent shall pay Petitioner permanent partial disability benefits of $300.00/week for 43.8 weeks, because the injuries sustained caused 40% loss of the index finger (17.2 weeks) and 70% loss of the middle finger (26.6 weeks) of the left hand, as provided in Section 8(e) of the Act.

The Illinois State Treasurer, ex-officio custodian of the Injured Workers' Benefit Fund, was named as a co-respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act. In the event the Respondent/Employer/Owner/Officer fails to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing the Petitioner pursuant to Section 5(b) and 4(d) of this Act. Respondent/Employer/Owner/Officer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent/Employer/Owner/Officer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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

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

Molly C Mason

Signature of Arbitrator

11/10/15
Date

NOV 10 2015

Nasaria Vera v. Scarlato & Sons and
Injured Workers' Benefit Fund
10 WC 37298

Arbitrator's Findings as to Sufficiency of Notice to Uninsured Respondent

This matter proceeded to hearing at 9:50 AM on Monday, October 26, 2015. No one associated with Respondent Scarlato & Sons checked in with the Arbitrator prior to that time. At the hearing, Petitioner's counsel and counsel for the Injured Workers' Benefit Fund [hereafter "the Fund"] represented they had had no contact from anyone purporting to represent Scarlato & Sons during the preceding year. Petitioner offered into evidence, with no objection from the Fund, four letters Petitioner's counsel sent in connection with the hearing. Counsel sent these letters to Scarlato & Sons Realty Development, Ron Scarlato, Scarlato Realty and Martin Banuelos. All four letters reference the claim and a hearing of October 26, 2015 at 9 AM. PX 3. Petitioner's counsel also indicated on the record that, at the Arbitrator's request, he paged Scarlato & Sons at the reception area of the Commission shortly before the hearing started and received no response. Petitioner's counsel also represented that, prior to the hearing, he conducted searches of the Secretary of State's records and learned the following: 1) Scarlato & Sons, with Ron Scarlato identified as president and agent thereof, was involuntarily dissolved in 2011; and 2) Scarlato & Sons Realty, LLC, was voluntarily dissolved in 2014. PX 4-5. Counsel for both parties represented they had no communication with Banuelos during the year preceding the hearing.

After considering all of the foregoing, the Arbitrator made a preliminary finding that Petitioner established adequate notice and that the hearing could proceed. At no time during the hearing did anyone appear on behalf of Scarlato & Sons.

Arbitrator's Findings Regarding Lack of Workers' Compensation Coverage

The Arbitrator, having reviewed senior investigator Shelton Wilson's attestation of December 3, 2012 (PX 2) and the NCCI certification of December 16, 2014 (PX 1), finds that Respondent Scarlato & Sons lacked workers' compensation coverage as of September 8, 2010.

Arbitrator's Findings of Fact

Petitioner testified through a Spanish-speaking interpreter. Petitioner testified she has used the name "Rosa Perez" in the past. She is presently 50 years old. She was born on May 14, 1965. She has three sons, who are currently 22, 20 and 16 years of age. She identified PX 6 as her sons' birth certificates. She has been married to Armando Vera for 24 years. She and Armando were never separated during that time. Their sons have always lived with them.

Petitioner testified she began working for Scarlato & Sons in 2002. Ron Scarlato hired her. Her duties included helping with the laundry and car wash operations, cleaning apartments, cutting grass and collecting rents at various locations.

Petitioner testified she initially worked for Scarlato & Sons seven days a week, six to eight hours per day. As of September 8, 2010, she was working five days a week. Regardless of her schedule, she received $300 in pay each week. She was paid in cash. Her supervisor, Francisco Mercado, gave her $300 in cash each week. Mercado also paid other employees.

Petitioner identified PX 7 as a photograph showing her, Ron Scarlato and other individuals at the offices of Scarlato & Sons on her birthday (May 14) in 2009. The Arbitrator sustained the Fund's foundational objection to PX 7. PX 7 is marked as a rejected exhibit.

Petitioner identified PX 8 as a business card Ron Scarlato made for her. Petitioner testified her name appears on the card, along with the name Scarlato & Sons Realty, the address 2795 Washington, Bellwood, Illinois and the phone number (708) 544-7373.

Petitioner testified she worked for Scarlato & Sons on September 8, 2010. She started work at 9 AM that day. She was directed to cut the grass in front of the office. She started cutting the grass, using a gas-powered lawn mower. Petitioner testified the mower was equipped with a lever that moved on its own because it was broken. Had the lever been working correctly, she could have adjusted it manually depending on the height of the grass. As she was cutting the grass, one of the rear wheels of the mower would not turn. She used her left hand to try to move the lever. The mower moved suddenly, causing a blade on the bottom of the mower to come into contact with and cut fingers on her left hand. One of her fingers was dislocated or broken as a result of the accident. She put that finger back in place and went into the office. Ron Scarlato was present. She ran hot water over her left hand. Then the same finger "collapsed again." Scarlato directed another worker, Sergio Volpe, to drive Petitioner to the hospital. Petitioner testified that Volpe used his own car to transport her to the Emergency Room at Westlake Hospital in Melrose Park. Only she and Volpe rode in Volpe's car. When they arrived at the Emergency Room, Volpe registered her. Petitioner testified she did not register herself because she was in a lot of pain. She denied talking with nurses at Westlake. No doctor arrived. Petitioner testified the Emergency Room employees tried to locate a surgeon but were unable to do so. Someone washed the blood off her hand but no one applied a bandage. At about 4 PM, she was transferred to Loyola University Medical Center via ambulance.

Petitioner testified that, at a later point in her treatment, she learned that the Emergency Room records from Westlake identified the patient as "Rosa Perez" rather than "Nasaria Vera." Petitioner expressed the belief that Sergio Volpe provided the name "Rosa Perez" to hospital personnel when he registered her at the Emergency Room. Petitioner testified she did not know why Volpe would do this. She returned to Loyola and presented her ID, in order to rectify the error, and was directed to Westlake. She went to Westlake and provided personnel there with her correct name and address. Petitioner testified she discussed the name issue with Volpe on several occasions and asked Volpe to appear at the Commission.

Petitioner offered into evidence Emergency Room records and itemized billing from Westlake Hospital concerning services provided on the morning of September 8, 2010. PX 9. The Fund objected to the admission of these documents, arguing that they do not relate to the claim insofar as they reference a patient with a name and birth date different from the name and birth date Petitioner testified to. The Arbitrator reserved ruling on the admission of PX 9. The Arbitrator, having had an opportunity to review both the records and itemized bill [see last page of PX 9], and compare same with Petitioner's credible testimony concerning her stay at Westlake, overrules the Fund's objection and admits PX 9 into evidence. While the records reference a patient named Rosa Perez born on June 10, 1965, they relate to treatment of traumatic injuries to the second, third and fourth fingers of the left hand sustained when the patient put her hand underneath a lawn mower. The records reflect that the patient was transferred by ambulance to Loyola University Medical Center at approximately 4:20 PM on September 8, 2010. The bill, in contrast with the records, sets forth Petitioner's name, Nasaria Vera, and address in Northlake. The bill sets forth itemized charges for Emergency Room treatment of the left hand rendered on September 8, 2010. The Arbitrator finds PX 9 sufficiently reliable to be admitted into evidence.

The Westlake records contain a left hand X-ray report documenting fractures of the distal phalanges of the second and third digits and a fracture of the distal portion of the middle phalanx of the third digit. The itemized bill reflects charges for an injection of pain medication, a tetanus injection and administration of Levaquin. PX 9.

The Loyola records (PX 10) reference Petitioner, not Rosa Perez. They reflect that Petitioner was transferred from Westlake for treatment of an injury involving the "left hand versus lawn mower." Dr. Bednar, an orthopedic surgeon, examined Petitioner at approximately 5:33 PM, noting that Petitioner had injured her left hand at work at 10:00 AM that day when her hand got caught in the blades of a lawn mower while she was attempting to clean the mower. On initial left hand examination, Dr. Bednar noted "gross deformity of distal index finger, middle finger and ring finger" along with lacerations of the same fingers "oozing venous blood." He recommended and performed surgery consisting of left index finger pinning of a distal phalanx fracture with nail bed repair, fusion of the left middle finger DIP joint with nail bed repair and debridement of lacerations to the left index, middle and ring fingers. In his operative report, Dr. Bednar documented an oblique fracture through the distal phalanx of the index finger, a comminuted intra-articular fracture of the distal end of the middle phalanx of the middle finger, with large nail bed lacerations to both fingers, and a large laceration over the pulp of the ring finger. The doctor indicated the ulnar condyle of the distal phalanx of the middle finger was no longer present and that he had to excise the radial condyle as well due to extensive articular carticular damage. He inserted Kirschner wires into both the index and middle fingers.

Following the surgery, Petitioner was admitted to the hospital overnight for observation. At discharge the next morning, she was given Norco for pain and directed to follow up with Dr. Bednar.

On September 16, 2010, Petitioner returned to Loyola and saw Dr. Bednar's associate, Dr. Bindra. Dr. Bindra noted that Petitioner's wounds were healing well. He applied new dressings, provided two protective splints and directed Petitioner to immobilize her proximal interphalangeal joints. He prescribed Clindamycin and Hydrocodone. He instructed Petitioner to return to Loyola in one week for removal of the sutures.

On September 23, 2010, Petitioner saw Dr. Nam, an orthopedic surgeon with offices in Chicago. Dr. Nam recorded a history of the work accident and subsequent care. He noted that Petitioner denied any prior left hand problems. He opted not to remove the dressings from Petitioner's left index, middle and ring fingers, since he lacked knowledge as to the extent of Petitioner's injuries. He recommended that Petitioner follow up with her surgeon. PX 11. [The Fund objected to the admission of PX 11, arguing that Dr. Nam's records referred to a patient named "Masaria Vera" rather than "Nasaria Vera." The Arbitrator reserved ruling on the objection. The Arbitrator, having had an opportunity to review the records and noting they contain a handwritten history form identifying the patient as "Nasaria Vera" with a birth date of May 14, 1965, overrules the objection and admits PX 11 into evidence.]

On October 15, 2010, Petitioner followed up with Dr. Bednar at Loyola. The doctor noted that the sutures were gone and that the wounds were clean and dry. He obtained X-rays, which showed the pins to be in good alignment. He instructed Petitioner to begin performing range of motion exercises of the PIP joints and to return in three weeks. PX 10.

Petitioner saw Dr. Bednar again on November 2, 2010. The doctor obtained new X-rays. He indicated the films "still do not show consolidation at the arthrodesis site of the middle finger." Given that two months had passed since the surgery, he removed the pins. He recommended that Petitioner start therapy. PX 10.

Petitioner underwent an initial occupational therapy evaluation at Loyola on November 4, 2010. The evaluating therapist noted that Petitioner exhibited decreased range of motion and strength, increased pain and edema, impaired sensation and decreased functional abilities. He recommended that Petitioner attend therapy two to three times per week for six weeks. PX 10.

Petitioner attended therapy at Loyola on November 8, 9, 11, 15 and 16, 2010. On November 15, 2010, the therapist noted an approximate 7 degree angulation of the tip of the middle finger. He contacted Dr. Bednar, who recommended that Petitioner wear the splint at all times other than when performing active range of motion exercises. At the next three sessions, on November 18, 23 and 24, 2010, the therapist noted that Petitioner was able to make a full flat fist with all digits touching her palm by the end of the session.

Petitioner saw Dr. Bednar again on November 30, 2010. On that date, the doctor noted "some motion to the DIP joint of the middle finger" and good motion in the rest of the left hand. He prescribed additional therapy and directed Petitioner to return to him in one month. PX 10.

On December 14, 2010, Petitioner complained to her therapist of increased pain and stiffness secondary to cold weather but was still able to touch all of her fingers to her palm after heat applications and stretching. PX 10.

Petitioner saw a resident, Dr. Ekram, at Loyola on December 16, 2010. Dr. Ekram noted that Petitioner had been unemployed since her injury. He recommended two to four more weeks of intensive occupational therapy. PX 10.

Petitioner attended therapy on December 22, 2010 but cancelled a subsequent appointment "due to payment/lawsuit issues." PX 10.

Petitioner testified she was unable to pursue additional therapy due to lack of funds. Neither she nor her husband had group insurance. She was unable to pay for the therapy on her own.

Petitioner saw Dr. Bednar again on January 5, 2011. The doctor noted that Petitioner complained of pain at the middle finger DIP joint and exhibited 10 to 15 degrees of painful motion. He indicated that Petitioner felt she could not return to her job due to this persistent pain. He obtained new X-rays and interpreted them as showing a "non-union of the attempted arthrodesis from the day of trauma." He recommended another surgery consisting of an arthrodesis of the DIP joint with screw fixation. He indicated that Petitioner consented to this surgery. PX 10.

Petitioner next saw Dr. Bednar on April 27, 2011. The doctor indicated that Petitioner was still experiencing pain in her left middle finger. He obtained new X-rays, which showed the non-union and about 20 degrees of deviation of the finger. He indicated that Petitioner wanted to undergo the recommended arthrodesis but was unable to do so due to lack of insurance. He also indicated that, at the direction of her attorney, Petitioner requested a letter allowing her to return to work with restrictions because she wanted to get a job cleaning houses. The doctor indicated he asked Petitioner if she felt she could perform full duty and Petitioner said she did not think she could. He went on to state: "the problem is, it is difficult to determine what restrictions she would need." He asked Petitioner to have her attorney send him a letter outlining what specific information was required. He directed Petitioner to patient financial services to see if there was a way for her to undergo the surgery. He indicated he would be glad to see Petitioner again on an "as needed" basis. PX 10.

Petitioner testified she did not undergo the second surgery that Dr. Bednar recommended because she had no money to pay for it. She was told she would have to pay $10,000 in advance in order to undergo this surgery.

Petitioner returned to Dr. Bednar on August 30, 2011. The doctor indicated Petitioner was still complaining of pain in the index and middle finger DIP joints but that, overall, her pain was less severe than in the past. He also indicated that Petitioner told him she wanted to

resume "weed jobs and cleaning" but felt she could not lift more than 20 pounds safely. Based on this representation, the doctor provided Petitioner with a note setting forth a 20-pound lifting restriction relative to the left arm. He explained to her that he had no objective evidence such as a functional capacity evaluation and that the restriction was based solely on her subjective reporting. He released Petitioner from care on an "as needed" basis. PX 10.

Almost two years later, on April 9, 2013, Petitioner returned to Dr. Bednar, with the doctor noting complaints relative to the left middle finger, the left little finger and the left thumb. On examination, the doctor noted a reduced range of motion in the DIP of the left middle finger, with 10 degrees of ulnar deviation and deformity. He also noted triggering of the left little finger and CMC arthritis of the left thumb.

Dr. Bednar obtained new left hand X-rays. He interpreted the films as showing a fusion at the DIP joint of the left middle finger, holding the finger in approximately 30 degrees of flexion. He saw no significant degenerative changes in the left thumb.

Dr. Bednar indicated he was no longer recommending surgery for the left middle finger since that finger had "gone on to auto fuse." He indicated Petitioner could contemplate an osteotomy in an effort to straighten the finger but, after discussing this with Petitioner, concluded additional surgery was not a good idea. He treated the little finger triggering via injection and prescribed a splint for the left thumb. He did not view the little finger or thumb problems as related to the original work accident. He released Petitioner from care on a PRN basis. PX 10.

Petitioner testified that, after the accident, she did not attempt to communicate with Ron Scarlato to request restricted duty because she knew she could not perform her duties using only one hand. Eventually, she looked for work elsewhere. In approximately 2013, she began working part-time at a banquet hall. She worked three or four hours per day, two days per week. Her duties consisted of cleaning and putting out silverware. There was no opportunity for her to work more hours at this job. In April 2015, she began working at a Nestle factory through a staffing agency. She works at the factory one to three days a week, from 7 AM to 3 PM. At one point, she was assigned to work in a cold area inside the factory. She was unable to tolerate this environment because it caused increased left hand symptoms.

Petitioner testified she completed sixth grade in Mexico. She denied undergoing any other schooling or training. At the present time, her work schedule is erratic. Sometimes she works only one day a week. She is unable to perform heavy lifting. In her opinion, her injury has affected her ability to secure stable employment.

Petitioner testified she received bills from Westlake and Loyola. She did not pay these bills because the treatment arose out of a work accident. In some respects, she felt responsible for payment but she had no money to pay the bills.

Petitioner testified she knows Sarai Hernandez. Hernandez was her co-worker at Scarlato and Sons.

Under cross-examination, Petitioner testified she takes Tylenol for left hand pain. She no longer sees a doctor for her hand. Her surgeon found her capable of lifting only 20 pounds. She never went by the name "Rosa Perez" and never claimed a birth date of June 10, 1965. She does not have any documents reflecting this date of birth. She last communicated with Sergio Volpe in March 2015, when she encountered him at a store having nothing to do with Scarlato and Sons. About two weeks after the accident, Mercado paid her for the last week of work she performed at Scarlato and Sons. She and Mercado did not discuss the issue of her returning to work.

On redirect, Petitioner testified her supervisor at Scarlato and Sons told her what to do but did not set her schedule. She typically worked from 9 AM to 3 PM.

Francisco Mercado testified on behalf of Petitioner. Mercado testified he presented an ID card to security personnel on entering the State of Illinois building before the hearing.

Mercado testified her worked for Scarlato and Sons from 1989 until approximately 2010. He managed the car wash and laundry. Petitioner also worked at Scarlato and Sons. He and Petitioner both worked for Scarlato and Sons on September 8, 2010. His understanding is that Petitioner "got cut" that day when she lifted a mower while cutting grass.

Mercado testified he sometimes paid employees of Scarlato and Sons. Ron Scarlato would give him envelopes to hand out to the employees. The envelopes contained cash and were printed with the name "Scarlato and Sons." It was his understanding that the cash in the envelopes represented wages for work performed by the employees. One of the envelopes was for him. The others were for Petitioner and the cashier. There were other individuals who worked at Scarlato and Sons but they did not receive envelopes. They worked at the car wash and received only tips. The cash he gave to Petitioner represented Petitioner's salary. Petitioner earned $300 per week.

Sarai Hernandez also testified on behalf of Petitioner. Hernandez testified she worked for Scarlato and Sons from April 2005 through July 2010 and again in September 2010. She no longer works for Scarlato and Sons. She worked with Petitioner during the time she worked at Scarlato and Sons. She correctly identified Petitioner in the hearing room.

Hernandez testified she worked at Scarlato and Sons on September 8, 2010. On that date, Petitioner was cutting grass at work when the mower "caught her fingers." She learned of this when she talked with Petitioner about three days after September 8, 2010. Her boss, Francisco Mercado, and other workers were aware of the accident. She cannot recall the names of the other workers. They worked in the back of the car wash, while she worked in the front. To her knowledge, these workers received only tips. She believes Ron Scarlato owned the car wash.

The Fund did not call any witnesses or offer any documentary evidence.

Arbitrator's Credibility Assessment

Petitioner's testimony that she did not communicate with the nurses at Westlake Hospital and did not identify herself as "Rosa Perez" was less than credible, given that the records from this hospital contain a "consent to transfer" form bearing the signature "Rosa Perez." Nevertheless, the Arbitrator found Petitioner credible overall as to the critical issues of employment and accident. The Arbitrator has no reason to doubt Petitioner's detailed account of the work she performed for Scarlato and Sons, the manner in which she was paid and the circumstances of her accident.

Francisco Mercado and Sarai Hernandez, Petitioner's two witnesses, were also credible.

Arbitrator's Conclusions of Law

Was Scarlato and Sons operating under the Act as of Petitioner's claimed work accident?

The Arbitrator finds that Scarlato and Sons was operating under the Act as of Petitioner's claimed work accident of September 8, 2010 by virtue of Petitioner's credible testimony that she was operating a gasoline-powered lawn mower that had sharp blades at the time of the accident. Section 3 of the Act provides that the provisions of the Act shall apply automatically, and without election, to employers engaged in extra-hazardous businesses, with such businesses defined so as to include those that use "sharp edged cutting tools" [sub-section (8)] and gasoline-powered equipment [sub-section (15)].

Was the relationship between Petitioner and Scarlato and Sons one of employee and employer as of the claimed accident?

The Arbitrator finds that Petitioner was an employee of Respondent Scarlato and Sons as of the claimed work accident. In so finding, the Arbitrator relies in part on Petitioner's credible testimony concerning her hiring in 2002 and the work she performed for Scarlato and Sons thereafter. There is no evidence suggesting Petitioner was an independent contractor. She worked for Scarlato and Sons for an extended period before the accident and testified she took direction from a Scarlato and Sons supervisor. The Arbitrator also relies on the credible testimony of Francisco Mercado, who confirmed that Petitioner worked for Scarlato and Sons as of the accident and that he regularly disbursed cash wages to her before the accident.

Did Petitioner sustain an accident on September 8, 2010 arising out of and in the course of her employment?

The Arbitrator finds that Petitioner sustained an accident on September 8, 2010 arising out of and in the course of her employment by Scarlato & Sons. In so finding, the Arbitrator

relies primarily on Petitioner's credible testimony concerning the mechanics of her injury and the corroborating histories in the treatment records. Petitioner testified the accident occurred during a regular workday while she was performing a work-related task. The Arbitrator also relies on the credible testimony of Petitioner's former supervisor, Francisco Mercado, and co-worker, Sarai Hernandez, both of whom stated Petitioner cut her fingers while working.

Did Petitioner establish a causal connection between the accident of September 8, 2010 and her current left hand condition of ill-being?

The Arbitrator finds that Petitioner established a causal connection between the accident and her current left index and left middle finger condition of ill-being. In so finding, the Arbitrator relies on the following: 1) the lack of evidence of any pre-accident left hand injuries or treatment; 2) Petitioner's credible description of the mechanism of injury; and 3) the treatment records, which describe the accident in the same manner Petitioner described it.

The Arbitrator further finds that the accident resulted in a laceration to the pulp of the left ring finger which required surgical repair, via three sutures, but that this laceration resolved within a short time of the accident. Petitioner described the left ring finger injury as a cut.

The Arbitrator finds that Petitioner did not establish causation as to the left thumb and left little finger problems Dr. Bednar diagnosed on April 9, 2013, about 2 ½ years after the work accident. Dr. Bednar did not link these problems to the accident.

Did Petitioner provide Scarlato and Sons with timely notice of the accident?

Petitioner credibly testified that she went into Respondent's office immediately after being injured. Petitioner also credibly testified that Ron Scarlato was in the office at that time and directed another worker, Sergio Volpe, to drive Petitioner to a hospital. Francisco Mercado, Petitioner's former supervisor at Scarlato and Sons, credibly testified he was aware of the accident.

Based on the foregoing credible testimony, and noting that Petitioner filed and served her original Application on September 28, 2010, well within the statutory 45-day notice period, the Arbitrator finds that Petitioner established timely notice.

What was Petitioner's age as of the accident?

The Arbitrator finds that Petitioner was 45 years old as of September 8, 2010. In so finding, the Arbitrator relies on Petitioner's testimony that she was born on May 14, 1965 and her children's birth certificates (PX 6), which confirm that date of birth.

What was Petitioner's marital status as of the accident? Did Petitioner have dependent children as of the accident?

Petitioner credibly testified she was married and had three dependent children as of the September 8, 2010 accident. The Arbitrator relies on this credible testimony and finds that Petitioner was married with three dependent children as of September 8, 2010.

What were Petitioner's earnings?

Petitioner credibly testified she consistently received $300 in wages per week, regardless of her hours, during the lengthy period she worked for Scarlato and Sons. Petitioner also credibly testified she received those wages in cash, with her supervisor, Francisco Mercado, paying her weekly. Mercado confirmed Petitioner's testimony.

Based on the credible testimony of Petitioner and Mercado, the Arbitrator finds that Petitioner's earnings were $15,600 during the year preceding the accident and that Petitioner's average weekly wage was $300.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims bills from three medical providers: 1) Westlake Hospital, $3,476.00 (Emergency Room, 9/8/10, PX 9); 2) Loyola University Medical Center, $14,779.90, PX 11; and 3) Chicago Orthopaedics, $349.00 (Dr. Nam, 9/23/10, PX 11).

The Arbitrator finds that the treatment underlying these bills was reasonable, necessary and causally related to the work accident of September 8, 2010. The Arbitrator also notes that the Westlake bill (see last page of PX 9) references the name "Nasaria Vera," not "Rosa Perez," and that the charges on that bill correlate, time- and service-wise, with the Emergency Room treatment Petitioner described at the hearing. The Arbitrator specifically finds that the Westlake bill in PX 9 relates to treatment necessitated by the September 8, 2010 work accident.

There is no evidence that Scarlato and Sons, or any other entity, has made payments toward the claimed bills.

The Arbitrator awards the claimed bills from Westlake Hospital, Loyola University Medical Center and Chicago Orthopaedics, subject to the fee schedule.

What is the nature and extent of the injury?

This is a pre-amendatory claim, since Petitioner's accident occurred prior to September 1, 2011.

The Arbitrator has previously found that Petitioner established causation as to her current claimed left index and left middle finger condition of ill-being. The treatment records reflect that Dr. Bednar diagnosed open fractures and lacerations in both of these fingers, with the left index finger fracture described as oblique, through the distal phalanx, and the left middle finger fracture described as a "comminuted, intra-articular fracture of the distal end of

the middle phalanx." Petitioner required surgery on the day of the accident, with Dr. Bednar reducing the fractures, inserting K-wires and repairing the lacerations and nail beds. The operative report reflects that Dr. Bednar excised the radial condyle and removed subchondral bone from the distal phalanx of the left middle finger. It also reflects he repaired the left ring finger laceration, using three sutures. PX 10. The doctor removed the K-wires from the left index and middle fingers about two months later, in early November 2010, and recommended occupational therapy, noting angulation of the tips of those fingers. Petitioner underwent therapy for a while, making progress along the way as to range of motion, but had to discontinue due to lack of funds. Dr. Bednar later recommended a second surgery, an arthrodesis, of the left middle finger, to try to correct the angulation of that finger, but that Petitioner was unable to pursue the recommendation, again due to lack of funds. Dr. Bednar subsequently indicated that a formal arthrodesis was no longer needed because the finger went on to fuse on its own. When he last saw Petitioner, in April 2013, he documented 30 degrees of flexion of the left middle finger. He did not comment on the left index finger. He discussed the possibility of another surgery to correct the flexion but ultimately did not recommend it. There is no evidence indicating Petitioner has undergone additional treatment since April 2013.

At the hearing, Petitioner credibly testified she has difficulty using her left hand to lift items. She also testified that cold weather increases her left hand symptoms. She takes Tylenol to address those symptoms.

In assessing permanency, the Arbitrator has considered the 20-pound lifting restriction imposed by Dr. Bednar. The Arbitrator notes that, according to the doctor's August 2011 note, Petitioner requested this restriction and the doctor indicated he was imposing it based solely on Petitioner's subjective reporting, since he lacked any objective assessment such as a functional capacity evaluation. The Arbitrator further notes that the restriction is limited to Petitioner's left hand. Petitioner testified she believes the injury and restrictions have affected her ability to find steady employment but she did not introduce any opinion evidence from a vocational rehabilitation counselor. The Arbitrator thus elects to award permanency under Section 8(e) of the Act.

The Arbitrator finds that Petitioner established permanency equivalent to 40% loss of use of the left index finger (17.2 weeks) and 70% loss of use of the left middle finger (26.6 weeks) under Section 8(e) of the Act. The permanency award totals 43.8 weeks. The Arbitrator awards permanency at the weekly rate of $300. [The applicable minimum rate is $319.00, based on the date of accident and number of dependents but the minimum rate cannot exceed the average weekly wage. The Arbitrator has previously found the average weekly wage to be $300.]

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WALKER, JEMEL A Case# **11WC000030**

Employee/Petitioner

SNELLING STAFFING SERVICES

Employer/Respondent

On 11/9/2015, 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 0.28% 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:

1994 LAW OFFICE OF DAVID GALLAGHER
PO BOX 13
CLARENDON HILLS, IL 60514

0167 DOWD & DOWD
JOHN E RYAN
617 W FULTON ST
CHICAGO, IL 60661

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

Jemel A. Walker
Employee/Petitioner
v.
Snelling Staffing Services
Employer/Respondent

Case # **11** WC **00030**

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 24, 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 _____

FINDINGS

On **10/21/10**, 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*** sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, the Petitioner earned **$17,290.00**; the average weekly wage was **$332.50**.

On the date of accident, Petitioner was **26** years of age, ***single*** with 0 children under 18.

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 **$12,191.85** for TTD benefits previously paid.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$221.67** per week for **55** weeks, commencing **10/22/10 through 11/10/11**, as provided in Section 8(b) of the act.

Respondent shall pay Petitioner a total of **$9,908.75** for unpaid medical bills, as provided in Section 8(a) and subject to Section 8.2, where appropriate, of the Act.

The Respondent shall pay the Petitioner the sum of **$220.00** per week for **22** weeks as provided in Section 8(e)5 of the Act, because the injuries sustained caused one hundred percent **(100%)** loss of use of petitioner's right small finger.

The Respondent shall pay the Petitioner compensation that has accrued since **11/10/11**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

November 9, 2015
Date

NOV 9 2015

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jemel A. Walker,	)	
	)	
Petitioner,	)	
	)	
vs	)	**No. 11 WC 00030**
	)	
Snelling Staffing Services,	)	
	)	
Respondent.	)	

FINDINGS OF FACT

The Petitioner testified that on October 21, 2010, he was employed by the Respondent, Snelling Staffing Services. The Respondent is a temporary staffing agency.

On October 21, 2010, the Petitioner testified, the Respondent sent him to work at Zeman Manufacturing, which is located in Lisle, Illinois. Zeman Manufacturing fabricates custom metalwork. The Petitioner's job duties included cutting, pressing and grinding metal. On such date, one of the Respondent's machines came down on and crushed the Petitioner's right small finger. The Petitioner was taken to Edward Hospital where the medical staff performed surgery on his finger.

The records of Edward Hospital indicate that on October 21, 2010, Chris C. Huang, M.D., performed, on the Petitioner, an irrigation and debridement of the right small finger, an open reduction/internal fixation of the right small finger open proximal phalanx fracture and a closed reduction and percutaneous pinning of the right small finger middle phalanx fracture. Dr. Huang's post-operative diagnosis is as follows: Right small finger open proximal phalanx fracture, Right small finger middle phalanx fracture. (Px #1)

The Petitioner testified that he followed up with Dr. Huang. Dr. Huang treated the Petitioner. The Petitioner testified that he was unable to work from October 21, 2010 through January 26, 2011. Dr. Huang checked his finger and presented different options, which included amputation of the finger. On April 21, 2011, which is Dr. Huang's last documented appointment with the Petitioner, Dr. Huang found, upon examination that the Petitioner has minimal range of motion and some scissoring of the right small finger. He further found that the Petitioner has some hypersensitivity along the ulnar aspect of the DIP joint of the small finger, decreased sensation to light touch along the radial aspect of his small fingertip (but can feel pressure) and intact sensation to light touch along the ulnar aspect of his small fingertip. An FCE indicated severe limitation in

range of motion and muscle strength of the right small finger and significant impairments of the right hand fine motor skills relating to functioning of the small finger and sensory concerns. The FCE further indicated that the patient is not able to use the 5th digit for typing, using a mouse or manipulating small objects in his right hand. (Px #2) Dr. Huang then wrote, *inter alia*, the following:

> The patient is a 26-year-old male who is status post an I&D and ORIF of a right small finger open proximal and middle phalanx fracture on October 21, 2010, and who is status post removal of 2 K-wires from the right small finger on February 3, 2011 *** We reiterated to the patient today that as a result of the severity of his crush injury to his right small finger, that he may not have a functioning small finger. We went over the results of his functional capacity evaluation with the patient today. We explained to the patient that he will need to find a job that will allow him to perform physical demands associated with a medium level job. At this time, we will leave the patient's future appointments open. The patient was asked to come back and see me if he has any questions or concerns; otherwise, we will see him back on an as needed basis. (PX #2)

The Petitioner testified that he saw Dr. John Stogin one time for an evaluation. The record/report indicates that John M. Stogin, Jr., M.D, examined the Petitioner on November 20, 2012. (Px #5) Dr. Stogin offered the following post-examination opinion:

> I believe Mr. Walker has sustained injury to his right small finger that has left his finger stiff, deformed, and with limited sensory function. His skin is at least somewhat threatened. Options include leaving his finger as is, amputation probably at the PIP level with hardware removal, DIP arthrodesis. I do not think she (sic) is a candidate for a joint replacement. Despite the fact he has early normal sensory function on the palmar aspect of his finger, if I had this injury, I would probably opt for amputation. Mr. Walker will consider his options. No further appointments have been scheduled for him at this time. (Px #3)

The Petitioner testified that he has considered amputation of his right small finger, but has not yet made a decision. He has sought counseling with "Karen." The Petitioner further testified that he is not able to do sports, which includes basketball and baseball. He is terrified of any moving parts. The Petitioner testified that his therapist said that he is not to lift more than 50 pounds occasionally. The Petitioner has an Associate's Degree and has started his own lighting company. The Petitioner testified that he has not received any bills at his home now for his finger injury.

On cross-examination, the Petitioner testified that he is left-handed and that the injury is to the small finger is on his right hand. Dr. Huang removed the pins from his right small finger. The Petitioner treated at the emergency room and then treated with Dr. Huang. He also participated in physical therapy for the finger. They put him on a work release. The Petitioner continued to see Dr. Huang while he participated in physical therapy. Dr. Huang released him from active medical care.

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 finds the following:

The Arbitrator notes that Px #4, a statement from Edward Hospital, has a billing date of "12/01/10." Although the Petitioner testified that he has not received any medical bills for his finger injury at his home now, there is no documentary evidence that such bills have been written off. The balance due is $8,918.75. The Respondent did not object to the admission of Px #4.

The Arbitrator further notes that an email message from Karen Bailey, LCSW, indicates that Ms. Bailey saw the Petitioner for a total of six (6) sessions. (Px #5) In her email message, Ms. Bailey did not indicate her dates of service, rate or balance due. (Px #5) The rate and the total are handwritten on the hard copy of the email message. (Px #5) The Arbitrator draws the reasonable inference that the balance due is $990.00. The Respondent stated that under the circumstances, he has no objection to Px #5.

The Arbitrator finds that the medical services that were rendered to the Petitioner were reasonable, necessary, and related to the accidental injury. The bills for such medical services total $9,908.75. (Px #4, Px #5) The Arbitrator orders the Respondent to pay the Petitioner $9,908.75 for the outstanding medical bills, as provided in Section 8(a) and subject to Section 8.2, where applicable, of the Act.

The Respondent is entitled to a credit for all medical bills previously paid.

In support of his decision with regard to issue (L) "What is the nature and extent of the injury?", the Arbitrator finds the following:

Based on the Petitioner's testimony, the medical records, the opinions of Dr. Huang and the opinions of Dr. Stogin, the Arbitrator finds that as a result of the October 21, 2010 accident, the Petitioner has sustained a permanent loss of use of his right small finger to the extent of 100%, pursuant to Section 8(e)5 of the Act. Therefore, the Respondent shall pay the Petitioner the minimum permanency rate of $220.00 per week (Section 8(b)2 of the Act) for twenty-two (22) weeks.

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GUERRERO, MARTHA Case# **11WC003862**

Employee/Petitioner

CITY OF CHICAGO

Employer/Respondent

On 11/10/2015, 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 0.34% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1315 DWORKIN AND MACIARIELLO
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0113 CITY OF CHICAGO
MICHELLE BRYANT
30 N LASALLE ST 8TH FL
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

Martha Guerrero
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **11** WC **3862**

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 **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **9/15/2015**. 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 _____

FINDINGS

On **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 not*** sustain an accident that arose out of and in the course of her employment.

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

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

In the year preceding the injury, Petitioner earned $**15,686.12**; the average weekly wage was $**301.66**.

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

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

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

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

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

ORDER

The Petitioner has not proven, by a preponderance of the evidence, that an accident occurred which arose out of and in the course of her employment therefore, not benefits are awarded, pursuant to the Act.

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

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

FINDINGS OF FACTS

The disputed issues in this matter are: 1) accident; 2) medical bills; 3) temporary total disability; and 4) the nature and extent of Petitioner's injury. *See*, AX1.

Testimony of Petitioner

Ms. Martha Guerrero, the 62 year old Petitioner testified that she sustained a work related injury while in the course of her employment as a crossing guard with the respondent, City of Chicago. Respondent disputes that an accident arose out of or in the course of the petitioner's employment.

Petitioner testified that on January 6, 2011, at approximately 2:10 p.m., she was helping children cross the street, when she tripped on a branch at the corner of California and Rosemont in Chicago, Illinois. Petitioner testified that she did not see the branch but that the branch was not big. She further testified that there are trees in the area, but she did not know where the trees are located.

On cross-examination, Petitioner testified that at the time of the alleged accident, she was assigned to the Clinton Elementary School, located at 6110 N. Fairfield St., Chicago, Illinois. At the time of the alleged accident, she had worked for the City of Chicago as a crossing guard, for nine (9) years. As of the date of the trial, she testified that she has worked for the City of Chicago and has been assigned to the same corner for fourteen (14) years.

Petitioner testified that on the date of the alleged accident, she worked two shifts; the first shift was 8:00 a.m. to 9:00 a.m.; and when asked about the second shift petitioner became unsure of the exact time, but testified that she started at either 2:00 p.m. or 2:30 p.m., ending at 3:30 p.m.

Petitioner testified that on January 6, 2011, the Clinton School dismissed at 2:45 p.m. and that she is supposed to be at her corner fifteen (15) minutes before dismissal.

Petitioner does not swipe in or out, but at the conclusion of her first shift, she is free to do whatever she wants until 2:30 p.m., when the second shift begins. She testified that the City of Chicago does not control her means of transportation to and from her assigned corner.

Petitioner testified that on January 6, 2011, she was not told to go to her corner early to start work. She testified that she does not get paid overtime or get any extra compensation if she reports to her corner early. She also testified that she did not call her supervisor Officer Hill to notify her that she got to her corner early that day. Petitioner testified that she completed her shift and reported the injury to the police and went to the hospital, where she reported complaints of left ankle pain.

On January 6, 2011, Petitioner was admitted to the emergency department ("ER") of Swedish Covenant Hospital at 3:58 p.m. While at the ER, petitioner reported that she tripped over a branch and twisted her ankle at 2:00 p.m. PX2.

X-rays of her left foot showed no acute fracture or dislocations and evidence of an old fracture in the dorsal aspect of the navicular bone. She was diagnosed with a possible medial malleolus chip fracture and referred to Dr. Alexopoulos for a follow-up. While in the ER, Petitioner spoke with two (2) police officers and reported that "while walking across street, Martha Guerrero (victim) stepped on a tree branch causing her to break her ankle/foot in three different locations." RX2.

On January 7, 2011, Petitioner reported to her supervisor, Officer Louise Hill, that while she was walking, she stepped on a tree branch and broke her ankle/foot in three different places. Petitioner reviewed and signed the accident report as true and accurate. RX1, pg. 2.

Testimony of Officer Louise Hill

Officer Hill testified that she has been the supervisor of crossing guards since 1996 and that on January 6, 2011, she was petitioner's supervisor. Officer Hill testified that Petitioner was assigned to the Clinton Elementary School located at 6464 N. Clark Street in Chicago, Illinois, where she worked two shifts; one from 8:00 a.m. to 9:00 a.m. and the second from 2:30 p.m. to 3:30 p.m.; and that the crossing guards are required to be at their designated corners, fifteen (15) minutes prior to the assigned schools dismissal. In the petitioner's case, Clinton Elementary School dismissed at 2:45 p.m., so Petitioner was required to be at her corner at 2:30 p.m.

Officer Hill testified that the crossing guards are not required to be on their corners any earlier than fifteen (15) minutes before dismissal and are not encouraged to begin their shift before the required start time. In the time Officer Hill has been the supervisor of crossing guards, she has not experienced any guards reporting to their corners early; however if she found out that crossing guards were coming in early, she would instruct them not to do so.

Officer Hill further testified that the corner, in question, did not have any trees and has four concrete buildings. At southwest corner there is a special needs school; at the northeast corner is Clinton Elementary. Officer Hill testified that at the southeast corner there is an apartment building and at the northwest corner there is a Jewish school.

On January 7, 2011, Petitioner was examined by Dr. Alexopoulos, whom she told that she stepped on a tree branch and twisted her left foot and ankle, while at work as a crossing guard. Dr. Alexopoulos noted no evidence of any breaks in the skin and opined that she may have injured multiple ligaments in her ankle. Dr. Alexopoulos prescribed an Unna boot dressing and advised Petitioner to elevate her foot.

On January 13, 2011, during a follow-up examination with Dr. Alexopoulos, it was noted that the foot was doing much better and that recent x-rays revealed no significant abnormalities of the left foot or ankle. Dr. Alexopoulos prescribed athletic tape for support.

On February 16, 2011, Petitioner saw Dr. Alexopoulos for the last time and he referred to the petitioner's injury as a sprain. Upon examination, Dr. Alexopoulos noted good range of motion, no discomfort with palpation along the medial or lateral ankle joint or along the anterior ankle joint area. Dr. Alexopoulos discharged Petitioner from care. Petitioner had four office visits with Dr. Alexopoulos and has not sought any additional treatment or care for her left ankle or foot.

Petitioner has not seen Dr. Alexopoulos or any other doctor regarding her left ankle since she was discharged from care on February 16, 2011. Petitioner testified that she occasionally takes Advil when she experiences pain.

CONCLUSIONS OF LAW

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

An injury is compensable under the Illinois Workers' Compensation Act only if it arises out of and in the course of employment. *Panagos v. Industrial Commission,* 177 Ill.App.3d 12, 524 N.E.2d 1018 (1988). The burden is upon the party seeking an award to prove by the preponderance of the credible evidence the elements of his claim. *Peoria County Nursing Home v. Industrial Commission, 115 Ill.2d 524, 505 N.E.2d 1026 (1987)*

It is within the province of the Commission to determine the factual issues, to decide the weight to be given to the evidence and the reasonable inferences to be drawn there from; and to assess the credibility of witnesses. *See, Marathon Oil Co. v. Industrial Comm'n,* 203 Ill. App. 3d 809, 815-16 (1990). And it is the province of the Commission to decide questions of fact and causation; to judge the credibility of witnesses and to resolve conflicting medical evidence. *See, Steve Foley Cadillac v. Industrial Comm'n,* 283 Ill. App. 3d 607, 610 (1998).

The Arbitrator finds that the Petitioner did not suffer an accident that arose out of or in the course of her employment with Respondent. In so finding, the Arbitrator notes there were many inconsistencies between Petitioner's testimony and her medical records.

Petitioner testified that she stepped on a branch, twisting her ankle as she was helping children cross the street however, the petitioner never mentioned helping children cross the street when providing a history to Swedish Covenant Emergency personnel or to the officers that took her statement or to her supervisor. Petitioner reported that she was simply walking when she stepped or tripped on a branch.

The first mention of helping pedestrian children cross the street was during her testimony at trial, four (4) years later. The Arbitrator finds the petitioner's testimony not credible and inconsistent with the medical records and statements provided at or near the time of the alleged accident.

For an injury to "arise out of" claimant's employment, the injury must have happened because of some risk connected with or incidental to the employment so that there is a causal connection between the employment and the injury. *Riley v. Industrial Comm'n,* 212 Ill.App.3d 62, 64 (1991). Typically, an injury "arises out of" one's employment if, at the time of the occurrence, the employee was performing acts he was instructed to perform by his or her employer, acts which the employee had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to his assigned duties. *Caterpillar Tractor Co. v. Industrial Comm'n,* 129 Ill.2d 52, 58 (1989). An injury occurs "in the course of" one's employment when it occurs within the period of employment at a place where the employee can reasonably be expected to be in the performance of his or her duties and while he or she is performing those duties or something incidental thereto. *Riley,* 212 Ill.App.3d at 64.

Petitioner told the nurse at Swedish Covenant that the alleged accident occurred at 2:00 p.m. Petitioner told the investigating officers that the alleged accident occurred at 2:10 p.m. Petitioner told her supervisor Officer Hill and signed an incident report stating that the alleged accident occurred at 2:10 p.m.

Petitioner testified that she could not remember what time her second shift started on January 6, 2011 however, she acknowledges that she had to be at her corner fifteen (15) minutes prior to her assigned schools dismissal. Petitioner testified that on January 6, 2011, Clinton Elementary School dismissed at 2:45 p.m.

Petitioner's supervisor Officer Hill testified that petitioner's second shift began at 2:30 p.m. and ended at 3:30 p.m. And that petitioner is supposed to be on her corner fifteen (15) minutes prior to her assigned school's dismissal. Officer Hill testified that on January 6, 2011, Clinton Elementary School dismissed at 2:45 p.m.; therefore, Petitioner needed to be at her corner at 2:30 p.m.

The testimony is clear that the petitioner worked two (2) shifts and between those two shifts, she was free to do whatever she pleased. The Arbitrator finds that the petitioner's second shift began at 2:30 p.m. The Arbitrator finds Officer Hill's testimony to be more credible than that of Petitioner.

The Arbitrator finds and concludes that the petitioner has not proven, by a preponderance of the evidence, that an accident occurred which arose out of and in the course of her employment by Respondent; therefore no benefits are awarded, pursuant to the Act. Having found that Petitioner has not proven an accident, all other issues are moot and will not be addressed.

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
11WC3962
SIGNATURE PAGE

L. Thompson

Signature of Arbitrator

November 10, 2015
Date of Decision

NOV 10 2015

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BARTELS, MELODY Case# **11WC010299**
Employee/Petitioner

ROGY'S CHILD CARE CENTER INC
Employer/Respondent

On 11/10/2015, 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 0.34% 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:

1608 MOSS & MOSS PC
DAVID M MOSS
122 WARNER CT PO BOX 655
CLINTON, IL 61727

4234 RIPES NELSON BAGGOT KALOBRATSO
MICHAEL BAGGOT
2353 HASSELL RD SUITE 115
HOFFMAN ESTATES, IL 60169

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

MELODY BARTELS
Employee/Petitioner

v.

ROGY'S CHILD CARE CENTER, INC.
Employer/Respondent

Case # **11 WC 10299**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Peoria**, on **October 22, 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 _____

FINDINGS

On **February 17, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**16,338.92**; the average weekly wage was $**314.21**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **2** 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 $**0.00** under Section 8(j) of the Act.

ORDER

Temporary Total Disability
In regard to temporary total disability, no benefits are awarded.

Medical Benefits
Respondent shall pay reasonable and necessary medical services totaling $6,695.58; bills to be paid pursuant to Sections 8(a) and 8.2 of the Act.

Permanent Partial Disability: Schedule injury

Respondent shall pay Petitioner permanent partial disability benefits of $309.33/week for 30 weeks, because the injuries sustained caused the 6% 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.

D. Douglas McCarty

Signature of Arbitrator

Nov. 3, 2015
Date

ICArbDec p. 2

NOV 10 2015

Findings of Fact

Petitioner, Melody Bartels, was employed by Respondent, Rogy's Child Care Center, Inc. on February 17, 2011. Petitioner began work with Respondent on June 7, 2010. Petitioner was working as a teacher in a daycare center.

On February 17, 2011, Petitioner has testified that she was moving a child's table, when one of the children ran into the table with a shopping cart, causing Petitioner to be pushed or jarred backwards.

Petitioner was first seen at Illinois Work Injury Resource Center (PX1). Petitioner complained of left sided low back pain.

Petitioner is reported as stating that she was pushing a kid's table with her legs and when she stepped back on her left foot, she immediately felt stabbing pain above the left buttocks.

Petitioner was noted as having a pinched sciatic nerve on her right side in 1987 and degenerative joint disease in her mid-back. Petitioner was reportedly taking Gabapentin for degenerative disc disease of the spine. Petitioner was diagnosed with a back strain, prescribed Toradol injections, Relafen and placed on work restrictions (PX 1).

Petitioner returned to Illinois Work Injury Resource Center on February 18, 2011, still in pain. Petitioner was prescribed Skelaxin, continued on Relafen, and continued on work restrictions (PX 1).

On February 19, 2011, Petitioner was seen at the Methodist Medical Center emergency room (PX 2). It was reported at that visit that Petitioner was at work moving furniture, stepped back, and felt a sharp pain to left lower back

that radiates down the left leg. Examination of the low back showed mild to moderate tenderness over approximately the 1-5 lumbar vertebrae. There was mild to moderate lumbosacral paravertebral spasm on the left side of the low back. The examiner was unable to elicit a trigger point. There was no evidence of lower extremity weakness. X-rays were performed. Petitioner was diagnosed with lumbar strain, decrease in lumbosacral spine mobility, muscle spasms of the lower back, calcific arteriosclerosis, and degenerative osteoarthritis. Petitioner was discharged from the emergency room (PX 2).

Petitioner returned to Illinois Work Injury Resource Center on February 21, 2011. Petitioner reported that her symptoms had not improved. In that visit, it is reported that Petitioner was following work restrictions and stated her employer was compliant with the restrictions that were given (PX 1).

Petitioner was assessed with a back strain with left radiculopathy and lumbar spasm. Petitioner was referred for physical therapy. Petitioner was placed on sedentary duty defined as lifting 10 pounds occasionally, sitting mostly (PX 1).

Petitioner returned to Illinois Work Injury Resource Center on February 22, 2011. The purpose of this visit was for physical therapy evaluation. Petitioner's provisional MDT (mechanical diagnosis and therapy principals) classification was spinal derangement with deformity. Petitioner's injury status was defined as acute. Petitioner is noted as undergoing a physical therapy initial evaluation and therapeutic exercises in that visit (PX 1).

Petitioner returned to Illinois Work Injury Resource Center on February 23, 2011. Petitioner is reported as continuing to complain of low back and left lower

extremity symptoms which extended to the left foot. Petitioner is noted as undergoing a home exercise program. Records do not disclose continuation of physical therapy at Illinois Work Injury Resource Center (PX 1).

On February 24, 2011, Petitioner was seen at Proctor Hospital emergency room (PX 3). In that visit, it was reported that Petitioner had sustained a back injury last week at work. Petitioner had been seen at Illinois Work Injury Resource Center. Petitioner reported at that time that Illinois Work Injury Resource Center would not see her anymore. Petitioner was unable to deal with the pain. The mechanism of injury as reported was of pushing a table and the location of Petitioner's pain complaints were to the lower back. An MRI was prescribed. Petitioner was given a note allowing her to return to work on February 28, 2011, with no lifting greater than 20 pounds for a period of one week. Petitioner was prescribed new medications of Lorcet and Valium (PX 3).

Petitioner returned to Proctor Hospital on February 25, 2011 and underwent a lumbar MRI without IV contrast. The MRI rendered an impression of mild central disc protrusion at L5-S1, which causes mild mass effect on the anterior thecal sac. No disc herniation or central canal stenosis was found (PX 3).

Petitioner was seen by Dr. James Ausfahl of Proctor First Care on February 28, 2011 (PX 4). Petitioner reported that she had hurt her lower back at work. Petitioner's complaints of pain in that visit were of midline back pain down the back of the leg into the left heel. Petitioner's lumbar MRI was reviewed. Petitioner was referred to Dr. Yibling Li of the Center for Pain Management. Petitioner was prescribed Diclofenac and Hydrocodone. On

March 2, 2011, Petitioner called Proctor First Care complaining of nausea. Petitioner was prescribed Phenergan (PX 4).

On March 7, 2011, Petitioner returned to Proctor First Care (PX 4). It was noted Petitioner was scheduled to see Dr. Li on March 15, 2011. Petitioner was given an excuse slip, excusing Petitioner from work until March 15, 2011. On March 15, 2011, Petitioner had her initial visit with Dr. Li (PX 5). Petitioner reported lower back pain since February 17, 2011. It was reported that Petitioner was a preschool teacher at Rogy's Learning Center for eight months. It was reported that Petitioner stated she was trying to move tables at work by using her legs and since then she feels stabbing pain to the back (PX 5). Petitioner reported a radicular pain to the left foot. Petitioner reported numbness and tingling in the left leg. Petitioner reported that walking aggravated the symptom. Petitioner reported difficulties sleeping at night. It was confirmed that Petitioner had undergone two days of physical therapy at Illinois Work Injury Resource Center, but had quit due to severe pain. In Dr. Li's assessment, it was noted "in my opinion, she likely suffered from muscle strain and left sciatica from piriformis syndrome" (PX 5).

Dr. Li also indicated, "she is unable to return to her work for now because the job requires some lifting, bending activities" (PX 5). It was reported that Petitioner will benefit from a multi-disciplinary team to have her pain management and functional rehabilitation in the next several months, such as pain medication, activity modifications, physical therapy, psychological support, epidural/trigger point injections, acupuncture, etc. Specifically, Dr. Li proposed an EMG/NCV of the lower extremity and lumbar neuro scan to screen for lumbar

sensory radiculopathy or plexopathy to rule out sciatica, piriformis syndrome, radiculopathy, continued off work until further notice, physical therapy with modalities, a functional capacity evaluation in the end and referral to pain psychology specialist (PX 5; 3/15/11 note).

On March 28, 2011, Petitioner underwent an electrodiagnostic test. It was reported, "this small nerve conduction study showed C-fiber or small plain fiber hyperesthetic change or possible CRPS with a superimposed left L5 sensory nerve root irritation" (PX 5). Petitioner was diagnosed with low back pain with hyperesthesia in the lower extremities. The clinical plan proposed was for two epidural steroid injections, Medrol Dos Pak, Lyrica 50 mg po bid for neuropathic pain, referral to pain psychology specialists, physical therapy, possible lumbar orthotics for support and follow up (PX 5).

On March 30, 2011, Petitioner did follow up with Dr. Li. Petitioner continued to complain of lower back pain stating that her back pain was worse. Petitioner reported feeling pressure on her tailbone area. The pain is reported as being constant. Petitioner reported her pain level as 8/10. There was reported radicular pain to the left leg with numbness and tingling in the left leg. There were no bowel or bladder changes. Petitioner was assessed with lower back pain with paresthesias in the extremities. The EMG/NCV was reported as showing possible left L5/S1 nerve root irritation/radiculopathy and small fiber hyperesthesia. Petitioner was again prescribed Lyrica. Petitioner was on Savella. A left L5/S1 epidural steroid injection was considered versus a piriformis muscle trigger point injection for left sciatica entrapment. Petitioner was prescribed pain psychology consult and a follow up appointment (PX 5).

Petitioner returned to Dr. Li on April 14, 2011. Petitioner was again assessed with lower back pain with paresthesias in the extremities. It was again planned that Petitioner undergoes left L5-S1 epidural injections for left sciatica entrapment. Petitioner was noted as having undergone a pain psychology consult which has helped her greatly. Petitioner was prescribed physical therapy. Petitioner was instructed to discontinue Lyrica and to follow up in one month.

On April 26, 2011, Petitioner was scheduled for an epidural steroid injection. It is noted that Petitioner's appointment was for 1:30 p.m. and that Petitioner arrived at 2:49 p.m. It was noted that Petitioner was to undergo an epidural steroid injection on that day. Testing on that day revealed focal tenderness of the lower sacral and gluteus muscles. The piriformis test was positive. There was decreased lumbar range of motion to 40%. Straight leg raising was positive on the left side. It was noted that Petitioner was taking Savella 25mg po bid (PX 5).

Petitioner was seen in follow up on May 10, 2011. In that visit, it was noted that Petitioner was scheduled for a second left L5-S1 epidural steroid injection.

It is noted that Petitioner was undergoing physical therapy at The Center for Pain Management and Rehab (PX 5).

Petitioner returned to Dr. Li on June 16, 2011. It was reported that Petitioner's low back pain was constant. Petitioner rated her pain as 6/10. Petitioner was reported as having radicular pain to the legs with numbness and tingling in both feet. Dr. Li reported, "her pain and functional status is better, but

she still has difficulty returning to her work and some weakness, numbness, pain." All twelve points of the Review of Systems was performed. Petitioner was noted as being positive for muscle ache, muscle pain, back pain, numbness and tingling. Dr. Li's assessment at that time was of lower back pain with paresthesias in the extremities. Dr. Li noted that Petitioner makes very slow progress at this point. "It seems we have done exhausted all our means of workups and treatments including injections, physical therapy, medication, psychology support, etc." (PX 5, Dr. Li note 6/16/11). Dr. Li suggested continued physical therapy and pain psychology counseling. Dr. Li proposed that Petitioner return to Dr. Ausfahl because of the nature of the work related injury. It was further proposed that Petitioner see a neurologist for weakness and paresthesias in the leg.

Of the medications involved, it is noted that Diazepam was not prescribed at that visit. Hydrocodone ephedrine HCl was not prescribed at that visit. Diclofenac sodium was not prescribed at that visit and Savella was not prescribed at that visit (PX 5).

On June 18, 2011, Petitioner experienced a medical emergency. On that day, Petitioner was seen at Methodist Medical Center emergency room (PX 2). It was reported that Petitioner, with a past medical history of fibromyalgia and back injury, woke up that day feeling numb. Petitioner experienced stuttering and her body shaking. Petitioner reported to the emergency room that she was on Savella and Vicodin and her last doses were taken the night before due to her doctor having stopped the prescription. Specifically, Petitioner reported that she awoke that AM with non-specific tingling to the upper lip, generalized malaise

and weakness to the bilateral lower extremities. Petitioner also reported that she had been stuttering since that morning, which was new for her. The symptoms were reported as involving both sides and were a mix of both motor and sensory deficits. There was bilateral weakness, primarily affecting the lower extremities. There was a definite history to suggest involvement of the facial muscles, thus putting any anatomic problem above the level of the spinal cord. Petitioner complained of numbness that affected the right side of the face and the left side of the face. It was reported that Petitioner did not appear to have stroke symptoms or symptoms of a cardiac origin. It was speculated that this was likely a medication issue, i.e. medication withdrawal (PX 2).

A head CT performed at Methodist Medical Center was reported as not showing any acute intracranial findings (PX 5).

Petitioner's condition was discussed with her personal care physician, Dr. Ausfahl. A follow up appointment was scheduled with Dr. Ausfahl and no further work up performed (PX 2).

On June 20, 2011, Petitioner was seen by Dr. Ausfahl in what was recorded as being a follow up from the emergency room visit PX 4). It is quoted that the opinion of the ER doctor was that her symptoms were likely due to the abrupt discontinuation of Savella which had been prescribed for her fibromyalgia. Dr. Ausfahl went on to opine, "...is on a truly huge dose of Vicodin for her low back: was informed that I would not and could not manage narcotics in that dose, and that she would have to find that prescription elsewhere." It was further noted that there was no further tingling and no further facial laxity; Petitioner still demonstrated stuttering and speech distortion.

Dr. Ausfahl assessed Cerebral Ischemia, which was a possible side-effect of abrupt discontinuation of Savella. Dr. Ausfahl's plan involved prescriptions for Vicodin, and a brain MRI (PX 4).

On June 23, 2011, at Proctor Hospital, Petitioner underwent a brain MRI (PX 3). It was noted that Petitioner had a history of transient cerebral ischemia. The MRI rendered an impression of no acute intracranial abnormality (PX 3).

Petitioner was seen on July 26, 2011, by Dr. Li of the Center for Pain Management (PX 5). It was noted that Petitioner was being seen for follow up of lower back pain. The pain was reported as being much worse with the pain rate of 8/10. Petitioner's findings were positive for radicular pain to both legs, numbness, and tingling in both arms and legs. Noted was Petitioner's recent complaint of numbness in the upper lip and stiffness. Petitioner was assessed with lower back pain with paresthesias in the extremities. It was noted Petitioner had experienced more panic attacks, depression, and anxiety along with the injury. It was reported that Petitioner is unable to go back to work. It was reported Petitioner is unable to function at all (PX 5).

Petitioner was ordered to resume physical therapy for muscle weakness. Petitioner was prescribed a Tens Unit. Petitioner was ordered to continue to see Dr. Ian Wickramasekera for psychological support. Petitioner was prescribed medications consisting of Xanax, and Butrans. Petitioner was referred to Dr. Buettner for chiropractic treatment.

Medical exhibits indicate that on July 27, 2011, Petitioner was seen at Methodist Medical Center, where she was treated for a laceration over the

dorsum of the right hand. The laceration arose due to Petitioner cleaning up broke glass (PX 2).

On August 2, 2011, Petitioner was seen by Dr. Buettner, D.C. for back pain upon the referral of Dr. Li (PX 6). Petitioner was being seen for low back pain. Petitioner underwent chiropractic manipulation. Following those chiropractic treatments, Petitioner advised Dr. Buettner that her pain had returned and increased. Petitioner was referred back to the treatment for Dr. Li (PX 6).

On August 5, 2011, Petitioner was seen by Dr. Li. Petitioner is reported as stating, as she came into therapy, that her low back had improved until she saw the chiropractor. Petitioner was diagnosed with bilateral low back pain. Petitioner was continued on medication prescriptions.

Petitioner returned to Dr. Li on August 12, 2011. At that time it is reported that Petitioner came into therapy stating her low back had increased due to getting mad at family and cleaning her house.

Petitioner returned to Dr. Li on August 17, 2011. Petitioner continued to complain of low back.

Petitioner returned to Dr. Li on August 19, 2011. Petitioner continued to complain of low back pain. Dr. Li recommended a referral to a neurologist for weakness and paresthesias in the leg.

On September 6, 2011, Petitioner was seen by Dr. Richard Lee, III of Neurological Associates/Illinois Neurological Institute Physicians, LLC (PX 7). Contained in Dr. Lee's medical chart is a medical records' review performed by Todd McCall on July 18, 2011 (PX 7). It is reported that "Dr." McCall saw no

surgically correctible abnormality that correlated with the patient's stated symptoms (PX 7).

Petitioner was seen by Dr. Lee on September 6, 2011, in consultation. Dr. Lee assessed minor injury resulting in diffuse pain and weakness, a question of fibromyalgia. Dr. Lee indicated she has low back pain, degenerative disease, which is mild, and memory changes. She is emotional. She has seen a psychologist and is working with them now.

Dr. Lee recommended an EEG and lab work. Dr. Lee noted there was a question as to whether Petitioner might have reflex sympathetic dystrophy or other chronic pain syndrome (PX 7).

An EEG was performed on September 8, 2011, at Proctor Hospital. The EEG was reported as abnormal. It was recommended this test be followed with an MRI scan of the brain.

Petitioner returned to Dr. Lee's office on September 15, 2011. At that time, Petitioner was present with multiple complaints and problems, including stuttering. It was reported by Dr. Lee that there had been a suggestion that Petitioner had had a reaction to Savella. Petitioner is quoted as believing the reaction to the Savella caused her stuttering. Dr. Lee opined, "...I did not think that was the cause of that issue."(PX 7). Dr. Lee assessed possible reflex sympathetic dystrophy, questionable history of fibromyalgia. Dr. Lee noted Petitioner's speech was a problem. Dr. Lee opined that Petitioner may have some mild cerebrovascular disorder and that she has had an abnormal EEG. Dr. Lee indicated that there does seem to be a significant psychological

component to Petitioner's situation. Dr. Lee prescribed Trileptal and recommended laboratory testing. A follow up was prescribed (PX 7).

Petitioner was seen again by Dr. Lee on September 30, 2011. Petitioner was being seen in follow up for headaches and abnormal EEG and various spells. It is reported Petitioner experiences bad headaches upon waking. It is reported Petitioner occasionally falls. It is reported that Petitioner fell in the bathroom the day before. It is reported that Petitioner walks slowly with a cane and is tearful. Petitioner was assessed in that visit with spells, headaches, abnormal EEG, fibromyalgia. Petitioner was reported as having had a negative MRI. Petitioner was reported also having had psychometric testing and that Petitioner was being seen by a psychologist on a regular basis. It was recommended that the Trileptal be increased and that Petitioner schedule a follow up appointment.

Petitioner returned to Dr. Lee on October 20, 2011. In that visit it was reconfirmed that Petitioner was seeing a psychologist and working with Dr. Ian Wickramasekera. It was reported Petitioner was expressing balance problems, memory difficulty, and speech issues. It was reported Petitioner's pain was increasing slowly. An EMG performed by Dr. Lee was reported as not showing any significant abnormalities. Dr. Lee's assessment was that Petitioner seemed to have fibromyalgia associated with depression, memory problems, and some ill-defined stuttering. It was reconfirmed that Petitioner had a negative MRI scan. Petitioner was reported as taking Trileptal, and it was recommended that Petitioner increase her dosage. Baclofen was added to Petitioner's medication list. Petitioner was scheduled for a follow up examination.

Petitioner testified that her treating physicians declined further treatment of her due to unpaid medical bills.

Medical exhibits document that Petitioner's next medical treatment was with Dr. Ann Hinz of OSF Medical Group Internal Medicine (PX 8). Petitioner was initially seen by Dr. Hinz on February 27, 2012. In that visit, Petitioner complained that Dr. Ausfahl and the other medical specialists were not offering her explanations for the tests that she was having, nor providing answers as to the basis for her symptoms. That visit documents a discussion regarding Petitioner's symptoms. In that visit, Petitioner explained that her symptomatology began with a work injury in February of 2011. As explained by Petitioner at that time, "there was a child who had some type of a cart she was pushing around and pushed it into the opposite edge of the table that the patient was pushing. She said basically she was jarred, stumbled backwards a couple of steps, but didn't fall. She instantly had this sharp low back pain that radiated to her left buttock and her left lower extremity. She thought it would get better, but when it didn't, she left work." (PX 8, 2/27/2012, Dr. Hinz medical note).

In Dr. Hinz's assessment, it is noted that Petitioner is being diagnosed with chronic pain. Dr. Hinz opined, "in total some of the pain that she is describing sounds as though it could be coming from her back, but other of the pain I do not believe could be explained by the injury she is describing, nor herniated disc." (PX 8). Dr. Hinz hoped to review Petitioner's medical records and schedule a follow up examination.

Petitioner did return to Dr. Hinz on March 19, 2012. Dr. Hinz performed a medical record review. Dr. Hinz assessed chronic pain and again emphasized

that, "...although this all started with this back injury, I certainly don't think all of her symptoms are explained by it, particularly in light of review of her records." (PX 8). Dr. Hinz increased Petitioner's prescription of Vicodin as well as Petitioner's Baclofen prescription. Petitioner was given a refill for Trileptal. Dr. Hinz made referral of Petitioner to a neurologist for a second opinion. Dr. Hinz considered a prescription for Amitriptyline. Dr. Hinz prescribed Lorazepam. Petitioner's records were sent to neurology.

On April 16, 2012, Petitioner was seen at INI Neurology Group, where it was reported that Petitioner was a new patient being seen for back pain and a second opinion, upon the referral of Dr. Ann Hinz. In that visit with Dr. Mattai, it was reported that there were no diagnoses linked to the encounter. At that visit, approximately an hour was spent reviewing Petitioner's medical history.

Petitioner returned to INI Neurology Group on February 18, 2012. In that visit, Dr. Mattai identified Petitioner as having multiple somatic complaints requiring multiple emergency room and office visits. Dr. Mattai indicated that she would focus on diagnosis and treatment only. In that visit, Dr. Mattai prescribed a series of diagnostic tests. There was also consideration given of referring Petitioner to a rheumatologist (PX 9).

Petitioner was next seen by Dr. Hinz on May 1, 2012. In that visit, it was confirmed that Petitioner had seen a neurologist. It was also confirmed that Petitioner had a cervical and thoracic MRI as well as blood tests. It was noted that Petitioner had an EEG that morning. The MRI's which are being referenced consisted of a cervical MRI performed at St. Francis Medical Center on April 25, 2012. On April 25, 2012, Petitioner underwent a cervical MRI. The cervical MRI

was reported mild degenerative disc dessication at C5-C6, and C6-C7 levels with minimal posterior spondylosis without displacement of the neuroelements and mild degenerative disc dessication at C7-T10 level without focal disc bulge or protrusion. The thoracic MRI also performed April 25, 2012, rendered an impression of no abnormalities to account for the patient's symptoms. The MRI was reported as a normal MRI of the thoracic spine. In addition to those tests, also performed on April 25, 2012, were a series of laboratory tests and blood tests. Dr. Hinz reported that the blood testing was unremarkable, other than low sodium.

Petitioner was referred to a rheumatologist at that time. Cymbalta was added to Petitioner's medication list. A follow up was scheduled.

On June 1, 2012, Petitioner was seen in follow up by Dr. Hinz. At that time, Dr. Hinz diagnosed chronic pain, cognitive decline, backache and headache. It was noted Petitioner was scheduled to see a rheumatologist. Petitioner was ordered to continue her current meds pending her appointment with the rheumatologist (PX 8).

On June 5, 2012, Petitioner was seen by Kathleen Voelker, Nurse Practitioner. That visit is noted as being for a rheumatology consultation. At that time, a full examination was performed. Petitioner's earlier laboratory tests as well as her cervical and thoracic and lumbar MRI's were reviewed. It was concluded in that visit that Petitioner's symptomatology is consistent with fibromyalgia or central sensitization. Paxil was prescribed for anxiety and decompression and Petitioner was referred to The Pain Clinic for biofeedback. In addition, additional tests were prescribed.

Petitioner returned to review the test results on June 8, 2012. The test results, which had been prescribed, were reviewed. Petitioner did follow up with rheumatology after that appointment. Petitioner was started on Vitamin D, Neurontin, and Paxil. Petitioner's diagnosis at that visit was Hypovitaminosis D, low back pain radiating to left leg, weakness, fatigue, Livedo reticularis, fibromyalgia chronic pain, cognitive decline, back pain, and headache. Petitioner was instructed to continue with plans made by rheumatology. A follow up appointment was scheduled.

On September 20, 2012, Petitioner was seen by Dr. Hinz. Dr. Hinz assessed acute grief reaction and stress. Diazepam and Trazodone was continued. A grief counseling referral was made (PX 8).

On December 17, 2012, Petitioner returned for a rheumatology evaluation. At that time, a repeat EMG and lumbar MRI was prescribed.

On December 17, 2012, Petitioner was also seen by Dr. Hinz. At that time, Dr. Hinz assessed Petitioner with chronic pain. Petitioner's Lyrica prescription was increased as well as her Baclofen prescription. The Vicodin prescription was not increased. Petitioner was scheduled for a follow up appointment.

Petitioner returned to Dr. Hinz on March 5, 2013. At that time, Petitioner complained of complaints of right knee pain as a result of a fall. Petitioner indicated that she had fallen out of her shower recently onto her bottom, but thought she may have twisted her knee.

On October 8, 2013, Petitioner was seen by Dr. Hinz due to chronic pain. It was noted in that visit that Petitioner had not followed up with rheumatology.

Dr. Hinz treated Petitioner at that time with medication. Petitioner's medical exhibits document follow ups with Dr. Hinz on December 10, 2013, for an emergency room visit following a fall on December 4, 2013. That fall injured Petitioner's left leg, and a visit with Dr. Hinz on February 25, 2014, where Petitioner followed with Dr. Hinz for what is categorized as generalized pain complaints.

Petitioner has testified that she left the care of Dr. Hinz and assumed care with Dr. Donna Hasou. Petitioner testified she last saw Dr. Hinz on February 14, 2014.

On October 21, 2013, Petitioner was issued a Notice of a Fully Favorable Decision by an administrative law judge of the Social Security Administration/Office of Disability Adjudication and Review (PX 11).

Petitioner was found by the Social Security Administration to have been disabled.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING ACCIDENT, THE ARBITRATOR MAKES THE FOLLOWING CONCLUSIONS OF LAW:

Respondent disputes the mechanism of injury to Petitioner's low back. That dispute is based on the histories of accident given by Petitioner to her treating physicians.

Specifically, Petitioner reported to Illinois Work Injury Resource Center that she was pushing a kid's table with her legs and when she stepped back on her left foot, she immediately felt stabbing pain above buttocks (PX 1).

At Methodist Medical Center emergency room, it was reported that Petitioner stated that Petitioner was at work moving furniture, stepped back, and felt a sharp pain to the left lower back that radiates down the left leg (PX 2).

When seen by Dr. Ausfahl of Proctor First Care on February 28, 2011, Petitioner simply reported that she had hurt her lower back at work (PX 4).

When seen by Dr. Li at the Center for Pain Management, it was reported that Petitioner stated that she was trying to move tables at work by using her legs and since then she feels stabbing pain to the back (PX 5).

When Petitioner was seen by Dr. Buettner, D.C., it is reported that Petitioner "was moving a little kid's table (3 to 5 pounds) one of the children ran into the table, caused her to step backward; patient felt immediate sharp pains" (PX 6).

In her visit with Dr. Hinz, Petitioner is reported as stating, "there was a child who had some type of a cart that she was pushing around and pushed it into the opposite edge of the table that the patient was pushing. She said basically she was jarred, stumbled backwards a couple of steps, but didn't fall. She instantly had this sharp low back pain that radiated to her left buttock and her left lower extremity she thought it would get better, but when it didn't she left work. (PX 8)

At hearing, Petitioner testified that as reported to Dr. Buettner she was moving a child's table when one of the children ran into the table with a shopping cart causing Petitioner to be pushed or jarred backwards.

The Arbitrator finds that while there is an inconsistency in the details of the accident, which initiated Petitioner's low back pain, Petitioner did sustain an

accident arising out of and in the course of her employment with Respondent on February 17, 2011.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING TEMPORARY TOTAL DISABILITY, THE ARBITRATOR MAKES THE FOLLOWING FINDINGS OF FACT AND CONCLUSIONS OF LAW:

Petitioner notes that she is claiming temporary total disability for the period of March 7, 2011, when Petitioner was issued an off work slip by Dr. Ausfahl (PX 4), through the present. That off work slip extended Petitioner's off work through March 15, 2011, when Petitioner was scheduled to see Dr. Li. Dr. Li indicated that Petitioner was unable to work because the job requires some lifting, bending activities (PX 5). Petitioner is also seeking temporary total disability for the period March 15, 2011, through the present.

The Arbitrator notes that while treating with Illinois Work Injury Resource Center, Petitioner was issued a restriction slip. Evidence indicates Petitioner was working pursuant to those restrictions. The Arbitrator notes the statement made by Dr. Hinz on February 27, 2012, when she quotes Petitioner as stating, "she thought it would get better, but when it didn't, she left work." This suggests that Petitioner voluntarily terminated her employment with Respondent. Petitioner's claim for temporary total disability is, therefore, denied.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING THE CAUSAL CONNECTION AND NATURE AND EXTENT OF PETITIONER'S LOW BACK INJURY, THE ARBITRATOR MAKES THE FOLLOWING CONCLUSIONS OF LAW:

The Arbitrator notes that Petitioner was initially diagnosed with a back strain with left radiculopathy and lumbar spasm. It is noted Petitioner had a pre-existing condition which had been diagnosed of degenerative disc disease

(PX 1). Dr. Li assessed Petitioner with muscle strain and left sciatica from piriformis syndrome (PX 5).

Petitioner sustained what the Arbitrator identifies as an intervening incident on June 18, 2011, when Petitioner incurred a medical condition resulting in what is identified as stroke-like symptoms.

A vast amount of the medical treatment rendered thereafter was directed towards symptoms, complaints, and medical conditions not arising as a result of low back sprain/strain injury.

The Arbitrator notes there was a suggestion that Petitioner's stroke-like symptoms were a result of her having taken the medication, Savella. Dr. Lee indicated, "I did not think that was the cause of that issue." In addition, Dr. Hinz opined, "In total some of the pain that she is describing sounds as though it could be coming from the back, but other of the pain I do not believe could be explained by the injuries she is describing, nor herniated disc." (PX 8).

Based on the medical evidence as presented by Petitioner, the Arbitrator concludes that Petitioner sustained a low back sprain/strain injury which aggravated pre-existing degenerative joint disease in Petitioner's low and mid-back. As a consequence, the Arbitrator finds Petitioner sustained a 6% loss of the person as a whole as a result of her work injury on February 17, 2011.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING MEDICAL BILLS, THE ARBITRATOR MAKES THE FOLLOWING FINDINGS OF FACT AND CONCLUSIONS OF LAW:

Petitioner has submitted as Petitioner's Exhibit 12, a list of medical bills through February 25, 2014. Based on Petitioner's testimony and the medical records submitted into evidence, the Arbitrator finds that medical bills incurred at

Illinois Work Injury Resource Center for dates of service February 17, 2011, February 18, 2011, February 21, 2011, February 22, 2011, and February 23, 2011, are causally connected to Petitioner's work injury of February 17, 2011, and are found compensable and are awarded Petitioner.

In regard to medical bills submitted by Methodist Medical Center of Illinois, the Arbitrator finds that treatment rendered on February 19, 2011, is causally connected to Petitioner's work injury and is compensable and the Arbitrator denies medical bills incurred on February 19, 2011, to Petitioner. The Arbitrator awards any other billing submitted or pursued by Methodist Medical Center of Illinois.

In regard to medical bills submitted by Proctor Hospital, the Arbitrator awards medical bills incurred on February 24, 2011, for an emergency room visit for low back and medical bills incurred on February 25, 2011, for a lumbar MRI. All other bills submitted from Proctor Hospital are denied.

In regard to medical bills from Proctor Prompt Care/Dr. Ausfahl, billing for office visits of February 28, 2011, and March 7, 2011, are found to be compensable and are awarded by the Arbitrator. Billing for June 20, 2011, is denied.

In regard to medical bills from the Center for Pain Management/Dr. Li, the arbitrator notes the reasonableness and necessity for the medical bills from March 15, 2011, through November 4, 2011, are disputed as not being reasonable and necessary. As noted, Petitioner had a pre-existing condition of low back pain. There is no indication that the complaints addressed by Dr. Li for

the period March 15, 2011, through November 4, 2011, are causally connected to Petitioner's February 17, 2011, injury. Those bills are denied.

On June 18, 2011, as indicated above, Petitioner sustained a medical incident, which resulted in symptomatology testing and medical treatment, which was not causally connected to Petitioner's work injury of February 17, 2011. The Arbitrator, therefore, specifically denies any medical treatment incurred after June 18, 2011, through the present as not being causally connected to Petitioner's work injury of February 17, 2011. Specifically, the Arbitrator denies billing from the Center for Pain Management as identified on Petitioner's Exhibit 12.

The Arbitrator denies billing from Illinois Neuro Associates as identified on Petitioner's Exhibit 12.

The Arbitrator denies billing from Dr. Hinz/OSF Medical Group Internal Medicine as identified on Petitioner's Exhibit 12.

The Arbitrator denies billing from St. Francis Medical Center as identified on Petitioner's Exhibit 12, specifically finding in that instance that testing as identified in the finding of fact were for cervical MRI, thoracic MRI, and blood testing, none of which is causally connected to Petitioner's accident of February 17, 2011.

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

BERDECIA, LUIS M Case# **11WC023383**

Employee/Petitioner

1555 N ASTOR CONDOMINIUM ASSOCIATION

Employer/Respondent

On 11/10/2015, 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 0.34% 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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CATHERINE K DOAN
20 S CLARK ST SUITE 1810
CHICAGO, IL 60603

2097 GRANT & FANNING
DANIEL K SWANSON
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CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Luis M. Berdecia,
Employee/Petitioner
v.
1555 N. Astor Condominium Association,
Employer/Respondent

Case # **11** WC **23383**

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 Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **May 26, 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. ☒ Is Petitioner entitled to any prospective medical care?

FINDINGS

On the date of accident, **April 21, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**36,991.24**; the average weekly wage was $**711.37**.

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 $**0** for TTD, $**97,202.61** for TPD, $**0** for maintenance, and $ for other benefits, for a total credit of $**97,202.61**.

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

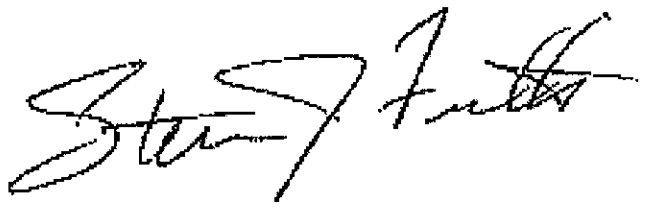
ORDER

Because Petitioner failed to prove a causal connection exists between the current condition of ill-being in his lumbar and the accident on April 21, 2011, prospective medical for the low back 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

November 9, 2015
Date

ICArbDec19(b)

NOV 10 2015

Luis M. Berdecia v. 1555 N. Astor Condominium Association
11 WC 23383

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth on May 26, 2015. The parties stipulated that Petitioner sustained bilateral shoulders injuries which were caused by an accident at work on April 20, 2011. There is no dispute regarding the necessity of medical care and treatment for the claimed shoulder injuries.

Petitioner also claimed to have sustained a low back injury caused by the accident. The disputed issues regarding Petitioner's claimed back injury were: ***F:*** Is Petitioner's current condition of ill-being causally related to the injury?; ***O:*** Is Petitioner entitled to prospective medical care?

FINDINGS OF FACT

Petitioner testified that he worked as a garage attendant for Respondent since August 2008. He testified that 1555 N. Astor is a 48 floor building. He parked cars for the residents, performed building maintenance, carried objects for the residents, and washed cars.

Petitioner testified that he had not sustained any accidents or injuries to his back prior to April 20, 2011. Further, Petitioner denied that he had any medical treatment for his back prior to April 20, 2011. Prior to the accident of April 20, 2011, Petitioner testified that he did not have any problems with his back.

On cross-examination Petitioner again denied any problems with his low back prior to April 21, 2011. When he was shown the chart note by Dr. Preston Wolin on May 31, 2011 (RX #1) reflecting "a back injury at work 2-3 years ago." Petitioner testified that he did not recall giving Dr. Wolin that history. He repeated that he had not sustained any accidents involving his back prior to April 20, 2011. Petitioner testified that he did not review the medical records of Dr. Wolin and did not have any control as to what was documented in the records.

On April 20, 2011, Petitioner was working maintenance and cleaning the downstairs garage with sweeping compound. Petitioner had to sweep the floor using a large broom. He began to feel pain in his back as he was sweeping. He also had to bring buckets of compound up and down the stairs. He carried 2 buckets at a time. Each bucket weighed 20-25 lbs. Petitioner had to climb up and down 3 flights of stairs approximately 3 times. As he was going down the stairs, carrying the buckets, he felt a pop in his shoulders and pain in his back.

Petitioner presented in the emergency department of Advocate Illinois Masonic Medical Center (PX #1) on April 21, 2011. Petitioner complained of left shoulder and

right lower back pain since that night before. He reported that he had been lifting 20 lb. pails of paint with each arm up and down stairs. He suddenly developed sharp 10/10 pain with a click in his left shoulder. He reported 10/10 lower back pain also. He reported back pain radiating into his buttock and mid-thigh. Petitioner gave a history of bilateral shoulder ligament surgery, left knee arthroscopy, and arthralgias, and myalgias. Petitioner reported that he smoked cigarettes.

On examination Petitioner's left shoulder was tender to palpation and upon abduction. Shoulder range of motion was limited by pain. Shoulder strength was diminished on the left. The low back was also tender to palpation. It was noted that Petitioner had a positive straight leg raise on the right, but then another note stated no pain on straight leg raise. He had an injection of a narcotic for pain. Petitioner was diagnosed with shoulder strain and lower back strain. He was discharged to home with prescriptions for Norco and Flexeril. He was to follow-up with his family doctor or Dr. Dormitorio.

Following the medical treatment at Illinois Masonic Medical Center, Petitioner returned to work for Respondent. He testified that while he was working he continued to experience pain in his back and shoulders.

Petitioner eventually sought medical treatment with Dr. Preston Wolin (PX #2) on May 31, 2011. Petitioner reported that he felt a pop in his shoulders as he was carrying buckets weighing 15-20 lbs. at work. He also complained of back pain. Petitioner gave a history a back injury 2-3 years before which was successfully treated with conservative care. Petitioner also reported that he had had a prior arthroscopy to the left knee and 2 prior arthroscopies to the right knee. He also had left shoulder surgery in 2003 and right shoulder surgery in 2006. Petitioner had been able to return to work without restrictions after that history of surgeries. Petitioner was a 1 pack-a-week smoker.

The back pain was on the right side and radiated into the posterior aspect of the right leg. Back range of motion was limited and Petitioner had a positive straight leg raise on the right at 70°. Leg strength was normal. Lumbar x-rays were normal. Dr. Wolin diagnosed lumbar sprain with possible herniated disc. Dr. Wolin recommended an MRA for both shoulders to rule out rotator cuff or labral pathology and physical therapy for the back for 4-6 weeks.

On a June 6, 2011 telephone call Petitioner's reported that his back condition was not improving. Dr. Wolin referred Petitioner to Dr. Lawrence Frank for further treatment for the low back. Thereafter Dr. Wolin provided medical treatment for Petitioner's bilateral shoulder condition and not his back condition. On June 14, 2011 Petitioner saw Dr. Wolin for his shoulders and discussed shoulder surgery. Dr. Wolin noted that Petitioner should continue treatment for his severe back pain and should follow up with him when his back improved.

Petitioner also saw Dr. Mehul Garala in June 2011. Dr. Garala diagnosed back strain complicated by facet syndrome. He too recommended facet injections.

Petitioner saw Dr. Wolin on August 12, 2011 in follow-up after shoulder surgery. Dr. Wolin noted Petitioner's report that he had had a series of back injections and was much improved. It was noted that Petitioner was free of back pain.

Petitioner continued to follow with Dr. Wolin 19 times for his shoulder problems and surgeries throughout 2011, 2012, and 2013 through July without mention of the condition of his back.

On August 13, 2013 Petitioner saw Dr. Wolin for his shoulder problems again. On the visit he reported that he had fallen onto his elbow and forearm while walking his dog. He complained of increased right shoulder pain. On September 17, 2013 Petitioner was in for another shoulder check. At that time he complained of lower right sided back pain radiating into his right leg. He also complained of numbness and tingling in the right foot. Petitioner stated these complaints began about 2 months before and were getting progressively worse. Dr. Wolin noted that there had been no new injury. He referred Petitioner back to Dr. Frank.

The only other Dr. Wolin notes about Petitioner's back condition were on December 7, 2013 and May 6, 2015. On December 7 he noted Petitioner's back problems were being managed by Dr. Frank. On May 6 he noted Petitioner's current care with Dr. Frank for his back but that shoulder physical therapy was limited by back pain.

Petitioner was examined by Dr. Frank (PX #3) on June 7, 2011. Dr. Frank noted a history of localized back pain from repetitive bending and lifting of 15 -20 lb. pails. Petitioner continued to work without restrictions as a garage attendant. Petitioner reported that back x-rays showed arthritis. Petitioner complained that he could only stand 10-15 minutes or walk half a block without pain. Dr. Frank diagnosed of lumbar sprain likely complicated by lumbar facet syndrome. He recommended a prednisone taper, Daypor, and physical therapy.

On June 15, 2011 Petitioner saw Dr. Frank with worsening back pain from working. Petitioner continued to report localized back pain with radiating into the bilateral buttocks. Dr. Frank recommended that Petitioner undergo bilateral L3-4, L4-5, and L5-S1 facet joint injections and begin physical therapy.

Dr. Frank administered the facet joint injections on August 4, 2011 at Elmhurst Outpatient Surgery Center. (PX #5) The post-operative diagnosis was facet syndrome, lumbar spondylosis, and lumbar sprain. Petitioner testified that the injections gave him some relief but that he still had some pain.

Petitioner followed up with Dr. Frank on August 11, 2011. Petitioner reported a 95% improvement in the back pain. He reported that he was able to sit and walk as he pleased. Petitioner had a slight soreness of the right gluteal region. Dr. Frank noted an impression of lumbar sprain complicated by facet syndrome, markedly improved. Dr. Frank cleared Petitioner to undergo surgery for his shoulder condition. He noted that Petitioner's back condition would not impede any potential recovery for shoulder surgery. Petitioner was to return as needed.

Dr. Frank performed an EMG/NCV for Petitioner's left shoulder and arm on August 17, 2011. On January 10, 2012 Dr. Wolin ordered work conditioning for Petitioner's shoulder. Petitioner underwent an FCE for his left shoulder at the recommendation of Dr. Wolin. Petitioner testified that he was not able to complete the FCE due to back pain and an injury to his thumb.

Petitioner testified that between August 2011 and September 2013 he did not receive any medical treatment for his back condition. However, he received ongoing medical treatment for his bilateral shoulder condition.

Petitioner also testified that between August 11, 2011 and September 2013 he did not sustain any new accidents involving his back. He testified that in early August 2013 he tripped over his dog. He reported this incident to Dr. Wolin. In his August 13, 2013 progress note Dr. Wolin documented that Petitioner had a fall 5 days before while walking his dog. He landed on his left side and scrapped his left forearm and right elbow. He noticed some increase in right shoulder pain. There was no note of back pain in reference to the fall. Petitioner testified that tripping over his dog did not affect his back condition. He noticed symptoms in his back prior to the fall. He did not report any back complaints to Dr. Wolin.

Petitioner testified that the pain in his back came back gradually after August 2011. The pain was the same as in 2011 and was in the same location as in 2011. Petitioner decided to seek medical treatment from Dr. Frank because the pain was becoming worse and traveling down his leg.

Petitioner saw Dr. Frank on September 23, 2013. (PX #3) Petitioner complained of right sided low back pain with radiation into the right leg into the great toe. Petitioner reported that the symptoms came on gradually 2 to 3 months prior to the visit. Dr. Frank documented no new back injury. Pain was noted at 7/10. Range of back motion was limited by pain. Sensation was normal. Leg strength was 5/5. Dr. Frank diagnosed lumbosacral spondylosis without myelopathy and lumbar radiculopathy. Dr. Frank noted that leg pain was a new feature. He recommended an MRI and continued Flexeril. Petitioner testified that it was not necessary to inform Dr. Frank of the August 2013 fall since it did not affect his back.

On October 11, 2013 Petitioner was unchanged. Dr. Frank noted that Petitioner had not sustained a new injury to his back; rather, he had gradually increasing back pain for 2-3 months without specific injury. Dr. Frank noted that the symptoms began in April 2011 while Petitioner was doing maintenance work and lifting 5 gallon buckets. Subjective complaints of back pain were noted on the physical examination. There were no objective findings. The exam was noteworthy for 3 positive Waddell signs, particularly exaggerated pain exclamations.

Dr. Frank diagnosed lumbosacral spondylosis without myelopathy, lumbar dis degeneration, and heartburn. He recommended lumbar facet joint injections at L3-4, L4-5, and L5-S1. He stated that the condition was work-related. Petitioner underwent the facet joint injections on October 31, 2013. (PX 5)

Petitioner returned to Dr. Frank on November 25, 2013. Dr. Frank noted that Petitioner had 100% symptom relief until about a week before when the pain in the buttock started to return. Petitioner had full range of motion but complained of pain with left bending. Waddell's were now negative. Dr. Frank recommended physical therapy and considered RFN (radiofrequency neurotomy). He again stated the condition was work-related.

On December 16, 2013 Dr. Frank recommended RFN at right L2, L3, L4, and L5. The physical exam was essentially unchanged, including negative Waddell's. He noted that Petitioner was having symptoms suggestive of facet and myofascial pain. He reiterated that the condition was work-related.

Petitioner was examined by Dr. Mark Levin pursuant to §12 of the Act on May 6, 2014. Petitioner gave a history of an injury on April 21, 2011 when he was working job duties that were not normal for him. He developed back pain so severe he almost fainted. Petitioner was treated at Illinois Masonic Medical Center and released. He continued to work until June 2011 without medical care. He reported pain at 5/10 at the beginning of his shift and increased to 7/10 by the end of shift.

Petitioner reported that he initially consulted Dr. Wolin, who referred him to Dr. Frank for his back pain. Dr. Frank gave Petitioner spinal injections which resolved his back pain.

Petitioner testified that he has not undergone the medical treatment recommended by Dr. Frank since it has not been authorized. He does want to undergo the RFN recommended by Dr. Frank.

Petitioner was examined by Dr. Mark Levin on May 6, 2014 pursuant to §12 of the Act. Petitioner testified that he was truthful and honest with Dr. Levin. Petitioner gave a history that he was hurt at work on April 21, 2011. Petitioner was covering for another worker and that he was not doing his normal job. As he was sweeping and carrying 25 lb. pails he developed low back pain so severe he almost fainted.

Petitioner was seen at Illinois Masonic Medical Center emergency room. He was treated and x-rayed. Petitioner continued to work until June 2011. During work he had 5/10 pain at the beginning of his shift and then 7/10 pain at the end of shift. He also reported occasional right leg pain then. Petitioner then consulted Dr. Preston Wolin. Dr. Wolin treated Pettioner's shoulder problems and referred him to Dr. Lawrence Frank for evaluation of the low back complaints.

Petitioner reported that Dr. Frank administered trigger point injections in his lumbar spine. He reported that his back pain resolved by the time of his shoulder surgery in August 2011.

Petitioner reported that he did not have any medical care for his back between August 2011 and October 2013. He went back to Dr. Frank on October 3, 2013 for a flare-up of back pain. Petitioner had an MRI and another lumbar injection. The last injection gave relief for only a month. Petitioner reported that Dr. Frank was

recommending a burning procedure for his nerve, which Dr. Frank said should relieve pain for about 2 years.

At the IME, Petitioner reported intermittent pain ranging from 4/10 to 6/10. He was not taking medication for his back. He reported pain after sitting or standing for 5-10 minutes, with minimal walking, and driving 30-60 miles.

On examination Dr. Levin observed Petitioner's side-to-side gait, but also noted Petitioner's ability to heel-heel and toe-toe walk. Petitioner could touch his knees but had pain on hyperextension. Petitioner reported low back pain on supine straight-leg at 70° but no pain complaints on seated straight-leg. Petitioner reported deceased sensation over the medial and laterals aspects of the thighs.

Dr. Levin then reviewed Petitioner's October 9, 2013 lumbar MRI and Petitioner's medical records from Dr. Wolin, Dr. Garala, and Dr. Frank. Dr. Levin noted that the MRI showed minimal right-sided bulging at L2-3 without evidence of a disc herniation. There was also facet arthritis without nerve impingement at L4-5 and L5-S1. Dr. Levin noted Dr. Frank's chart entry on August 11, 2011 that petitioner had realized 95% improvement in back pain. Thereafter Petitioner was treated by Dr. Wolin for his shoulders.

Dr. Levin noted Dr. Wolin's chart entry dated February 9, 2012 where Petitioner gave a history of a back injury 2 to 3 years before that was treated conservatively. Dr. Levin also noted the numerous clinical visits in 2012 and 2013 with Dr. Wolin where petitioner did not complain of back pain.

Dr. Levin noted that Petitioner reported back pain to Dr. Wolin during a September 17, 2013 clinical visit. Petitioner then returned to Dr. Frank on October 11, 2013 with back pain. Petitioner had reported to Dr. Frank that his back pain had returned 2 months before. Petitioner continued with Dr. Frank through November 25, 2103, at which time Dr. Frank was recommending radiofrequency (ablation) at right L2-3, L4, and L5.

In his May 6, 2014 report to Respondent's insurer (Exhibit #1 to RX #2) Dr. Levin opined that Petitioner's low back pain resolved by the end of 2011. The treatment in 2011 with facet injections resolved Pettioner's comaplints. He opined that the complaints of back pain at the time of the IME were due Petitioner's underlying facet syndrome.

Petitioner testified at the hearing that his back is getting worse. He has pain in his back which shoots down his right leg. Sometimes his right leg gives out. Petitioner said he has difficulty sitting and standing. He tries not to take pain medication for his back condition. He uses hot pads for his back pain.

Evidence Deposition of Dr. Lawrence Frank (PX #8)

Dr. Frank gave his deposition on February 17, 2015. Dr. Frank specializes in physical medicine and rehabilitation. He described his practice as nonoperative orthopedics or the cardiology of orthopedics. He is board-certified in physical medicine and rehabilitation, pain management, sports medicine, and electrodiagnostic medicine. The majority of Dr. Frank's practice deals with musculoskeletal medicine.

Dr. Frank refreshed his memory of Petitioner's case with his clinical records. He testified that petitioner presented on June 7, 2011 with complaints of low back pain for 6 weeks. Petitioner reported that he hurt his back with repetitive bending and lifting of 15-20 lb. pails. Dr. Frank recited his findings on physical exam as documented in his records. He confirmed his diagnosis of a lumbar sprain with facet syndrome. He noted that Petitioner had been unable to get physical therapy due to time constraints at work.

Dr. Frank recommended facet joint injections. He testified that the injections only provide temporary relief. Injections can provide relief from 2 weeks to several years. Dr. Frank administered injections on August 4, 2011. The injections provided 95% relief of Petitioner's symptoms. Dr. Frank testified that the injections were also diagnostic since the relief confirmed that the facet joints were the source of Pettioner's pain.

Petitioner returned to Dr. Frank on September 23, 2013 with complaints of right-sided back pain for the previous 2 to 3 months. Petitioner complained of pain radiating into the leg and great toe. Dr. Frank was concerned due to the new symptomology. He was aware that Petitioner had undergone some shoulder surgeries since he last saw petitioner in 2011. Dr. Frank restarted anti-inflammatory medication and ordered an MRI.

Dr. Frank reviewed the MRI with Petitioner on October 11, 2013. The MRI showed a disc herniation at L2-3 on the right, which did not correspond to Pettioner's leg complaints and numbness in the great toe. Dr. Frank had no explanation for the leg symptoms. At that time he recommended repeat facet injections. The injections were administered on October 31. On November 25, 2013 Petitioner reported 100% relief of his back pain for only 2 weeks. Thereafter the pain returned. At that time Dr. Frank recommended radiofrequency neurotomy. That procedure can provide relief anywhere from 6 months to 2 years.

Dr. Frank opined that Petitioner's diagnosis is facet syndrome. He also opined that the work related accident on April 20, 2011 caused Petitioner's current condition. He further opined that Petitioner is not at MMI. Dr. Frank went on to explain that the 2 year gap in his care for Petitioner was due to Petitioner being too busy with his care for his shoulder injuries.

Dr. Frank then testified to his disagreement with the opinions of Respondent's expert, Dr. Mark Levin. He disagrees with Dr. Levin's opinion that Petitioner's injury was an exacerbation because Petitioner never had back pain before the original injury.

Dr. Frank noted that Petitioner's complaints were exactly the same even though years apart.

On cross-examination Dr. Frank acknowledged that lumbosacral spondylosis with myelopathy is that same as facet syndrome. He also acknowledged that the 2 year gap from 2011 to 2013 could be because Petitioner was not having back pain. He did note that petitioner did not report that he fell while walking his dog in 2013. Dr. Frank further acknowledged that petitioner complaints in 2013 were gradual in onset over 2-3 months. Petitioner's MRI showed degenerative disc disease.

Dr. Frank admitted that he might change his causation opinion with new information about another incident. He also noted that he cannot rule out symptom magnification in any patient.

On re-direct examination Dr. Frank noted that petitioner presented with back pain comaplints in different locations in 2011 and in 2013. He continued and noted that Pettioner's complaints did not correspond to the LRI findings at L2-3. He testified that there is an 80% recurrence of back pain but it would depend on the circumstances if the recurrence related back to the original condition. Dr. Frank also testified that, assuming someone with Pettioner's condition fell, a fall could aggravate a pre-existing fact syndrome.

Evidence Deposition of Dr. Mark Levin (RX #2)

Dr. Levin gave his deposition on April 15, 2015. He devotes 20% of his professional time on IMEs, 90% of which are for the defense. He refreshed his recollection with his office records and narrative report. Dr. Levin repeated his findings and opinions set forth in his May 6, 2014.

Dr. Levin testified that Petitioner had denied any back pain or treatment for his back prior to the April 21, 2011 activity. He clarified that he did not believe that event on April 21 was an accident. Dr. Levin noted that clinical records documented Petitioner's report of a back injury and conservative medical care 2 to 3 years before the 2011 event. He again noted that Petitioner had no complaint of back pain in a sitting straight-leg test but had back pain on the right at 70° in supine on the right. He also noted that Petitioner had reduced pin-prick sensation over the medial and lateral aspects of his right thigh. The remainder of the neurological exam was normal.

Dr. Levin opined that Petitioner had chronic facet arthritis which was exacerbated by the April 21, 2011 work activities. He further opined that the care and treatment by Dr. Frank in 2011 was appropriate. He opined that the series of injections resolved Petitioner's complaints in 2011. Dr. Levin finally opined that Petitioner's complaints in 2013 and at the IME were consistent with Petitioner's underlying condition which pre-existed 2011. Therefore, he opined that Pettioner's complaints in 2013 were not causally related to the work activity in April 2011.

Dr. Levin did opine that Dr. Frank's treatment in 2013 was appropriate to relieve Petitioner's complaints but was not related to the 2011 injury.

On cross-examination Dr. Levin testified that the radiofrequency ablation recommended by Dr. Frank was appropriate treatment for Petitioner's condition. He reiterated his opinion that the April 2011 injury was an exacerbation of pre-existing arthritic facets. He noted Petitioner's complete, asymptomatic resolution after Dr. Frank's treatment in 2011.

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner failed to prove that a causal connection exists between his current lumbar condition of ill-being and the work accident in April 2011.

The Arbitrator finds that the Dr. Franks' opinion that Petitioner's current condition of lumbar pain is related to the April 2011 workplace incident is not persuasive. Dr. Frank's opinion is in part based on the history given by Petitioner that he had not had a prior back injury or had had prior treatment for his back. The Arbitrator finds that Petitioner was not credible when he made such a denial. At the hearing Pettioner repeated his denial of a prior back injury or treatement. Petitioner was confronted on cross-examination with the May 31, 2011 chart note of Dr. Wolin, wherein it was noted that Petitioner had injured his back 2 to 3 years before and had received medical treatment for that injury.

A physician's opinion is not credible if it is not based on an accurate patient history or the patient's accurate report of subjective complaints. The Arbitrator also notes that Petitioner denied a prior back injury at his IME with Dr. Levin. Dr. Levin noted inconsistent observations during straight-leg raise testing while seated and while supine. These issues further undermine Pettioner's credibility.

The Arbitrator notes that Petitioner, over time, had variously reported that he was injured on April 20, 2011 and on April 21, 2011. The Arbitrator does not place any weight on that discrepancy in evaluating Pettioner's lack of credibility.

In addition, even assuming *arguendo,* that Petitioner was truthful in his history to Dr. Frank, Dr. Frank's causation opinion regarding Petitioner's condition in October 2013 is based on speculation. While causation can be proved circumstantially by a chain of events that chain of events must be more closely related in time than what is present here. Dr. Levin's opinion that Petitioner's current condition is due to Petitioner's underlying pre-existing arthritic facets and is not related to the workplace incident is clearly more persuasive.

Also, during the course of his care with Dr. Frank Petitioner displayed 3 positive Waddell signs. The 5 panel Waddell is intended to identify non-organic causes for subjective complaints, complaints without relation to objective findings. This is another

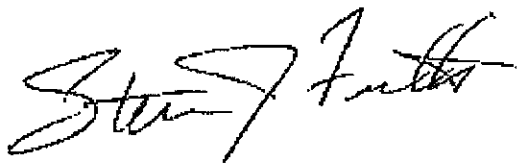
factor in assessing Petitioner's lack of credibility.

Finally, Dr. Frank did not know about Pettioner's fall while walking his dog in August 2013. This may in fact have been as minor as Petitioner described. However, it is unknown whether that event would have affected Dr. Frank's causation opinion. But, it is another example of an incomplete history provided by Petitioner. A valid opinion must be based on all available facts.

Therefore, as stated above, Pettioner failed to prove that the current condition of ill-being in his lumbar spine is causally related to the workplace incident in April 2011.

O: Is Petitioner entitled to prospective medical care?

In light of the foregoing findings this issue is moot. Therefore, Petitioner's claim for further prospective medical is hereby denied.



November 9, 2015

Steven J. Fruth, Arbitrator

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JACKOW, LESZEK Case# **11WC033962**
Employee/Petitioner

RYDER INTEGRATED LOGISTICS
Employer/Respondent

On 11/10/2015, 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 0.34% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0293 KATZ FRIEDMAN EAGLE ET AL
KEITH D SPARKS
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

0734 HEYL ROYSTER VOELKER & ALLEN
TONEY J TOMASO
PO BOX 129 102 E MAIN ST #300
URBANA, IL 61803-0129

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

LESZEK JACKOW
Employee/Petitioner
v.
RYDER INTEGRATED LOGISTICS
Employer/Respondent

Case # **11 WC 33962**

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 **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Wheaton, Illinois**, on **August 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. ☒ 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 **N/A**

FINDINGS

On **05/24/2011**, 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 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 $**41,600.00**; the average weekly wage was $**800.00**.

On the date of accident, Petitioner was **46** years of age, ***single*** with **0** children under 18.

Petitioner has failed to prove all received medical services are causally related to the accident in question; therefore, the treatment cannot be determined as reasonable and necessary.

Respondent is not responsible for any or all appropriate charges for any and 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 $**2,692.86** under Section 8(j) of the Act (previously-paid short-term disability benefits between 08/06/2011 through 10/09/2011).

ORDER

- **Petitioner has failed to meet his burden of proof and establish that on May 24, 2014, he sustained accidental injuries which arose out of and in the course of employment with Respondent.**

- **Petitioner has failed to provide sufficient evidence that he gave proper notice of the May 24, 2011, accident within the time limits stated in Section 6(c) of the Act.**

- **Petitioner has failed to meet his burden of proof and establish his current condition of ill-being is causally connected to the May 24, 2011, injury allegedly suffered during the course of his employment.**

- **The Arbitrator finds Petitioner is entitled to no TTD, medical or PPD benefits as there was a failure to meet the burden of proof and establish a compensable claim under the Act.**

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

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

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

Jason C. Myatt

Signature of Arbitrator

10/28/15
Date

NOV 10 2015

STATE OF ILLINOIS)
)SS
COUNTY OF DUPAGE)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

LESZEK JACKOW,	)	
Petitioner,	)	
	)	
v. Case No:	)	**11 WC 33962**
	)	
RYDER INTEGRATED LOGISTICS,	)	
Respondent.	)	

ADDENDUM TO THE DECISION OF ARBITRATOR

On August 21, 2015, this matter proceeded to hearing pursuant to Section 19(b) of the Illinois Workers' Compensation Act (the "Act") before Arbitrator Jessica A. Hegarty in Wheaton, Illinois.

The disputed issues with respect to Petitioner's claim are:

- Accident;
- Notice;
- Causal connection;
- Medical Bills;
- TTD;
- Nature & extent of Petitioner's alleged injury.

STATEMENT OF FACTS

Petitioner, Leszek Jackow, was a forty-six year old male employed by Respondent, Ryder Integrated Logistics, as a long haul truck driver at the time of the accident.

According to his testimony, on May 24, 2011, Petitioner was delivering steel tubing to a location in Detroit, Michigan. (T.13). Petitioner was helping unload bundles of steel tubing that weighed 200 pounds when he felt a sudden pain in his back which caused electric shocks to shoot down his legs. (T.13-15).

After the alleged accident, Petitioner continued to work which only involved driving the truck. (T.16). At the end his work day, Petitioner drove to a truck stop and slept there for the night in order to wait for the next day's deliveries to be assigned to him. (T.17).

Petitioner testified that he reported the accident to his supervisor, John French, the day after the accident, May 25, 2011 after returning to Chicago. (T.18). Petitioner indicated

that he still had pain in his lower back. (T.18). Petitioner testified that he told his supervisor, John French, that "while I was in Detroit I was lifting [sic] heavy object and something popped in my spine." (T.42).

On May 28, 2011, Petitioner first sought treatment with Dr. Slodowy, his primary care doctor. (Px.1). Dr. Slodowy's hand-written notes indicate that Petitioner had chronic back pain "off -on" for 4 months. (Id.). Dr. Slodowy examined Petitioner's lumbar spine and diagnosed Petitioner with cervical and thoracic radiculitis. (Id.). Dr. Slodowy does not note a work accident.

Dr. Slodowy's medical records show that he has been treating Petitioner since approximately 2006 for various causes. (Id.). Dr. Slodowy's treatment notes prior to May 28, 2011, make no mention of treatment in regard to his back. (Id.).

Petitioner acknowledged that Dr. Slodowy's medical notes do not identify any accident history in his May 28, 2011 record or any other of Dr. Slodowy's medical records. (T.37). Petitioner further testified that he did instruct Dr. Slodowy about his work accident and indicated that "I was lifting something and something popped in my spine." (T.43-44). Petitioner described that the pain he was experiencing in his back after the May 24, 2011 accident was different than any prior back pain he had experienced. (T.31). Petitioner indicated that after the work-related incident on May 24, 2011, his back pain now was constant and present all the time. (T.31).

On June 17, 2011, Petitioner returned to Dr. Slowdowy for a follow-up visit. (Px.1). Dr. Slodowy's hand written notes indicate that Petitioner complained of back pain. (Id.). At that visit, Petitioner was noted to have decreased range of motion and was diagnosed again with lumbar and thoracic radiculitis. (Id.). Dr. Slodowy issued an off work restriction. (Id.).

Petitioner followed-up with Dr. Slodowy on July 8, 2011, July 16, 2011 and August 2, 2011. (Id.). Dr. Slodowy's hand-written notes indicate that Petitioner was still having persistent pain and tenderness in the lumbar spine. (Px.1). There are other notations within these dates but they are difficult to read and decipher. Petitioner's last treatment date with Dr. Slodowy was on August 2, 2011. (Id.).

On August 4, 2011, Petitioner treated with Dr. Sokolowski on a referral from Dr. Slodowy. (Px.2). Dr. Sokolowski documented an injury during the course of employment as a truck driver. (Id.). Dr. Sokolowski diagnosed Petitioner with 1) cervical pain; 2) radiculopathy, 3) features of cervical myelopathy; 4) lumbar pain; 5) lumbar radiculopathy; and 6) left knee pain. (Id.). He recommended Petitioner undergo a cervical and lumbar MRI, physical therapy and take anti-inflammatories. (Id.). Further, Dr. Sokolowski gave Petitioner an off work restriction until his next appointment. (Id.).

On August 25, 2011, Petitioner returned to Dr. Sokolowski after an MRI on his cervical and lumbar spine was conducted. Petitioner had undergone three weeks of physical therapy. (Id.). Dr. Sokolowski noted that Petitioner's neck pain had significantly

decreased following physical therapy and that his lumbar pain was also improving, albeit more slowly. (Id.). Reviewing the MRI, it is noted that Petitioner's cervical spine shows no significant spinal stenosis but his lumbar spine revealed a left annular tear at L4-5. (Id.). Dr. Sokolowski continued the line of treatment and kept Petitioner off work until September 21, 2011. (Id.).

On September 21, 2011, Petitioner again treated with Dr. Sokolowski who noted that Petitioner's neck pain was improving but he still had low back pain with radiation into his left buttock and leg. (Id.). Dr. Sokolowski noted that Petitioner's symptoms resulted from his work-related injury. (Px.2). The doctor diagnosed Petitioner with cervical pain and radiculopathy, improved; and lumbar pain and radiculopathy, improving. (Id.). He then continued Petitioner's physical therapy program, prescribed Naprosyn and Tramadol, and gave Petitioner a light duty work restriction of no bending/squatting, lifting over 15 pounds and no prolonged standing/walking. (Id.).

On October 3, 2011, Petitioner returned to Dr. Sokolowski who noted that Petitioner's neck and left arm pain and low back pain with radiation to left buttock and leg was improving. (Id.).

Dr. Sokolowski returned Petitioner to full duty work starting October 10, 2011. (Id.). The doctor noted that Petitioner "has improved, but certainly not asymptomatic. He will transition from physical therapy to self-directed home exercise program going forward." (Id.). Petitioner was continued on Naprosyn and Tramadol as needed. (Id.).

Petitioner returned to work for Respondent working full duty as a truck driver. (T.25).

Petitioner resigned from his employment with Respondent on March 9, 2012 and is documented in a resignation letter signed by Petitioner. (Rx.7). Petitioner wrote that he has "to terminate work with [Respondent] because of my back pain. It causes that [sic] I'm getting tired very fast. I am very thankful to management for this experience I earned here." (Id.). Petitioner described that following his physical therapy treatment his cervical spine was doing well but his lower back remained an issue. (T.46).

Petitioner testified that from the time of his release from care with Dr. Sokolowski to March 2012, his low back "pain was increasing and finally I decided to quit my job." (T.47).

On March 16, 2012, Petitioner returned to Dr. Sokolowski with complaints of low back pain. (Px.2). Dr. Sokolowski noted that Petitioner was doing well for a period of time but "has had return of symptoms in precisely the same distribution as he had with his initial work-related injury. His symptoms were never altogether absent, but have become significantly more severe and are now rated as 4/10." (Id.). Dr. Sokolowski diagnosed Petitioner's injuries as 1) cervical pain; 2) cervical radiculopathy; 3) lumbar pain; 4) lumbar radiculopathy. (Id.). The doctor opined that Petitioner's injuries were causally related to the work accident (Id.). Petitioner was given an off-work restriction, anti-inflammatories and referred to physical therapy. (Id.).

On April 25, 2012, Petitioner presented to Dr. Sokolowski who noted that Petitioner's symptoms had improved "somewhat." (Id.). The doctor noted that when Petitioner is sedentary at home, Petitioner does not experience significant pain. (Id.). However, with activity, Petitioner experiences a significant increase in back pain with radiation into his legs. (Id.). Dr. Sokolowski notes in his records that Petitioner is "unable to return to his prior occupation, as lifting, twisting, bending, pushing, and pulling all cause him significant increase in pain." (Id.). Petitioner was offered a lumbar epidural injection but Petitioner denied the injection as he was nervous of the potential side effects. (T.27, Px.2).

On June 29, 2012, Petitioner again treated with Dr. Sokolowski where his pain was noted as continuing to diminish. (Px.2). The medical notes indicate that Petitioner has been riding his bicycle for aerobic exercise. (Id.). Dr. Sokolowksi continued to diagnose Petitioner, causally related to work injury, with: 1) cervical pain; 2) cervical radiculopathy; 3) lumbar pain; 4) lumbar radiculopathy. (Id.). Petitioner was returned to full duty work starting July 2, 2012 and released from care with follow-up treatment as needed. (Id.).

On August 3, 2013, Petitioner went to Elmhurst Memorial Hospital emergency room with back pain complaints. (Px.3). Petitioner testified that his back started hurting again because "I was moving boxes upstairs." (Id.). The emergency record notes that his back pain started 2 days ago while lifting some boxes and that Petitioner had a back injury years prior and his current pain is similar. (Id.). Further, the departure assessment indicates that "he had back problems starting 2 yrs ago, worse today after working yesterday." (Id.). Petitioner testified any back pain he was continuing to experience following treatment with Dr. Sokolowski and the pain after the ER visit on August 3, 2013 was different. (T.28). When asked by the Arbitrator to elaborate the difference, Petitioner responded, "it was [sic] sharp pain for short term."

On May 1, 2014, Petitioner was examined by Dr. Coe at the request of Petitioner's attorney. (Px.5). Dr. Coe noted that Petitioner's accident occurred when he was at work lifting two heavy pieces of pipe and experienced the onset of a sharp pain in his lower back that radiated into both legs. (Id.). Petitioner reported that he is no longer followed by a specialist for his lower back, continued to take medications for his back and continued to perform home exercises prescribed by his physical therapists. (Id.).

At the time of the examination, Petitioner complained of pain in the mid-portion of his lower back, made worse by prolonged sitting or standing and bending or lifting. Petitioner reported the pain no longer radiated into his legs and denied numbness or tingling in his legs. On examination, Dr. Coe found Petitioner had decreased range of motion in his lumbar spine's extension and bilateral bending. (Id.). Petitioner indicated to Dr. Coe he had returned to being a truck driver but that his current employment did not require heavy or repeated lifting, described as primarily "short haul." (Id.).

Dr. Coe opined that Petitioner suffered an injury to his lower back while lifting heavy material at work for Respondent. (Id.). Further, he opined that the injury aggravated degenerative disc disease and degenerative arthritis in his lumbar spine causing left-

sided annular tearing, chronic lumbar discogenic and myofascial pain and left lumbar radiculopathy symptoms. (Id.).

Dr. Coe concluded that there is a causal relationship between Petitioner's work injury and his current back symptoms and state of impairment. (Id.). Further, Dr. Coe indicated that in his opinion, Petitioner was in need of ongoing treatment for his chronic lumbar discogenic and myofascial pain. Appropriate treatment would include physician follow-up and prescription medication and potentially lumbar epidural steroid injection if his symptoms persisted or increased. (Id.).

On September 3, 2014, Petitioner was examined by Respondent's section 12 examiner, Dr. Zelby. (Rx.2). Dr. Zelby noted that Petitioner reported a May 2011 work injury when he lifted a piece of steel tubing weighing an estimated 100 pounds from the ground and felt a sharp pain in the low back with a feeling of electric shock in his legs. (Id.).

Petitioner reported that his employment, post-Respondent, has been truck driving without physical labor. (Id.). It was noted that Petitioner's duties with Respondent were truck driving including loading and unloading which Petitioner described as heavy physical labor. (Id.).

Dr. Zelby reviewed Petitioner's July 19, 2011 x-rays of his lumbar spine as normal. (Id.). The doctor noted that the August 8, 2011, MRI showed minimal degenerative changes, less than would be expected for someone Petitioner's age. Dr. Zelby noted the MRI was normal. (Id.). In reviewing Petitioner's lumbar MRI, Dr. Zelby indicated that it showed minimal degenerative disc disease at L3-L4 without loss of disc height and miniscule bulging discs at L3-L4 and L4-L5 without stenosis or neural impingement. The doctor noted a tiny partial-thickness annular tear far laterally on the left at L4-L5 and indicating study is essentially normal. (Rx.2).

Dr. Zelby reviewed Dr. Coe's evaluation of Petitioner noting Dr. Coe's descriptions of the accident but indicates that Dr. Coe's conclusions were not available for review. (Id.).

Dr. Zelby indicated that based on the objective medical evidence, Petitioner suffered a soft tissue muscular spinal strain and nothing more. (Id.). Further, that Petitioner's persistence and reported severity of his symptoms were inconsistent with his objective medical findings, and inconsistent with the natural history of his objective medical condition. (Id.). Dr. Zelby opined that Petitioner, at the time of injury, needed only 3-4 weeks of physical therapy before transitioning to self-directed exercise program and that Petitioner should have reached maximum medical improvement by August 2011. (Id.).

Dr. Zelby further opined that Petitioner does not need any work restrictions and that further treatment is unnecessary. (Id.).

Respondent called witness John Weber to testify at trial in regard to the events of Petitioner's work-related accident. On May 24, 2011, and prior, Mr. Weber was employed with Respondent as Senior Logistics Manager. (T.50). Mr. Weber is

responsible for multiple accounts in the Chicagoland area, one of which included where Petitioner was located. (T.51).

Mr. Weber testified that on May 24, 2011, John French was the location manager for Petitioner. (T.51). Further, he testified that Mr. French would report directly to Mr. Weber. (T.52). Mr. Weber indicated that he would be at Mr. French's location approximately once a week but would have direct contact on a daily basis. (T.53). At the time of trial, Mr. French was no longer an employee of Respondent. (T.53).

Mr. Weber testified that he experienced and was familiar with Petitioner while he was working for Respondent. (T.54). He further testified that during the months of May, June, July of 2011, his understanding of Petitioner's back condition was not reported as a work injury. (T.56).

According to his testimony, company procedure for reporting an injury was for the employee to notify the immediate supervisor as soon as they can about an injury and then the supervisor documents the incident on their first report of injury system. (T.57-58). After completing this electronic report, a copy is automatically forwarded to his attention. (T.58). Mr. Weber acknowledged that company's accident procedure is for the injured employee to only verbally tell their immediate supervisor, and that the electronic first report of injury documentation is to be filled out by the supervisor and not the injured employee. (T.70-72).

Mr. Weber testified that Respondent's exhibit 1 consisted of Petitioner's employment records. (T.58). He identified them as notes drafted by Petitioner's supervisor, Mr. French, and placed in Petitioner's file. (T.58). Mr. Weber testified that as supervisor, Mr. French, is trained to keep employing notes about employee situations as part of the company protocol. (T.59-60). Mr. Weber testified that Petitioner's back injury was not reported as a work-related injury because the protocol for documenting his injury would have followed the first report of injury system rather than documenting his injury in his employee file. (T.61).

Mr. Weber testified that the first time Petitioner's alleged work injury was reported was on August 30, 2011. (T.64). He further testified that Respondent's exhibit 9 is the "First Report of Injury" print out from the electronic system which indicates a reported date of August 30, 2011. (T. 64).

Petitioner testified that the day after the work accident, he told his supervisor of the work accident. (T.18, T.35). He testified that he did not tell his supervisor he injured his back at home. (T.33). After telling his supervisor of the accident, Petitioner acknowledge he never wrote down an accident description. (T.42). Petitioner testified he was unaware if his supervisor, after Petitioner reported the injury, wrote down Petitioner's accident description. (T.42).

Petitioner is currently employed with PAM Transportation as a truck driver. (T.28). His current position does not include loading or unloading his truck. (T.29). Petitioner indicated that he currently is in good condition but still has pain in his lower back.

(T.29). Specifically, Petitioner has issues with extended periods of sitting or walking and continues to take medication for his back only when he experiences pain in his back. (T.30).

CONCLUSIONS OF LAW

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

The Arbitrator notes during the course of the August 21, 2015 arbitration hearing, the services of an interpreter (Polish) were utilized in conjunction with the testimony of Petitioner Leszek Jackow. The interpreter was identified as Ms. Maria Kapelski (T. 6). Although the services of the interpreter were utilized throughout the course of the trial, it was readily apparent to the Arbitrator Mr. Jackow knew and understood the English language based upon the fact he was answering questions before those questions were interpreted from English into Polish. (T. 7-15). This was also confirmed by the trial testimony of Respondent witness, John Weber, who confirmed he had prior conversations with Leszek Jackow in the past and at no time was there a language barrier, as the two individuals were able to understand each other. Lastly, the Arbitrator notes when trial exhibits and post-trial discussions were taking place, no Polish interpretation was taking place, and by all appearances Petitioner had a good understanding as to what was going on due to his knowledge of the English language.

The Arbitrator also makes careful note of the fact Petitioner was nonresponsive and uncooperative throughout the course of the August 21, 2015 trial wherein Petitioner would answer questions which were not posed to him, give responses which were not appropriate under the circumstances based upon the questions posed, and this lack of responsiveness was not due to Petitioner's misunderstanding but rather his desire to testify as he saw fit. Petitioner had to be formally admonished on the record in order to comply with the rules governing trial procedure as set forth by the Arbitrator during the August 21, 2015 trial. (T. 10, 12, 15-17, 23-25).

The Arbitrator also places great weight on the initial reporting of the alleged injury, or lack thereof, from a medical perspective (and the initial treatment notes following the alleged injury). Petitioner sought initial treatment four days after his alleged work accident, on May 28, 2011 with Dr. Slodowy who noted reports of "chronic back pain" which was "off and on" over the last four months. Nowhere within the confines of the May 28, 2011 initial treatment note from Dr. Slodowy is there mention of workplace activities, workplace injuries, a May 24, 2011 incident, or anything which could be related to a workplace trauma. Rather the complaints made by Mr. Jackow were general in nature and chronic by definition.

It was not until Petitioner presented himself to Dr. Mark Sokolowski on August 4, 2011, that any history of an alleged injury at work dating back to May 24, 2011 is reported. (PX 2) (RX 6).

Dr. Andrew Zelby performed an independent medical examination on Petitioner on September 3, 2014. (RX 2). Dr. Zelby opined, when reviewing medical evidence concerning both the cervical and lumbar spine, that Petitioner suffers from a "mild degenerative" condition regarding his lumbar and cervical spine and there is no substantial finding which could be described as acute or post-traumatic in nature. The objective findings could easily be determined as normal for this 47-year old individual (identified as a normal spine exam).

Additional evidence relied upon by the Arbitrator herein in order to find there is no causal relationship between the alleged injury of May 24, 2011 and Petitioner's current condition of ill-being are the business records kept in the normal course and scope of business activities by Respondent, and specifically its Location Manager, Mr. John French. (RX 1). These notes, kept contemporaneous in time with the activities and happenings in the Spring/Summer of 2011, clearly show conversations took place between Mr. French and Petitioner involving Petitioner's low back complaints which specifically note there was no work-related injury, but rather a pre-existing condition based upon a prior injury suffered by Petitioner at home.

The Arbitrator finds the evidence contained in the record overwhelmingly supports a finding that Petitioner did not suffer a work-related injury. The medical records, and lack of a clear, distinctive history alleging a May 24, 2011 accident, are very telling. The Arbitrator finds Petitioner's credibility is lacking and there is simply no evidence to establish an accident occurred on or about May 24, 2011, consistent with the assertions made by Petitioner. As such, the Arbitrator must find the current condition of ill-being or the complaints identified by Petitioner during the course of the trial, are not related to the May 24, 2011 accident. Petitioner has failed to meet his burden of proof and establish his condition of ill-being involving his lumbar spine is causally related to the May 24, 2011 accident. Accordingly, the Arbitrator finds Petitioner's May 24, 2011 claim is deemed non-compensable.

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

Petitioner further asserts after the alleged injury he reported the accident to his supervisor, John French. Mr. French's supervisor, John Weber, testified that once an accident is reported, a "First Report of Injury" is electronically filled out and filed with Respondent. Mr. Weber explained no such accident report was produced on or about May 24, 2011. Further, in conjunction with Respondent's policy with respect to accident reporting, the injured worker, once it is identified he was injured at work, is then required to fill out, in his own words, an accident report as to how he was injured and what type of injury he suffered. In this case, neither accident report was produced, created or drafted by either John French or Petitioner.

Pursuant to Section 6(c) of the Act, Petitioner is required to report the alleged injury within 45 days of the accident date. The Arbitrator finds the Petitioner failed in reporting the accident in a timely fashion, and as such deems this a non-compensable claim. As evidence of this failure, the Arbitrator relies upon the testimony of John

Weber, Respondent's Exhibit No. 9, and the medical evidence in the form of Petitioner's initial treatment notes and records from Dr. Slodowy (PX 1) (RX 5). First, as it relates to Mr. John Weber's testimony, the Arbitrator notes a timely "First Report of Injury" was not reported on May 24, 2011. Rather, there is proof of notes put together by Petitioner's supervisor, John French, as seen in Respondent's Exhibit No. 1, which clearly outline and delineate conversations which took place between Petitioner and Mr. John French wherein the Petitioner asserts he was injured at home and not at work (when discussing low back pain and complaints). The Arbitrator also notes the alleged injury was not reported until August 30, 2011 (RX 9) wherein Petitioner alleged a May 24, 2011 low back injury while at work. This assertion was reported more than three months after the alleged accident date and does not comply with the 45-day statutory period identified above. The medical evidence identified as the initial treatment records (May 28, 2011) (PX 2) (RX 5) fail to identify a May 24, 2011 injury suffered by Petitioner at work. All medical evidence fails to establish proper notice was provided to Respondent in a timely fashion by Petitioner. There is no formal or informal basis by which Respondent could be credited with knowledge as it relates to the alleged accident date of May 24, 2011. As a matter of fact, all evidence points to a different conclusion which could reasonably be reached by Respondent, which was Petitioner injured himself at home and not at work based upon representations made by Petitioner to his supervisor, Mr. John French, and reported pursuant to company policy and recorded as a business record. (RX 1). As such, the Arbitrator finds Petitioner failed to meet his requirement of providing sufficient notice under Section 6(c) of the Act. As such, the Arbitrator must deny compensability on this claim.

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 references and incorporates herein the findings made in Sections "C", "E" and "F" as noted above.

The Arbitrator finds Petitioner has failed to meet his burden of proof and establish an accident occurred on or about May 24, 2011, arising out of and in the course and scope of his workplace duties and activities with Respondent, and further Petitioner has failed to provide sufficient notice pursuant to Section 6(c) of the Illinois Workers' Compensation Act to the Respondent as it relates to the alleged injury of May 24, 2011. Lastly, Petitioner has failed to meet the burden of proof that his current condition of ill-being is causally related to the May 24, 2011 accident. As such, the medical care and treatment undertaken by Petitioner Leszek Jackow between May 28, 2011, up and through August 13, 2013, are deemed non-compensable and therefore will be the responsibility of Petitioner and not that of the Respondent. The Arbitrator makes note the Petitioner's outstanding medical bills with Dr. Slodowy, Dr. Sokolowski, Athletico Physical Therapy, Bloomington Open MRI, Elmhurst Hospital, and Elmhurst Emergency Medical Services total $3,758.25 (PX 6), and said medical bills will remain the responsibility of Petitioner personally. These bills are determined to be not related and non-compensable, consistent with the Arbitrator's findings above.

K. What temporary benefits are in dispute?

The Arbitrator references and incorporates herein the findings made in Sections "C", "E", "F" and "J" as noted above.

The Arbitrator finds Petitioner has failed to meet his burden of proof and establish an accident occurred on or about May 24, 2011, arising out of and in the course and scope of his workplace duties and activities with Respondent, and further Petitioner has failed to provide sufficient notice pursuant to Section 6(c) of the Illinois Workers' Compensation Act to the Respondent as it relates to the alleged injury of May 24, 2011. Lastly, Petitioner has failed to meet the burden of proof that his current condition of ill-being is causally related to the May 24, 2011 accident.

Petitioner has asserted he is owed temporary total disability benefits between June 18, 2011, through October 9, 2011, representing 16 and 1/7 weeks of TTD benefits. The Arbitrator finds, consistent with her findings above, Petitioner has failed to meet his burden of proof and therefore Respondent does not owe Petitioner any temporary total disability benefits and none are awarded herein.

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

The Arbitrator references and incorporates herein the findings made in Sections "C", "E", "F", "J" and "K" as noted above.

The Arbitrator finds Petitioner has failed to meet his burden of proof and establish an accident occurred on or about May 24, 2011, arising out of and in the course and scope of his workplace duties and activities with Respondent, and further Petitioner has failed to provide sufficient notice pursuant to Section 6(c) of the Illinois Workers' Compensation Act to the Respondent as it relates to the alleged injury of May 24, 2011. Lastly, Petitioner has failed to meet the burden of proof that his current condition of ill-being is causally related to the May 24, 2011 accident.

The Arbitrator finds Petitioner is not entitled to permanent partial disability benefits based upon her findings above.

N. Is Respondent due any credit?

The Arbitrator references and incorporates herein the findings made in Sections "C", "E", "F", "J", "K" and "L" as noted above.

The Arbitrator finds Petitioner has failed to meet his burden of proof and establish an accident occurred on or about May 24, 2011, arising out of and in the course and scope of his workplace duties and activities with Respondent, and further Petitioner has failed to provide sufficient notice pursuant to Section 6(c) of the Illinois Workers' Compensation Act to the Respondent as it relates to the alleged injury of May 24, 2011. Lastly, Petitioner has failed to meet the burden of proof that his current condition of ill-being is causally related to the May 24, 2011 accident.

Based upon the Arbitrator finding above, wherein this claim was deemed non-compensable, the issue concerning a credit to be asserted by Respondent is moot and therefore calculations and identification of said credit is unnecessary under Section 8(j).

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LARSON, MARK
Employee/Petitioner

Case# **11WC045713**

LASALLE COUNTY SHERIFF'S DEPARTMENT
Employer/Respondent

On 11/9/2015, 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 0.28% 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:

4642 O'CONNOR & NAKOS LTF
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CHICAGO, IL 60602

0263 HERBOLSHEIMER LANNON ET AL
WILLIAM P HINTZ
654 FIRST ST PO BOX 539
LA SALLE, IL 61301

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Mark Larson
Employee/Petitioner

v.

LaSalle County Sheriff's Department
Employer/Respondent

Case # **11** WC **45713**

Consolidated cases: _____

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christine Ory**, Arbitrator of the Commission, in the city of **Ottawa** , on **09/30/2015 & Chicago on 10/09/2015**. By stipulation, the parties agree:

On the date of accident, **11/02/2011**, 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 $**56,401.20**, and the average weekly wage was $**1,084.63**.

At the time of injury, Petitioner was **38** years of age, ***single*** with **2** dependent children.

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

Respondent shall be given a credit of $**26,129.46** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**26,129.46**.

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

ORDER

Respondent shall pay Petitioner the sum of $**650.78**/week for a further period of **13.2** weeks, as provided in Section **8 e 5** of the Act, because the injuries sustained caused **60% loss of use of the right little finger.**

Respondent shall pay Petitioner compensation that has accrued from **10/08/2012** through , and shall pay the remainder of the award, if any, in weekly payments.

Respondent agreed to pay ATI Physical Therapy bill in the amount of $255.39 plus University of Illinois Medical Center in the amount of $322.00 pursuant to the fee schedule.

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

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

Christine Moy

Signature of Arbitrator

11/05/2015
Date

NOV 9 2015

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mark Larson,	)	
Petitioner,	)	
vs.	)	**No. WC 11 WC 45713**
LaSalle County Sheriff's Department,	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

Petitioner testified that on November 2, 2011 he was employed by respondent as a corrections officer for twelve years. His duties included cell checks, laundry delivery, serving meals, as well as anything to do with the flow of inmates within respondent's facility. On November 2, 2011while serving a meal to an inmate, he snapped his right small finger when refraining an inmate from leaving his cell. Petitioner is right-handed.

He went to the emergency room at St. Elizabeth Medical Center in Ottawa. X-rays showed a comminuted spiral fracture of the mid shaft, distal shaft and head of the proximal phalanx of the fifth digit (PX.1). Petitioner was referred to Dr. Ortinau for surgery.

Dr. Ortinau performed an open reduction and internal fixation of the articular proximal phalanx fracture on November 8, 2011(PX.3, pp.4-5). He received follow up care by Dr. Ortinau (PX.2). Physical therapy was started on December 20, 2011at ATI (PX.5).

On February 2, 2012, Dr. Ortinau noted a DIP joint contracture. Additional surgery was performed by Dr. Ortinau on February 28, 2012, which consisted of manipulation and examination under anesthesia as well as exploration and release of volar capsule and checks rein ligaments, PIP joint right fifth finger (PX.3, pp. 23-25). Post-operatively he received additional therapy at ATI (PX.5). On March 2, 2012 petitioner complained of numbness in the finger (PX.2, p.19). He continued to complain of pain and numbness in his little finger (PX.2, pp.20-23). On March 29, 2012, occupational therapy was stopped (PX.2, pp.23).

Petitioner returned to Dr. Ortinau on April 12, 2012, a week earlier than scheduled, due to difficulty with therapy and flexion contracture at 45 degrees. Dr. Ortinau referred him to Dr. Alfonso Mejia of University of Illinois, Chicago (PX.2, p.26).

Dr. Mejia first saw him on April 19, 2012 and noted a 90 degree contracture and a non-union of the fracture (PX.6, p.46-47). On petitioner's return visit to Dr. Mejia on May 3, 2012, Dr. Mejia recommended a fusion to extend the right small finger to 45 degrees so as to allow petitioner to use a firearm (PX.6, pp.44-45). Surgery was performed by Dr. Mejia on May 25, 2012 which included a bone graft harvested from petitioner's iliac crest bone and plates and screws (PX.6, pp.18-20).

Petitioner received additional physical therapy from July through December, 2012 (PX.5).

Respondent had petitioner examined by Dr. John Fernandez on August 31, 2012 pursuant to §12 of the Act. Dr. Fernandez was concerned with a non-union and recommended a CT scan (PX.4, pp.4-8).

Petitioner saw Dr. Mejia on September 27, 2012 (PX.6, pp.31-32). He reviewed the CT scan which was performed on September 19, 2012 (PX.1, p.15). Dr. Mejia determined petitioner's PIP joint was fused (PX.6, pp.31-32). Dr. Mejia released the petitioner to full duty on November 5, 2012 (PX.6, pp.31-32).

Petitioner returned to Dr. Fernandez reportedly for treatment on October 23, 2012. The CT scan had been obtained. Dr. Fernandez reviewed the CT scan and concluded petitioner's PIP joint was fused (PX. 4, pp.21-22).

Petitioner again saw Dr. Fernandez on December 4, 2012. Dr. Fernandez noted the PIP joint was fused to 30 degrees. Dr. Fernandez believed petitioner was at maximum medical improvement at that time, but noted petitioner may need to have surgery to remove the plate if it became irritated (PX.4, pp.26-27).

He received follow up care by Dr. Mejia through April 25, 2013. Dr. Mejia reported petitioner had returned to full duty employment without complaints or pain. Dr. Mejia declared petitioner to be at maximum medical improvement (PX.6, pp.27-28).

Petitioner returned to Dr. Mejia on June 25, 2014 due to pain along the 5th metacarpophalangeal joint. Dr. Mejia did not recommend any further treatment as the pain was mild. However, Dr. Mejia indicated if the condition worsened he would recommend occupation therapy and if very severe would recommend an arthroplasty which would likely end petitioner's career as a law enforcement officer (PX.6, pp.161-162). Petitioner has not received any treatment for the injury since June 25, 2014.

Petitioner testified that on certain days, depending upon the weather, his finger hurts. He has problems opening and gripping things. He has difficulty filing papers. He also has difficulty carrying boxes of items such as toilet paper. He has been able to qualify for firearms. The only problem he has when using a gun is grabbing and releasing the magazine clips. He has difficulty in making a fist as he cannot completely bend his little finger due to the fusion. He has problems opening jars as his little right finger sticks out.

He enjoyed race car driving and bowling before the accident. After the accident he claims to have modified the stock car to prevent using his finger. He also claimed he quit bowling about a half a year after the accident as it was painful. He was inducted into the Bowlers' Hall of Fame in 2013.

He sometimes does his own mechanical work on his cars, but will occasionally have problems applying pressure loosen or tightening items as he has problems gripping tools. He claims his penmanship is down.

Petitioner reported to the physical therapist, at time of his discharge on December 3, 2012, that he was physically capable of returning to his leisure activity of bowling and his grip strength was again at a level where he could return to car racing (PX.5, p.134).

Petitioner's supervisor, Jason Edgecomb, testified in behalf of respondent. Mr. Edgecomb confirmed petitioner had been capable of performing all of his duties without difficulties; had passed his firearm qualification every year since he returned to work; had not asked for any time off due to the injury; and has asked not requested any accommodations.

CONCLUSIONS OF LAW

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

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

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. Therefore, the Arbitrator can give no weight to this factor.

With regard to (ii) of §8.1b (b) the occupation of the injured employee, the Arbitrator notes petitioner is employed as a corrections officer and that he was capable of returning to his regular employment as such without any modifications. Petitioner's job required him to lift boxes, serving meals, delivering laundry and operating a firearm. Petitioner has been capable of performing all of these tasks since he returned to work, including qualifying to operate a firearm. Therefore, the Arbitrator gives less weight to this factor.

With regard to (iii) of §8.1b (b) the age of the employee at the time of the injury was 38 years of age, the Arbitrator notes the petitioner has a significant work life ahead of him. Therefore, the Arbitrator gives greater weight to this factor.

With regard to (iv) of §8.1b (b) the employee's future earning capacity, the Arbitrator notes the hardware remains in petitioner's little finger which may require future surgery to remove and possibly need career-ending arthroplasty. The Arbitrator therefore gives greater weight to this factor.

With regard to (v) of §8.1b (b) evidence of disability corroborated by the treating medical records, the Arbitrator notes the treating physician reports petitioner's finger has a permanent contracture at between 30 and 45 degrees and the plate remains in the finger. A portion of bone was removed from petitioner's iliac crest to use for the finger fusion. The Arbitrator gives greater weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 60% loss of use of right little finger pursuant to § 8(e) of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RUBIO, ERNEST A Case# **12WC001934**

Employee/Petitioner

CITY OF CHICAGO

Employer/Respondent

On 11/9/2015, 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 0.28% 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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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

Ernest A. Rubio
Employee/Petitioner
v.
City of Chicago
Employer/Respondent

Case # 12 WC 01934

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 **9/1/2015**. 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 _____

FINDINGS

On **1/9/2012**, 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* causally related to the accident.

In the year preceding the injury, Petitioner earned **$73,216.00**; the average weekly wage was **$1,408.00**.

On the date of accident, Petitioner was **58** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$19,176.51** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$19,176.51**. The Parties agreed that Petitioner was entitled to TTD benefits of **$938.66/week for 20-3/7 weeks** commencing **1/10/2012** through **5/31/2012**, as provided in **§8(b) of the Act,** and that all benefits have been paid.

Respondent is entitled to a credit of **$974.70** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary **medical services** of **$16,490.44**, as set forth below, as provided **in Sections 8(a) and 8.2 of the Act.**

Respondent shall pay Petitioner permanent partial disability benefits of **$695.78/week** for **50 weeks** because the injuries sustained caused the **10% loss of use of a man as a whole** pursuant to **Section 8(d)2 of the Act.**

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

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

Signature of Arbitrator

November 6, 2015
Date

NOV - 9 2015

FINDINGS OF FACT

On January 9, 2012, Petitioner was employed by Respondent as a construction laborer in the Water Department. He had worked for Respondent for more than 20 years. He assisted technicians in finding underground leaks by carrying their equipment and by lifting sewer covers. He was required to lift and push 75-80 pound objects on a daily basis. He performed his job with no difficulty. Petitioner denied prior problems with his low back, ribs, shoulders and neck. On cross examination, Petitioner recalled a prior workers' compensation low back injury (20 years ago). He had no problems with his back thereafter until after January 9, 2012.

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on January 9, 2012. He was riding as a passenger in a City of Chicago SUV vehicle driven by a co-worker going back to Respondent's work yard. Petitioner was in the front passenger seat. As the vehicle approached the red light it was coasting; the light changed to green. Petitioner's vehicle proceeded into the intersection and was struck on the right passenger side by a Chevrolet Impala that failed to stop for a red light. Petitioner characterized the impact as hard, although airbags were not deployed. The impact of the other vehicle caused Petitioner's vehicle to swing around and the other vehicle hit Petitioner's vehicle a second time. Petitioner saw the other car coming and grabbed an overhead hand grip to brace himself and turned to his left. Petitioner's head hit the window and his elbow hit the side of the door. He had difficulty breathing after the impact. Firemen were called to the scene. Petitioner was removed from his vehicle by the firemen and he was taken by ambulance to Northwestern University Medical Center.

The medical records and bill of Northwestern Memorial Hospital were admitted in evidence as Petitioner's Exhibit 3. These records reveal that Petitioner was treated in the emergency room on 1/9/2012, giving the history of: restrained passenger in motor vehicle collision; back passenger side impact; complaining of shortness of breath and left rib pain; also complaining of bilateral lower extremity pain; denies neck pain; cervical collar and backboard removed by M.D. during triage. PX 3, p7. These medical records also describe right lateral rib pain. PX 3, p 14. A chest x-ray was performed and was interpreted to show no acute pulmonary process. PX 3, p9. Petitioner was discharged with a diagnosis of rib pain. PX 3, p 16.

Petitioner testified that when he was discharged, he was feeling pain in his rib cage, neck and right hip. He left the hospital and went home. He had difficulty sleeping that night. The next morning, he had difficulty getting out of bed. He went into work because his boss directed him to come into work. He had to sign papers. He was sent by his supervisor to Mercy Works.

The medical records and bill of Mercy Works were admitted in evidence as Petitioner's Exhibit 4 and Petitioner's Exhibit 5. These records indicate that Petitioner was examined on January 10, 2012, giving a history of accident consistent with his testimony at trial. The history indicates that during the impact his right head, right side of the neck, right shoulder, right rib cage and his right leg hit the side door of the vehicle. He also injured his left anterior chest wall and lower back. He was given ibuprofen and hydrocodone by Northwestern Hospital emergency room. PX 5, p 2. Petitioner complained of neck pain when turning his head to the left; the left anterior chest wall shows an area of ecchymosis with tenderness in the upper portion. He complained of tenderness of the right shoulder including the trapezius subacromial area acromioclavicular joint and deltoid; tenderness in the bicep, deltoid and lateral aspect; tenderness in the lateral aspect of the right chest; tenderness in the anterior inferior aspect of the right chest wall; tenderness in the lumbosacral spine including the left paralumbar area in the left sacroiliac joint; tenderness in the lateral aspect of the right thigh; tenderness in the lateral and medial aspects of the right knee. X-rays of the right shoulder and lower back showed no fractures. The diagnosis was: contusion of neck, right shoulder, right upper arm, right chest wall, left anterior chest wall,

lumbosacral spine, right thigh and right knee; strain of the neck, lumbosacral spine and right calf; status post motor vehicle accident. He was ordered to take ibuprofen, Vicodin, ice pack then heat and home exercise. Work restrictions and a follow-up visit were ordered. PX 4, p 3.

Petitioner did not return to restricted work duty for Respondent. The next day he went to his own physician.

The medical records and bill of Herron Medical Center/Dr. Ravi Barnabas M.D. were admitted in evidence as Petitioner's Exhibit 6. These records reveal that petitioner was examined on January 12, 2012. He gave history of the accident consistent with his testimony at hearing. He complained of right rib pain, back pain and neck pain. He reported the neck pain level 7-8 going down both arms greater right then left, aggravated by moving, coughing sneezing and has worsened since the date of the accident. Back pain was reported level 8 going down his right leg worsened by coughing, sneezing and has worsened since the day of the accident. The pain is reported better with lying down. Vicodin helps a little bit. Rib pain is level 6-7; worsened with breathing, difficulty sleeping. After examination, a MRI of the cervical and lumbar spine and rib x-ray were ordered. Back brace was ordered. Continued Vicodin and Ibuprofen was ordered, with the addition of Colace. Therapy was to be considered after review of the MRI. PX6, p15-16.

The medical records and bill of Delaware place MRI were admitted in evidence as Petitioner's Exhibit 9. These records reveal that the MRI of the cervical spine was performed on January 12, 2012. This was interpreted to show diffuse changes of degenerative disc disease, facet arthropathy; spondylotic change throughout the cervical spine; moderate central canal stenosis at C4-C5 level with a focal central disc protrusion measuring a practically 7 mm causing mild cord compression; no cord edema; less significant levels of central canal narrowing are suggested on a level by level basis; varying degrees of neural foraminal stenosis present; most significant at C5-C6 level where moderate to severe bilateral neural foraminal stenosis is noted. PX 9, p 5-6. The MRI of the lumbar spine was performed on January 12, 2012 and was interpreted to reveal diffuse changes of disc desiccation and degeneration present throughout the lumbar spine complicated by scattered levels of facet arthropathy and ligamentous hypertrophy; with a small annular tear suggested along the left posterior parasagittal aspect of L5-S1 intervertebral disc; mild central canal stenosis at L4-L5; no additional levels of central canal narrowing were identified; varying degrees of neural foraminal stenosis present; most significant at L4-L5 with moderate neural foraminal stenosis noted bilaterally; bulging disc material is noted to efface on the exiting L4 nerve roots; and correlation with the dermatome of the patient's radicular symptoms is recommended; moderate left lateral recess stenosis at L5-S1 adjacent to a focal annular tear; bulging disc material noted to posteriorly displace the transversing left S1 nerve root; correlation with the dermatome of the patient's radicular symptoms is advised. PX 9, p 7-8. The x-ray of the right ribs was interpreted to reveal no acute fractures. PX 9, p 9. Petitioner was ordered off work by Dr. Barnabas. PX 6, p 28. On January 13, 2012 Dr. Barnabas referred petitioner to Dr. Sean Salehi, a neurosurgeon, for consult regarding cervical radiculopathy and lumbar radiculopathy. PX 6, p 26.

Petitioner testified he underwent a course of physical therapy at Aleveo Physical Therapy.

The medical records and bill of Alivio Physical Therapy were admitted in evidence as petitioner's Exhibit 7. These records reveal that Petitioner began a course of physical therapy performed by Dr. Ruben Bermudez D. C. PAC. Range of motion in the lumbar spine was reported as painful and limited in all directions. Petitioner was again referred to Dr. Salehi for surgical consultation. PX 7, p 13.

Petitioner testified he was referred by Dr. Barnabas to Dr. Osama Abdellatif at Pro-Clinics.

The medical records and bill of Pro-Clinics/ Dr. Osama Abdellatif were admitted in evidence as Petitioner's Exhibit 10. These records reveal that Petitioner was seen by Dr. Osama Abdellatif on January 17, 2012 on a referral by Dr. Bermudez. Petitioner reported low back pain, increased lumbar radiculopathy in the bilateral lower limbs, decreased range of motion, neck pain and bilateral shoulder pain with minimal response to physical therapy or medications. An EMG of the upper extremities was ordered, along with MRIs of the bilateral shoulders. Physical therapy for six weeks was ordered. PX 10, p 2-7.

On January 26, 2012, an EMG of upper extremities was performed by Dr. Syed Navsad, M.D., of Neurological Consultants Group, Ltd.. These records and bill were admitted in evidence as Petitioner's Exhibit 8. The EMG was interpreted to be consistent with bilateral C6-C7 cervical radiculopathy and bilateral distal median mono neuropathy, worse on the left. PX 8, p 6.

Petitioner returned to Dr. Osama Abdellatif on 2/22/2012. He complained of neck pain radiating to the right shoulder and low back pain radiating to the right leg tingling and numbness and rib cage pain. Continued physical therapy was ordered. PX 10, p 8-9.

On 2/24/2012, Petitioner was seen by Dr. Bermudez for physical therapy. He was ordered to follow up with pain management and also to see Dr. Sean Salehi. PX 7, p 6.

On 2/27/2012, Dr. Osama Abdellatif administered cervical facet injections. PX 10, p 10-15. On 3/6/2012, petitioner reported 30% improvement to Dr. Abdellatif. Petitioner continued to complain of low back pain radiating to the left buttock and to the bilateral legs. PX 10, p 16-17.

On 3/2/2012, Petitioner was examined by Dr. Sean Salehi. After review of diagnostic testing and examination Dr. Salehi diagnosed cervical spondylosis, herniated cervical disc and lumbar spondylosis. He indicated that Petitioner had neck pain result of a herniated disc at C4-5 and mechanical low back pain secondary to exacerbation of lumbosacral spondylosis as a result of the reported accident. The patient noted improvement in his symptoms with physical therapy. He recommended continue another 4 to 6 weeks to address strengthening of the cervical and lumbar spine. More cervical epidural steroid injections would be appropriate if symptoms worsen. PX 6, p 18-21.

On 3/12/2012, Petitioner was seen by Dr. Barnabas. Petitioner's low back pain was reported 4/10 and his neck pain 6/10. He was diagnosed with acute lumbar strain/sprain; lumbar disc herniation; lumbar radiculitis; cervical disc strain, headaches; cervical radiculopathy. More aggressive therapy was ordered. PX 6, p 4. Physical therapy was ordered by Dr. Barnabas. PX 6, p 17.

On 3/26/12, Petitioner started a course of physical therapy at Advanced Occupational Medicine Specialist. These records and bill were admitted in evidence as Petitioner's Exhibit 12.

On 3/16/2012, Dr. Abdellatif administered a lumbar facet injection. PX 10, p 19-24. On 4/4/12, Petitioner reported that he felt better after the lumbar facet block injection. PX 10, p 25. On 4/6/12, Dr. Osama Abdellatif administered more lumbar facet injections. PX 10, p 29-34. On 4/20/12, Petitioner reported to Dr. Osama Abdellatif that he felt 70% better after the injections. PX 10, p 35. Dr. Osama Abdellatif ordered Petitioner to start work conditioning program and have a FCE and follow up in four weeks. PX 10, p 36. On 5/15/12, Petitioner reported feeling 90% better. FCE and follow-up were ordered. PX 10, p 38-39. On 5/29/2012, Dr. Abdellatif noted Petitioner had minimal low back pain with no radiating pain,only feels tightness and stiffness occasionally. Petitioner was ready to start working at full duty. Petitioner was ordered to follow up in four weeks. PX 10, p 40. On 6/26/2012, Dr. Osama Abdellatif noted Petitioner had minimal low back pain radiating

to the bilateral legs causing tingling and numbness occasionally. Petitioner was ordered to continue working full duty. PX 10, p 42-43. On 7/10/2012, Petitioner reported low back pain radiating to the left side when bending radiating to left buttocks causing tingling and numbness. Sitting too long was painful. Petitioner was ordered to continue work and follow-up in four weeks. He was working full duty. PX 10, p 44. On 8/7/2012, Petitioner reported minimal lumbar pain, no longer radiating. The pain is localized and is minimal. The patient had improved range of motion. Dr. Osama Abdellatif found Petitioner to be at maximum medical improvement and ordered follow-up as needed. PX 10, p 46. On 10/30/2012, Dr. Osama Abdellatif noted Petitioner had minimal lumbar pain with no radiating pain. The pain was minimal and localized. The patient was at maximum medical improvement and was instructed to follow-up as needed. Petitioner was ordered to continue working full duty. PX 10, p 49.

On 5/17/2012, Petitioner was examined by Dr. Rajeev Khanna, at the request of Respondent, pursuant to §12 of the Act. Dr. Khanna's impression was: status post motor vehicle accident resolved; cervical disc protrusion resolved; lumbar disc syndrome resolved; cervical degenerative disc disease not work-related; lumbar degenerative disc disease not work-related. He opined that Petitioner made a complete recovery from the work accident that occurred on January 9, 2012; that Petitioner has had appropriate medical treatment to date and does not require any further medical treatment; that Petitioner does not report any pre-existing conditions or injuries to his neck or lower back; that Petitioner's cervical and lower back complaints were causally connected to the motor vehicle accident of January 9, 2012; that the cervical and lumbar physical examinations are unremarkable as of the date of the examination; that Petitioner may return to work at regular duty as a laborer without restrictions; that Petitioner has completely recovered from his motor vehicle accident; there is no indication for surgery; he has returned to his preaccident status; Petitioner is at MMI; he may return to work regular duty without restrictions. (ResEx. 1)

Petitioner testified that the cervical injections and lumbar injections did help the pain in his neck and low back. He returned to work full duty, at the end of May 2012, to his regular job. He earns the same income in that job as he did before the work accident. He did not injure his back, neck, right or left rib cage or shoulders in any other accident after January 9, 2012. Petitioner testified that about once a month he has problems with his neck. The neck will stiffen up and he gets a sharp pain in it. He takes Ibuprofen and Extra Strength Tylenol. The pain is at the lower end of the cervical spine in the center. Lifting a lot of sewer lids at work will bring the pain on. Petitioner also testified that he continues to have some pain in his buttocks. The pain is in the posterior leg above the knee and down to the calf on the right side. Petitioner experiences that pain about once a month. Sometimes, if he is sleeping, it starts to hurt and if he turns sometimes it helps and sometimes it continues to hurt. He takes Tylenol and walks around and then the pain usually goes away and he is able to fall asleep. He did not have that pain before the accident. Once in a while his right shoulder will have pain, depending upon if he sleeps on it. He has no problem with his left shoulder. He has no problem with his rib cage on the right or left.

No doctor has ever recommended that Petitioner undergo any surgery for the neck or back. He has had no medical treatment for his neck or back since his return to work in June of 2012. He has no current appointment to see a doctor for his work injury, as of the date of trial. Petitioner did not have any retirement plans at the time of hearing and continues to work his job as a construction laborer.

Respondent's Exhibit 2 was the itemization of benefits paid in support of its claim for a §8(j) credit in the amount of $974.70 for medical bills incurred on the date of accident. Respondent's Exhibit 3 was a waiver regarding the balance of the EMS bill. Respondent's Exhibit 4 was the Payment Listing for this claim. Respondent's Exhibit 5 was the payment itemizations for medical bills paid by Respondent.

CONCLUSIONS OF LAW

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

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 current condition of ill-being, to wit: status post MVA with multiple trauma; cervical disc protrusion, lumbar disc syndrome, cervical and lumber degenerative disc disease, aggravated by the MVA, is causally related to the injury, based upon the unrebutted testimony of Petitioner and the medical records.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the medical treatment rendered to Petitioner to be reasonable and necessary to treat the injuries resulting from the accident of January 9, 2012. Respondent's IME physician, Dr. Khanna, opined that the treatment to the date of his report was reasonable and necessary.

The Arbitrator finds that Petitioner chose to be treated initially by Dr. Barnabas, who referred him to Dr. Bermudez, Dr. Osama Abdellatif, Dr. Salehi, and Dr. Navsad. The Arbitrator finds that the treatment at Northwestern University Medical Center was emergency treatment and did not constitute one of Petitioner's choices of physicians. Petitioner was sent by Respondent to Mercy Works, which did not constitute one of Petitioner's choices of physician.

The Arbitrator finds that the following bills were reasonable and necessary charges for causally related medical treatment to treat the injury: City of Chicago EMS $243.10; Pro-Clinics $3,413.84; Herron Medical Center $406.76; Advanced Occupational $3,194.00; Neurological Surgery and Spine Surgery $471.00; Advanced Lab Services $417.79; Lakeshore Surgery Center $7,337.73, Physicians $225.00; Northwestern Memorial Hospital $718.02; Mercy Works $63.20; Alivio Physical Therapy $530.00. No portion of this award is for the payment of travel expenses, which are not appropriate §8(a) expenses in this case. Respondent is ordered to pay the foregoing subject to the Fee Schedule and §§ 8(a) and 8.2 of the Act.

Respondent is given a credit for all bills paid (including the waiver of the EMS charge). Respondent is given a credit of $974.70 pursuant to §8 (j) of the Act.

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

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

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

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

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

No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. Therefore, this factor is given no weight in determining PPD.

With regard to subsection (ii) of §8.1b(b), the Arbitrator notes that Petitioner was employed as a construction laborer at the time of the accident and he was able to return to work at this position. This factor is given minimal weight in determining PPD.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that petitioner was 58 years old at the time of the accident. This factor is given some weight in determining PPD, because Petitioner will have to live with the effects of the injury for some time, given his age.

With regard to subsection (iv) of §8.1b(b), the Arbitrator notes that Petitioner's future earning capacity is about the same as before the injury, as he returned to his regular job with Respondent. This factor is given minimal weight in determining PPD.

With regard to subsection (v) of §8.1b(b), the Arbitrator notes that Petitioner does have some residuals as a result of the injuries and the same are supported by the treating medical records. Petitioner has made a good recovery after the injections and therapy. This factor is given the most weight in determining PPD.

Based on the above factors, and the Record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 10% loss of use of a person as a whole, pursuant to §8(d)2 of the Act.

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

PHILLIPS, LONNIE Case# **12WC029972**
Employee/Petitioner

ILLINOIS STATE TOLL HIGHWAY AUTHORITY
Employer/Respondent

On 11/9/2015, 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 0.28% 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:

0312 BOUDREAU & NISIVACO LLC
NINA MARIANO
120 N LASALLE ST SUITE 1250
CHICAGO, IL 60602

2461 NYHAN BAMBRICK KINZIE & LOWRY
ROBERT DELANEY
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

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

1024 IL STATE TOLL HIGHWAY AUTHY
2700 OGDEN AVE
WORKERS COMPENSATION DEPT
DOWNERS GROVE, IL 60515

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

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

NOV 9 2015

GERALD A. HARRIA, 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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

LONNIE PHILLIPS,
Employee/Petitioner
v.

Case # **12 WC 29972**

Consolidated cases:

ILLINOIS STATE TOLL HIGHWAY AUTHORITY,
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 **DAVID KANE**, Arbitrator of the Commission, in the city of **CHICAGO**, on **September 25, 2015** and **October 22, 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, August 1, 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; Petitioner previously reached MMI.

In the year preceding the injury, Petitioner earned $**60,052.20**; the average weekly wage was $**1,154.85**.

On the date of accident, Petitioner was **34** 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 $10,383.57 for TTD, $0 for TPD, $0 for maintenance, and $0 for other benefits, for a total credit of $ $10,383.57 .

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

ORDER

Medical benefits

On basis of the finding above that the Petitioner's current condition is not related to the accident the Petitioner is not awarded medical bills or prospective medical care.

Respondent is not required to provide any prospective medical treatment.

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.

David A. Kane
Signature of Arbitrator

November 9, 2015
Date

ICArbDec19(b)

NOV - 9 2015

STATE OF ILLINOIS)
) ss.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lonnie Phillips

Petitioner,

v.

Illinois State Toll Highway Authority

Respondent.

Court No. 12 WC 29972

RIDER

Petitioner treated for a low back and left knee injury suffered at work on August 1, 2012. He testified that he was assisting at a crash location on the Tri-State Tollway in Northlake when a vehicle driving past the scene grazed and struck him. He described that the vehicle then stopped and drove at him again with the vehicle running over his foot. He was wearing steel-toed boots and suffered no injury to his foot.

At different times he underwent conservative treatment for the low back and the left knee involving physical therapy. He is currently working full duty for the respondent. The current issue is a recommendation that the petitioner have a disc replacement surgery, which the respondent denies. The parties are in dispute concerning the current treatment because the petitioner treated for three months and was discharged from treatment on

October 30, 2012, and returned to regular duty. More than a year later he returned to doctors with low back pain complaints. There is no dispute over benefits related to the lumbar spine up until October 30, 2012.

Respondent contends the injury sustained on August 1, 2012, involved a lumbar strain that resolved within three months. Medical records at that point indicate the petitioner's condition had improved substantially and allowed a discharge from medical care and resumption of full duty at work.

One of the doctors the petitioner saw in 2014 was Dr. Harel Deutsch, who saw petitioner on one occasion on August 27, 2014, and recommended a disc replacement surgery to the lumbar spine to remedy the petitioner's pain symptoms. Dr. Deutsch is the only medical provider that has described the petitioner's condition as a disc herniation. Dr. Deutsch disagrees with the preliminary diagnosis of lumbar strain because it would have resolved within three months whereas the petitioner described that the conservative treatment was ineffective and the symptoms never resolved other than for short periods of time.

Dr. Deutsch never reviewed any medical records prior to his visit with the petitioner except for lumbar MRIs. His understanding of the petitioner's medical recovery or lack of one is based solely on what the petitioner told him.

Dr. Stanford Tack, the Respondent's examining doctor, testified that his physical examination on October 8, 2014, was essentially normal, although the petitioner subjectively complained of back pain. There was no evidence of radicular pain (RX 1, p 15). Dr. Tack described the petitioner's injury at work involved a lumbar strain (RX 1, p.16). He expected the recovery from a strain to be up to three months, which coincided

approximately to when the petitioner's doctor released him back to work on October 30, 2012. Dr. Tack noted an MRI finding on September 6, 2012, of degenerative disc disease in the lumbar spine, which would not have occurred in a period of five weeks after the injury at work on August 1, 2012 (RX 1, p.18).

Dr. Tack also disagreed with Dr. Harel Deutsch's plan for a disc replacement surgery as only being an appropriate option where the patient is functionally incapacitated due to the back, which the petitioner was not (RX 1, p.20).

Dr. Deutsch also testified. He saw the petitioner for the only time on August 27, 2014 at which time the petitioner gave a history of experiencing back pain since falling at work on August 1, 2012. Dr. Deutsch described the prior treatment history as involving physical therapy and epidural injections, although the petitioner agreed that he did not receive any injection. The petitioner told Dr. Deutsch that he did not improve with the initial conservative treatment. The petitioner described the pain intensity as severe. Dr. Deutsch did not see the petitioner again. He never reviewed other treatment records from 2012 except for the MRI results. The only source of his understanding of the medical treatment in 2012 came from what the petitioner told him (PX 1, p.21). His physical examination of the back was "uneventful." (PX 1, p.27). There was a negative straight leg raise. There was no swelling or tenderness noted. Range of motion of the lumbar spine was normal.

Dr. Deutsch diagnosed the petitioner with a disc herniation in the lumbar spine (PX 1, p. 29). None of the other medical providers made a similar diagnosis. Dr. Deutsch disagreed with describing the injury on August 1, 2012, as a strain because a strain would resolve within three months (PX 1, p. 30).

The petitioner agreed that he was truthful when he saw doctors about the condition of the back. He also agreed that he did not make any false statements when he sought a release to work on October 30, 2012. The petitioner testified that in telling his doctor on October 30, 2012, that he had no back symptoms, he was limiting his account to what he was experiencing on that date. If he felt symptoms the day before he saw no reason to tell the doctor at DuPage Medical Group on October 30, 2012, about it. He did return to full duty for the respondent on November 5, 2012, and by and large has continued to work full duty through the date of hearing on September 25, 2015.

The petitioner was discharged from physical therapy on October 29, 2012, due to the fact that he met his goals. A work hardening course was discussed to aid the petitioner' return to work, but apparently never occurred as the petitioner was released to full duty and did so.

The petitioner did not obtain any further medical treatment for the low back until 2014. He testified that he was advised at DuPage Medical Group when he was discharged on October 30, 2012, that he should return in a year for follow-up. The petitioner testified that he tried to return in October of 2013, but it was not approved under workers' compensation or group insurance at first. He did return to DuPage Spine Center on July 15, 2014. He later saw Dr. Deutsch for a single visit on August 27, 2014.

The petitioner's explanation for the delay in seeing a doctor about his back even though he continued to experience back pain over a course of three years is that his doctor told him in October of 2012, that he could come back in a year. He anticipated he would be able to go back in October of 2013. He testified that he never felt a reason to try going back before October of 2013.

The petitioner testified that he did get treatment including physical therapy for his knee injury in the first half of 2013. There was no treatment or diagnosis in these records of any current back injury. One therapy record related that the petitioner described back pain at that time. There is no indication he requested medical treatment at the time.

The petitioner testified that at some unspecified point in 2013 or 2014 he started getting pain in his low back again.

Petitioner had lumbar MRIs on September 6, 2012, and August 4, 2014. They have been described by the medical specialists that the tests were essentially the same. The reports discuss a central disc bulge at L4-5. Dr. Frank Phillips saw the petitioner at Midwest Orthopaedics on October 2, 2012, and described the same diagnostic results of mild L4-5 bulging that effaces the thecal sac with endplate spurring and mild foraminal stenosis along with a posterior annular tear at L4-5. Dr. Deutsch interpreted the results as a disc herniation.

Petitioner testified that he has experienced pain and difficulty performing his job for the respondent during the past three years, which involved heavy labor. He testified that he works on a team with multiple workers out on the state's tollways and frequently is given the most physically demanding jobs because of his age and physical condition to suggest that he was deemed the best person able to perform such tasks.

He described that he could not perform the tasks very easily and often had to stop and rest after just ten minutes of performing work. He agreed that his ability to perform physical work has not brought any change to the assignment of heavy work tasks.

The petitioner went back to work in full capacity on November 5, 2012 after advising his doctor on October 30, 2012, that he had no back symptoms and felt he was able to do the job again. The petitioner testified that the first time he thought about going back to the doctor was in October of 2013, that being the time when his doctor suggested a follow-up.

CONCLUSIONS OF LAW

IN SUPPORT OF HIS DECISION WITH REGARD TO ISSUE (F), IS THE PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY? THE ARBITRATOR FINDS AND CONCLUDES AS FOLLOWS:

The evidence does not establish the petitioner's current condition is causally related to the injury at work on August 1, 2012. The petitioner's testimony at hearing and history to Dr. Deutsch are contradictory to the medical records in 2012 concerning the petitioner's recovery from a back injury. The medical findings in 2014 relate to degenerative changes in the lumbar spine. The petitioner's description to Dr. Deutsch that his symptoms have continued unabated from the date of injury is not credible. Neither is the idea that he routinely worked with significant pain symptoms after November 5, 2012. It is described as a heavy duty job and it would not be possible for the petitioner to work in such a position for more than a year with complaints and not see a doctor, especially since he was already seeing a doctor for a knee injury and attending physical therapy for

approximately two months in 2013. Most critically, the petitioner freely testified that there was an unspecified time when his symptoms began again. The Arbitrator finds that the Petitioner recovered from the initial complaints after a few months, returned to his usual activities, and at some point experienced new symptoms.

IN SUPPORT OF HIS DECISION WITH REGARD TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?, THE ARBITRATOR FINDS AND CONCLUDES AS FOLLOWS:

The evidence described by all medical doctors other than Dr. Deutsch is that the petitioner suffered a lumbar strain injury on August 1, 2012, which resolved within three months. Dr. Deutsch did not agree with the strain diagnosis because it would have resolved within three months. Unfortunately, Dr. Deutsch did not have the benefit of medical records that include the physical therapy discharge on October 29, 2012, or the discharge from all treatment at DuPage Medical Group on October 30, 2012, with the petitioner explaining that he had no symptoms in the low back and could resume his usual job. It is unknown whether Dr. Deutsch's opinion would be different if he did have access to these records. Certainly his understanding of the petitioner's history would be different. The resolution of symptoms by October 30, 2012, and ability to resume a heavy duty job for the respondent is enough to find the petitioner strained his back on August 12, 2012.

The petitioner's history to Dr. Deutsch is not reliable in that the petitioner described that the conservative treatment was ineffective and that his symptoms continued ever since an incident at work on August 12, 2012. Dr. Deutsch's understanding of the conservative treatment that failed was not even accurate. He believed in error the petitioner was given epidural injections for the back.

The petitioner's contention that he felt capable to return to work in November of 2012 but found that performing the job was still a problem is not credible. Most individuals would not wait twelve months to go back to the doctor just because the doctor told him to return at that point. Petitioner testified that he believed he would be allowed to go back to the doctor after one year or if necessary. He understood he did not have to wait a year if medical circumstances required otherwise. Yet, he only tried to return at the one-year mark and only because his doctor recommended it, not because his condition had changed. The evidence is not persuasive that the petitioner continued to have problems with his back.

The petitioner also testified that he began to experience pain in his back again at some point at an unidentified time in 2013 or 2014 which contradicts his claim that his back problems never resolved after August 12, 2012.

The petitioner told Dr. Deutsch that his back pain was severe. He testified at the time of hearing that Dr. Deutsch did not see fit to prescribe a pain medication. The petitioner described that he used over-the-counter Advil for his symptoms. Yet, Dr. Deutsch supposedly found the symptoms were significant enough to recommend back surgery.

The arbitrator is not persuaded by the totality of the evidence that any current condition is causally related to an incident at work on August 12, 2012, to award surgery or other medical treatment under workers' compensation. It is not even certain that surgery is appropriate. Both Dr. Tack and Dr. Deutsch described essentially normal examinations of the back on the respective dates of visit. Both found the petitioner had full range of motion and lacked evidence of swelling or tenderness. The MRI finding in 2014 was the same as one done in September of 2012, after which doctors released the petitioner from medical care and allowed him to return to regular duty.

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

DELLINGER, JAMES Case# **12WC043640**
Employee/Petitioner

AMERICAN NICKELOID
Employer/Respondent

On 11/9/2015, 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 0.28% 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 LLP
SCOTT J GANASSIN
2101 MARQUETTE RD
PERU, IL 61354

1408 HEYL ROYSTER VOELKER & ALLEN
KEVIN J LUTHER
PO BOX 1288
ROCKFORD, IL 61107

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
19(b)

James Dellinger
Employee/Petitioner

v.

American Nickeloid
Employer/Respondent

Case # **12** WC **43640**

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 **Christine Ory**, Arbitrator of the Commission, in the city of **Ottawa**, on **September 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. **X** Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. **X** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. **X** Is Petitioner entitled to any prospective medical care?
L. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
M. **X** Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **11/19/2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$39,977.60**; the average weekly wage was **$768.80**.

On the date of accident, Petitioner was **54** years of age, ***married*** with **0** dependent children.

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

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

Respondent is entitled to a credit of **$1,851.62** under Section 8(j) of the Act.

ORDER

Respondent shall reimburse the petitioner the sum of $2,197.52 and pay the following medical bills: $1,054.00-St. Margaret's Hospital; $120.00 & $124.00-St. Margaret's Clinic; $339.00-Hospital Radiology; $129.00-Loyola University Physicians; and $168.36-Loyola University Medical Center, all subject to §8 and §8.2 of the Act.

Respondent shall authorize and pay for all reasonable and necessary costs relative to the prescribed treatment by Dr. Ghanayem, including surgery, and the attendant care pursuant to §8 and §8.2.

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.

Christine Moy

Signature of Arbitrator

11/05/2015
Date

IC ArbDec19(b)

NOV - 9 2015

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James Dellinger,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 12 WC 43640**
	)	
American Nickeloid,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on November 19, 2012, 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 on that date the Petitioner sustained accidental injuries that arose out of and in the course of the Petitioner's employment with the Respondent 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. They further agree that in the year preceding the injuries, the Petitioner earned $39,977.60, and that his average weekly wage was $768.80.

At issue in this hearing is as follows: (1) Is the Petitioner's current condition of ill-being causally connected to this injury; and (2) Is Respondent liable for the unpaid medical bills; (3) is the Petitioner entitled to any prospective medical care to his cervical spine, including surgery; and (4) is Petitioner entitled to penalties pursuant to §19 l, §19k and attorneys' fees pursuant to §16.

STATEMENT OF FACTS

Petitioner testified he was employed by respondent for 37-1/2 years. Respondent is in the business of pre-fab steel. Petitioner testified that on November 19, 2012 he was struck in the forehead by an overhead crane being operated by the plant manager. The impact caused his neck to go back. He had immediate head and neck pain, and was dizzy. He continued to work. After a week his symptoms did not improve so he sought treatment from his family physician, Dr. Thaw Tun.

Petitioner first saw Dr. Tun for the injury on November 29, 2012. Petitioner provided a history of being struck in the left forehead on November 20, 2012. Petitioner reported lightheadedness and dizziness, left sided headache, and significant neck pain after the accident. He reported the symptoms had gotten slightly worse over the past seven days. He also reported some memory loss and confusion off and on. Dr. Tan made note of petitioner's previous cervical spine fusion in 2006 (PX.6).

Dr. Tun reported petitioner had restrictions of movement in all directions of the cervical spine. Petitioner also had spasm over the left trapezius muscle. Dr. Tun's diagnosis was head injury, concussion, as well as cervical strain versus cervical disc disease. Dr. Tun ordered a CT scan of the head and MRI of the cervical spine (PX.6).

On December 27, 2012 followed up with Dr. Tun for the head and cervical injury. At that time, Dr. Tun reported petitioner had the CT scan of the head, but the MRI for the cervical spine was denied by workers' comp due to the previous cervical spine injury. Dr. Tun strongly recommended petitioner see another physician for a second opinion, possibly by his work (PX.6).

Thereafter, petitioner came under the care of Dr. Ghanayem, whom he first saw after the November 19, 2012 accident on January 14, 2013. Dr. Ghanayem noted petitioner remained under the care of Dr. Bajaj for his lower and thoracic spine complaints. Dr. Ghanayem also ordered an MRI of the cervical spine (PX.3). On January 31, 2013 petitioner returned to Dr. Tun with significant neck pain and pain from the left side of the neck and left shoulder and radiated to both sides. He had tingling sensation in his left hand also lateral aspect of the left arm along with significant pain in both shoulders and neck with neck movement. He was referred to Dr. Ghanayem. He returned to Dr. Tun on February 21, 2013 with the same complaints (PX.6).

On March 4, 2013, petitioner returned to Dr. Ghanayem after obtaining a cervical MRI on January 23, 2013. Dr. Ghanayem noted cervical disc herniation and stenosis at C3-4 and C4-5, which were two levels above the prior fusion. Dr. Ghanayem concluded that the herniation/stenosis at the C3-4 and C4-5 were aggravated/caused by his work injury of November 19, 2012. Dr. Ghanayem ordered physical therapy for the cervical spine (PX.3).

Petitioner returned to Dr. Ghanayem on May 2, 2013. Petitioner reported a little bit of relief with physical therapy. Dr. Ghanayem recommended continued physical therapy and then a cervical epidural. Dr. Ghanayem also compared the previous MRI to the new [January 23, 2013] MRI and found clear structural changes from the C3-4 and C4-5. Dr. Ghanayem confirmed the changes were caused by the November, 2012 accident. Petitioner returned to Dr. Ghanayem on June 6, 2013. At that time, petitioner had one injection with two days' relief. Dr. Ghanayem ordered another injection and modified the physical therapy program. On July 18, 2013, the petitioner returned to Dr. Ghanayem who then proposed a cervical decompression and fusion at the C3-4 and C4-5 for the work injury (PX.3).

On July 31, 2013 respondent had petitioner examined by Dr. Zelby, pursuant to §12. Petitioner's history to Dr. Zelby's was consistent with his testimony. Dr. Zelby reviewed the cervical MRIs from January 23, 2013and November 2, 2007. Based upon petitioner's history, his examination and the diagnostic tests, Dr. Zelby concluded the cervical fusion as prescribed by Dr. Ghanayem was reasonable and necessitated by the work injury of November 20, 2012 (sic) (PX.8).

Petitioner returned to Dr. Ghanayem on October 24, 2013. His cervical condition remained unchanged. Petitioner reported some tenderness in the right mid flank after moving sheets of produce in September. Dr. Ghanayem advised petitioner to let him know when he decided to proceed with the cervical surgery. On March 27, 2014 petitioner returned to Dr.

Ghanayem. His condition was unchanged. Petitioner told Dr. Ghanayem he was scared to have surgery, but was suffering with the ongoing cervical spine condition (PX. 3).

On January 12, 2015 petitioner returned to Dr. Ghanayem and voiced a concern as to whether he could be causing permanent nerve damage by delaying the surgery. Dr. Ghanayem ordered a repeat MRI (PX.3). On March 5, 2015 he again saw Dr. Ghanayem, but had not yet had the suggested repeat MRI. Dr. Ghanayem would not proceed with surgery without the repeat MRI (PX.3).

Petitioner obtained another MRI on February 18, 2015. The MRI showed large disc bulges at C3-4 and C4-5 with the C4-5 representing the most significant worsening since the prior exam with severe neural foraminal encroachments at both levels (PX.2).

Petitioner saw Dr. Ghanayem on February 26, 2015. According to Dr. Ghanayem, the C3-4 disc problem remained, but the C4-5 the disc was about a millimeter and a half bigger than on the old study, but Dr. Ghanayem's surgical approach remained the same (PX.3).

On March 30, 2015, respondent again had petitioner evaluated by Dr. Zelby pursuant to §12. Dr. Zelby reviewed the MRI of February 18, 2015 and found a significant worsening of the disc herniation at the C4-5 level. Dr. Zelby opined that, although petitioner still required an anterior cervical disc decompression at C3-4 and C4-5, the need for surgery was no longer the result of the work accident of November 20, 2012 (sic). Dr. Zelby based this reasoning on the fact that petitioner was able to work, there was a new herniation at the C4-5 level and that petitioner's condition had reached a stable condition as of November, 2013 (RX.1)

Petitioner returned to Dr. Ghanayem on April 30, 2015. Dr. Ghanayem reviewed Dr. Zelby's March 30, 2015 report. Dr. Ghanayem was critical of Dr. Zelby's new opinion on causation of the petitioner's cervical condition. Dr. Ghanayem did not find the increase in the disc herniation at the C4-5 level to be uncommon as the petitioner had continued to work with the condition as he contemplated and dealt with his fear of surgery. Dr. Ghanayem felt the findings were the natural progression of the injury (PX.3).

As a referral by Dr. Ghanayem, petitioner saw Dr. Patrick T. O'Leary of Midwest Orthopaedic Center on July 2, 2015 as a surgical referral. Dr. O'Leary agreed petitioner should undergo a 2-level fusion at the C3-4 and C4-5 level. Dr. O'Leary acknowledged petitioner had the pre-existing disc disease but noted petitioner's symptoms seemed to have worsened since the [work accident of November 19, 2012] (PX.5).

On July 30, 2015 he was referred by a friend to Dr. Patrick Sweeney of Minimally Invasive Spine Specialists for a second opinion regarding cervical spine surgery. Dr. Sweeney agreed with Dr. Ghanayem's opinion that petitioner required C3-4 and C4-5 surgery and agreed with Dr. Ghanayem's opinion on causation (PX.4).

The records of Dr. Ghanayem included treatment at Loyola by Dr. Giudo Marra and Dr. Bajaj. The records dated back to 2009. Dr. Marra's treatment was for an unrelated right shoulder injury, for which Dr. Marra performed surgeries on April 13, 2009 and February 15, 2010. These records also showed petitioner received treatment for his unrelated lower and thoracic back condition by the pain doctor, Dr. Bajaj, as well as Dr. Ghanayem. Although Dr. Ghanayem had performed previous cervical surgery at the C5-6 and C6-7 level, which was in

2006 or 2008, there is no indication in these records, or any other records introduced into evidence, that petitioner had received any treatment to his cervical spine since his release in approximately 2008 (PX.6).

CONCLUSIONS OF LAW

In support of the Arbitrator's decision with regard to whether Petitioner's present condition of ill-being is causally related to the injury, the Arbitrator makes the following conclusions of law:

The undisputed evidence indicated petitioner injured his cervical spine in the work accident of November 19, 2012. Petitioner's treating physicians, Dr. Tun and Dr. Ghanayem, as well as subsequent petitioner's examining physicians, Dr. O'Leary and Dr. Sweeney, all concur petitioner's present cervical condition for which he should undergo a cervical fusion at the C3-4 and C4-5 level was caused by the work accident of November 20, 2012.

Additionally, at the time of his initial exam on July 31, 2013, Dr. Zelby, concluded petitioner's neck injury required surgery and the need for the surgery was due to the work accident. Petitioner was scared to undergo the surgery at that time. Nothing in the record explains how Dr. Zelby came to the conclusion that petitioner's condition had reached a plateau in November, 2013. There was no evidence petitioner suffered any intervening accident or injury to his neck. Dr. Zelby concluded petitioner's present condition was not related to the work based upon the assumption petitioner was able to function with the condition. Dr. Zelby failed to take into consideration the natural progression of the condition as Dr. Ghanayem had addressed. As such, the Arbitrator finds Dr. Zelby's change of opinion from July 30, 2013 to be without merit, not credible and gives it no weight.

Based upon the foregoing, the Arbitrator finds petitioner's cervical herniated discs, spinal stenosis with encroachment at the C3-4 and C4-5 level, for which petitioner needed and continues to need surgery, was caused by the work accident of November 19, 2012.

In support of the Arbitrator's decision with regard to the medical bills incurred, the Arbitrator makes the following conclusions of law:

As the Arbitrator has found petitioner's cervical spine injury at C3-4 and C4-5 was caused by the work accident, and the medical evidence supports the medical bills claimed by the petitioner, the Arbitrator awards all medical bills incurred for the sums due pursuant to§8 and §8.2 of the Act. Respondent shall be given credit for all payments made pursuant to §8j.

In support of the Arbitrator's decision with regard to whether cervical spine surgery is reasonable and necessary to cure petitioner of the injury, the Arbitrator makes the following conclusions of law:

All doctors, including Dr. Zelby, agreed petitioner needs a cervical decompression and fusion at the C3-4 and C4-5 level. Dr. Zelby originally agreed in 2013 that petitioner's need for the cervical surgery was due to the November, 2012 work accident. The only reason it was not done at that time was due to petitioner's fear of surgery. The change of opinion by Dr. Zelby from July 31, 2013 as to the need for the surgery is without merit. Therefore, the Arbitrator finds the cervical spine fusion at C3-4 and C4-5 is reasonable and necessary to cure the petitioner

of his work injury of November 19, 2012. The Arbitrator further finds that Respondent shall authorize and pay for the recommended treatment, including surgery, and the attendant care pursuant to §8 and §8.2.

In support of the Arbitrator's decision with regard to penalties pursuant to §19l, §19k and attorneys' fees pursuant to §16, the Arbitrator makes the following conclusions of law:

Although Dr. Zelby's opinion is insufficient to deny petitioner's claim for incurred and future medical treatment, respondent's actions does not rise to the level of unreasonable or vexatious. Therefore, petitioner's claim for penalties and attorneys' fees is denied.

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KHAMISSI, EBTESSAM Case# **12WC044245**
Employee/Petitioner

PHONAK LLC
Employer/Respondent

On 11/10/2015, 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 0.34% 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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2837 LAW OFFICES JOSEPH MARCINIAK
BRENT HALBELIB
2 N LASALLE ST SUITE 2510
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)
X None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Ebtessam Khamissi
Employee/Petitioner
v.
Phonak, LLC
Employer/Respondent

Case #12 WC 44245

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Jessica A. Hegarty, Arbitrator of the Commission, in the city of Wheaton, on 8/19/15. 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, 2/14/12 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 $**23,545.60**; the average weekly wage was $**452.80**.

On the date of accident, Petitioner was **49** 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 $**1,577.44** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**1,577.44**.

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

ORDER

Medical Benefits

Respondent shall pay reasonable and necessary medical services of $1,700.16, as provided in Section 8(a) of the Act.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $301.86/week for 5 5/7 weeks, commencing 2/15/12 through 2/16/12, 2/21/12 through 2/24/12, and 2/28/12 through 4/1/12.

Respondent shall be given a credit of $1,577.44 for temporary total disability benefits that have been paid.

Permanent Parital Disability: Person as a whole

Respondent shall pay Petitioner permanent partial disability benefits of $271.68 per week for 112.5 weeks, because the injuries sustained caused the 22½ % disability, 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.

Jason C. Hyatt

Signature of Arbitrator

11/3/15

Date

NOV 10 2015

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

EBTESSAM KHAMISSI Petitioner,	)	
Vs.	)	**No. 12 WC 42245** Wheaton
PHONAK, LLC Respondent	)	

ADDENDUM TO THE DECISION OF THE ARBRITATOR

This matter proceeded to hearing on August 19, 2015, in Wheaton, Illinois before Arbitrator Jessica A. Hegarty.

Respondent has stipulated to all issues except causal connection and nature and extent of the injury. (Arb. 1).

FINDINGS OF FACT

Ebtessam Khamissi ("Petitioner") was an employed by Phonak, LLC., ("Respondent") as a technician in the production of hearing aids. She testified that she sat down during her job.

On February 14, 2012, Petitioner was involved in an undisputed accident when she fell off a broken stool and landed on her back and buttocks while opening mail. Petitioner noted pain in her tailbone area as a result of the fall. She was treated that day at Edward Hospital Occupational Health where she complained of low back pain. Petitioner continued to treat at Edwards Hospital Corporate Health from February, 2012 until October of 2012 (PX 9).

On March 7, 2012, Petitioner underwent an MRI of her sacrum that showed a non-displaced fracture extending transversely through the sacral segment.

Petitioner was treated by Dr. Andreshak and Dr. Vinita Matthew at Orthopedic Associates of DuPage, where she was diagnosed with low back pain and a fractured sacrum/coccyx (PX 10). She was also treated by Dr. Paul Belich at Loyola University who diagnosed her with Coccydynia and opined that she was not a good candidate for surgery. Dr. Belich recommended sacral nerve blocks and sacral coccygeal plexus blocks in a pain clinic (PX 7).

On April 19, 2013, Dr. Kevin Koutsky of Elmhurst Orthopedics diagnosed Petitioner with a sacral fracture and chronic pain. Petitioner continued to treat with Dr. Koutsky until October of 2013. (PX3).
Petitioner was referred to Dr. Humaira Khatoon, a pain management doctor, by Dr. Koutsky who performed three bilateral sacroiliac joint steroid injections on 7/8/13, 7/29/13, 9/9/13 (PX5).

Petitioner underwent conservative care including physical therapy. Petitioner returned to work without restrictions on April 2, 2012. It was recommended Petitioner sit on a donut for work.

Petitioner worked full duty for the Respondent from April 2, 2012 to April, 2015 when she was terminated. She testified that she was able to perform her job duties during that the 3 year period.

Dr. Koutsky opined in his June 9, 2014, report that the Petitioner's sacral fracture was well healed and that she did not need a sacroplasty.

Dr. Tian Xia, Respondent's Independent Medical Evaluation doctor, diagnosed Petitioner with a non-displaced fracture of the sacrum/coccyx and opined that a sacroplasty would not be effective or necessary. Dr. Xia found Petitioner's subjective complaints of pain supported by his exam. The doctor opined that the capacity in which Petitioner returned to work should be determined by a Functional Capacity Evaluation. Dr. Xia further opined and that Petitioner's condition resulted from work accident. Dr. Xia did not anticipate Petitioner would return to her pre-injury status.

On February 14, 2015, a Functional Capacity Evaluation concluded that Petitioner has the physical capacity to perform sedentary work, with ergonomic recommendations of an oversized chair to accommodate her large girth and allow for the placement of a lumbar roll or support behind her lower back to diminish direct pressure on the coccyx, as well as an angled foot-rest to accommodate her short stature. It was also concluded that Petitioner should be allowed occasional breaks of five minutes every hour to get out of a chair to intermittently relieve pressure on the coccyx. It is noted that Petitioner was working full duty at the time of the FCE and had been for nearly 3 years.
(PX 1)

Petitioner testified that she was terminated from Phonak in February, 2015 and is currently seeking employment.

Petitioner testified that she is in a constant state of pain. She testified the pain feels like she is being hit with "lashes" all the time. Petitioner currently treats with her family physician who prescribes medication for her pain.

Petitioner's Exhibit 11 is a bill in the amount of $1,700.16 from Lakeshore Sports Physical Therapy for the Functional Capacity Evaluation conducted on February 14, 2015. The Respondent had no objection to this exhibit.

CONCLUSIONS OF LAW

Is Petitioner's current condition of ill being causally connected to the injury?

The Arbitrator finds that the Petitioner's condition of ill being is casually connected to the injuries she sustained at work on February 14, 2012. The Arbitrator relies on the medical records of Edwards Hospital, Orthopedic Associates of DuPage, Elmhurst Orthopedics and the June 9, 2014 letter authored by Dr. Koutsky, as well as Respondent's Independent Medical Examination, performed on December 3, 2013 by Dr. Tian Xia with respect to this finding.

The Arbitrator also places significant weight upon the unrebutted testimony of Petitioner whom the Arbitrator found to be credible. Petitioner testified that she continues to experience pain all of the time. She testified that her pain feels like she is continuously being hit with "lashes". Petitioner testified that when she sits she has a lot of pain and that when she stands she has a lot of pain . Petitioner treats with her family doctor who prescribes pain medication. The Arbitrator finds Petitioner's current complaints to be supported by the medical evidence in the record.

Nature and Extent of the Injury

For injuries occurring on or after September 1, 2011, all permanent partial disability awards shall be established using the following criteria under Section 8.1b of the Act:

(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 employees's future earning capacity; and
(v) Evidence of disability corroborated by the treating medical records.

No single factor shall be the sole determinant of disability, the weight given to each factor must be explained in the written arbitration decision.

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

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, Petitioner was employed as a technician in the manufacture of hearing aides. Petitioner sat while she was working on the hearing aides. Although she returned to her pre-injury job with Respondent, Petitioner was terminated in February of 2015 and, as of the date of the hearing, continues to look for work. The Arbitrator notes the medical records corroborate the fact that Petitioner was in pain while she performed her job duties for

Respondent after the accident. Based on the fact that Petitioner was terminated by Respondent after performing her pre-injury job in pain for three years, the Arbitrator assigns *less* weight to this factor in her determination of a PPD award.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 49 years old at the time of the accident. The Arbitrator considers Petitioner's age to be *somewhat* advanced in age. The Arbitrator therefore finds this factor to be relevant in her PPD analysis and assigns *greater* weight to this factor.

With regard to subsection (iv) of §.1b(b), Petitioner's future earnings capacity, although the Petitioner had returned for 3 years to work for the Respondent, the Arbitrator finds this fact is mitigated by the treating medical records that reflect persistent complaints of pain from the time of the accident through the 2/14/15 FCE. The Arbitrator also notes Dr. Tian Xia, Respondent's Independent Medical Evaluation doctor, did not anticipate Petitioner would return to her pre-injury status. The Arbitrator also notes that the FCE examiner determined that Petitioner could only work in a sedentary capacity.

Petitioner testified that Respondent terminated her in February of 2015 and that she has been looking for employment since that time. The Arbitrator further takes notice of the fact that Petitioner does not speak English and required the services of a Farsi interpreter at the arbitration hearing.

The Arbitrator finds the above facts relevant in the determination of future earning capacity and therefore gives *greater* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes:

- The 3/7/12, MRI of Petitioner's sacrum that showed a non-displaced fracture extending transversely through the sacral segment.

- Dr. Bellich's 12/26/12 note where Petitioner reported attending 2 physical therapy sessions with "very minimal relief." The doctor further noted "she gets pain with sitting and also pain with prolonged standing." Petitioner reported that she was currently working in a factory making hearing aides and that she sits on a "cushion-type device." (PX7).

- The treating records of Dr. Andreshak and Dr. Vinita Matthew which notes a diagnosis of low back pain and a fractured sacrum/coccyx (PX 10).

- The treating records of Dr. Paul Belich at Loyola University who diagnosed Petitioner with Coccydynia and opined that she was not a good candidate for surgery. Dr. Belich recommended sacral nerve blocks and sacral coccygeal plexus blocks in a pain clinic (PX 7).

- The treating records of Dr. Kevin Koutsky of Elmhurst Orthopedics in which he diagnosed Petitioner with a sacral fracture and chronic pain.

- The 4/19/13 note from Dr. Koutsky in which Petitioner presented with chronic sacral pain. On exam, paralumbar and parasacral tenderness to palpation with minimally limited range of motion was noted.

- The pelvic MRI performed on 4/26/13 indicating "chronic deformity at the sacrococcygeal junction probably chronic residue from old fracture deformity."

- Dr. Koutsky's 6/5/13 note in which Petitioner reported chronic lower back and sacral pain. Petitioner's pain medication was refilled.

- The treating records of Dr. Humaira Khatoon, who performed three bilateral sacroiliac joint steroid injections on 7/8/13, 7/29/13, 9/9/13.

- The 7/8/13 notation by Dr. Khatoon in which Petitioner reported tailbone pain for the past 2 years. Sitting, walking and standing were reported as exacerbating factors. On exam, paraspinal and SI joint tenderness was noted.

- Dr. Khatoon's 7/29/13 note reflecting Petitioner's medications included hydrocodone, flexeril, meloxicam (NSAID) and ibuprofen.

- The 10/4/13 notation by Dr. Koutsky in which Petitioner reports "a fair amount of pain in the back despite therapy and 3 injections. She has been working full duty with the exception of taking 5 minute breaks as needed to change positions." The doctor noted that she "has failed conservative management including medications, therapy, and injections. She continues to have symptoms that interfere with her functions." Petitioner was diagnosed with lumbosacral pain and radiculitis and her pain medications were refilled.

- The February 14, 2015, FCE that concluded Petitioner has the physical capacity to perform sedentary work, with ergonomic recommendations of an oversized chair to accommodate her large girth and allow for the placement of a lumbar roll or support behind her lower back to diminish direct pressure on the coccyx, as well as an angled foot-rest to accommodate her short stature. It was also

> concluded that Petitioner should be allowed occasional breaks of five minutes every hour to get out of a chair to intermittently relieve pressure on the coccyx. (PX 1)

Given that the aforementioned records do support and corroborate Petitioner's testimony with respect to chronic pain and disability, the Arbitrator assigns *greater* weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 22½ % loss of use of her body as a whole pursuant to §8(d)(2) of the Act. Respondent shall pay_Petitioner permanent partial disability benefits of $271.68 per week for 112.5 weeks.

Temporary Total Disability

Respondent stipulated that Petitioner was entitled to temporary total disability benefits of $301.86/week for 5 5/7 weeks, commencing 2/15/12 through 2/16/12, 2/21/12 through 2/24/12, and 2/28/12 through 4/1/12.

Respondent shall be given a credit of $1,577.44 for temporary total disability benefits that have been paid.

Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

The parties agree that Respondent has not paid the bill for the Functional Capacity Evaluation from Lakeshore Sports Physical Therapy in the amount of $1,700.16. There being no objection by Respondent to this Exhibit, the Arbitrator finds that Respondent is liable for the Functional Capacity Evaluation bill in the amount of $1,700.16.

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

STAINE, MICHAEL W Case# **13WC019605**
Employee/Petitioner

BRIUS TELECOM SOLUTIONS LLC
Employer/Respondent

On 11/9/2015, 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 0.28% 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
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STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Michael W. Staine
Employee/Petitioner

v.

Brius Telecom Solutions, LLC
Employer/Respondent

Case # **13 WC 19605**

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 **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago** on **August 25, 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 **May 29, 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 regarding the left shoulder is causally related to the accident, Petitioner current condition of ill-being regarding his alleged right shoulder and cervical injury ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $ **88,200.00**; the average weekly wage was $ **2,940.00**.

On the date of accident, Petitioner was **41** years of age, ***married*** with **2** dependent children.

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

Respondent shall be given a credit of $ **107,676.73** for TTD, $ **0.00** for TPD, $ **0.00** for maintenance, and $ **0.00** for other benefits, for a total credit of $ **107,676.73**.

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

ORDER

Petitioner's current condition of ill-being regarding the left shoulder is causally related to the accident. Petitioner current condition of ill-being regarding his alleged right shoulder and cervical injury is not causally related to the accident.

Petitioner has not proven, by a preponderance of the evidence that he is entitled to prospective medical treatment therefore, none is awarded.

Respondent shall be given a credit of $**107,676.73** for TTD, $**3,567.75** for TPD, and $**0.00** for maintenance benefits, for a total credit of $**107,676.73.**

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.

Finding of Facts

The disputed issues in this matter are: 1) accident; causal connection; 3) medical bills; 4) temporary total disability; 5) temporary partial disability; and prospective medical treatment. *See,* AX1.

Mr. Michael W. Staine ("Petitioner") alleges injuries to his left shoulder, right shoulder and cervical spine incurring on May 29, 2013. He testified that he was working for Brius Telecom Solutions, LLC ("Respondent") at a cell site when he tripped on conduit and fell into a cabinet, trying to catch himself with his left arm. Petitioner went to Winfield Moody Health Center on May 31, 2013, for a follow up visit for muscle spasms and twitching all over the body. The history noted pain in the back of the left shoulder for two to three (2-3) days. He next went to Dr. Silver on June 6, 2013, where history was noted as working on May 29, 2013, when he tripped on a conduit and tried to stop his fall by grabbing a pole with his left arm and wrenching his shoulder. Diagnosis was left shoulder rotator cuff impingement and he was given a cortisone injection and referred for physical therapy. He returned to Dr. Silver on July 30, 2013, where continued pain in the left shoulder was noted. Petitioner saw Dr. Dasgupta on August 27, 2013, presenting with right upper extremity pain and it was noted he had been treated previously for low back pain. Tr. pp. 33-34; PX2-4, 5.

An MRI of the left shoulder, performed on September 23, 2014, showed a suspected small focal tear involving the mild insertional fibers of the distal supraspinatus tendon; at least partial-thickness and involving the bursal surface. An MRI of the right shoulder, performed the same date, showed mild tendinosis and/or strains of the distal supraspinatus and infraspinatus tendons with suspected shallow fraying along the bursal surface of the distal supraspinatus tendon. Petitioner returned to Dr. Silver on October 1, 2013; and arthroscopic surgery for the left shoulder was recommended.

Petitioner subsequently changed his mind about surgery and wanted to try additional conservative care first, including injections. His condition did not improve, and surgery was again scheduled for December 13, 2013. The surgery was then rescheduled to the end of January 2014, but petitioner had not received cardiac clearance. Petitioner again saw Dr. Silver on March 7 2014, where it was noted he was to do a stress test over the next three days and will proceed with surgery, if he got clearance. Petitioner finally underwent left shoulder arthroscopy by Dr. Silver on May 20, 2014. PX2.

Petitioner started physical therapy, and then returned to Dr. Silver on July 18, 2014 wherein the doctor noted right shoulder pain and claimed that Petitioner injured it at the time of the original injury. Petitioner underwent examination of the cervical spine by Dr. Patel, on September 15, 2014, and a October 22, 2014 MRI of the cervical spine showed degenerative cervical spondylosis with broad-based disc bulges. On October 29, 2014 Dr. Silver recommended a right shoulder arthroscopy. PX4.

Petitioner subsequently underwent an independent medical examination ("IME") by Dr. Forsythe on December 29, 2014. He provided an accident history of tripping on a conduit when he lunged with his left upper extremity to hold onto something and felt pain, and that his right shoulder subsequently struck a bank of cabinets. Dr. Forsythe found that the petitioner likely sustained a contusion of the right shoulder which has since resolved; and a left shoulder rotator cuff strain, which was

subsequently treated with arthroscopy. The doctor opined that he would consider both conditions causally related if, in fact, the petitioner's stated history to him was accurate. He found Petitioner manifested mild symptom magnification with inconsistent effort and non-physiological responses, and that the left and right shoulder examinations were essentially normal with subjective complaints not supported by objective findings. As such, he recommended the Petitioner return to full duty work, and that no further treatment was indicated. RX1.

A repeat cervical MRI performed on February 23, 2015, was read to show a disc bulge at C6-7. Petitioner saw Dr. Mehta on May 12, 2015 and an EMG was recommended, following review of the cervical MRI and another injection. He returned to Dr. Mehta on June 9 2015, and it was noted that the neck pain was much better. The petitioner returned periodically for follow-up visits with Dr. Silver, who continued to recommend right shoulder arthroscopy, as of July 30, 2015. PXs 2-4.

Deposition of Dr. Ronald Silver, dated June 29, 2015

In his evidence deposition, the doctor stated that Petitioner fell to the ground on his right shoulder. Later in the deposition he testified that the initial note referred to Petitioner falling on the left shoulder. He then proceeds to claim that petitioner fell on both shoulders; hitting the ground on one shoulder and then rolling over on his other shoulder. Not only does that mechanism of injury seem highly unlikely, it is also unsupported by the petitioner's testimony at hearing. Dr. Silver agreed that there is no mention of any injury or pain complaints to the right shoulder or cervical spine in his records for three (3) months following the date of accident. He also testified that it is his practice to take accurate notes. However, he then goes on to claim that he had a "personal recollection" that the petitioner initially told him about the right shoulder. The Arbitrator notes that this doctor's testimony regarding the petitioner mechanism of accident is confusion and contradictory. PX1.

Deposition of Dr. Amit Mehta, dated June 11, 2015

On direct examination, this doctor testified that the petitioner's condition of ill-being regarding his neck and right should were causally related to the accident of May 29, 2013; after cross-examination, after confirming that the medical records hold no reference to any injury to these body parts for at least three (3) after the accident; the doctor admitted that it was possible that Petitioner's complaints regarding those regions were not related to this accident. PX3.

Conclusions of Law

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

A decision by the Commission cannot be based upon speculation or conjecture. *Deere and Company v Industrial Commission*, 47 Ill.2d 144, 265 N.E. 2d 129 (1970). A petitioner seeking an award before the Commission must prove by a preponderance of credible evidence each element of the claim. *Illinois Institute of Technology v. Industrial Commission*, 68 Ill.2d 236, 369 N.E.2d 853 (1977). Where a petitioner fails to prove by a preponderance of the evidence that there exists a causal connection between work and the alleged condition of ill-being, compensation is to be denied. Id.

The facts of each case must be closely analyzed to be fair to the employee, the employer, and to the employer's workers' compensation carrier. *Three "D" Discount Store v Industrial Commission*, 198 Ill.App. 3d 43, 556 N.E.2d 261, 144 Ill.Dec. 794 (4th Dist. 1989).

The burden is on the Petitioner seeking an award to prove by a preponderance of credible evidence all the elements of his claim, including the requirement that the injury complained of arose out of and in the course of his or her employment. *Martin vs. Industrial Commission*, 91 Ill.2d 288, 63 Ill.Dec. 1, 437 N.E.2d 650 (1982). The mere existence of testimony does not require its acceptance. *Smith v Industrial Commission*, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require that an award be entered or affirmed whenever a Petitioner testified to an injury no matter how much his testimony might be contradicted by the evidence, or how evident it might be that his story is a fabricated afterthought. *U.S. Steel v Industrial Commission*, 8 Ill.2d 407, 134 N.E. 2d 307 (1956).
It is not enough that the petitioner is working when an injury is realized. The petitioner must show that the injury was due to some cause connected with the employment. *Board of Trustees of the University of Illinois v. Industrial Commission*, 44 Ill.2d 207, 214, 254 N.E.2d 522 (1969); see also *Hansel & Gretel Day Care Center v Industrial Commission*, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991).
The Illinois Supreme Court has held that a Petitioner's testimony standing alone may be accepted for the purposes of determining whether an accident occurred. However, that testimony must be proved credible. *Caterpillar Tractor vs. Industrial Commission*, 83 Ill.2d 213, 413 N.E.2d 740 (1980). In addition, a Petitioner's testimony must be considered with all the facts and circumstances that might not justify an award. *Neal vs. Industrial Commission*, 141 Ill.App.3d 289, 490 N.E.2d 124 (1986). Uncorroborated testimony will support an award for benefits only if consideration of all facts and circumstances support the decision. *See generally, Gallentine v. Industrial Commission*, 147 Ill.Dec 353, 559 N.E.2d 526, 201 Ill.App.3d 880 (2nd Dist. 1990), *see* also *Seiber v Industrial Commission*, 82 Ill.2d 87, 411 N.E.2d 249 (1980), *Caterpillar v Industrial Commission*, 73 Ill.2d 311, 383 N.E.2d 220 (1978). It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence, and assign weight to the witness' testimony. *O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253, 403 N.E.2d 221, 223 (1980); *Hosteny v Workers' Compensation Commission*, 397 Ill. App. 3d 665, 674 (2009).

The parties agree that Petitioner sustained an accidental injury to his left shoulder. However, there is a dispute as to whether the petitioner injured his right shoulder and cervical spine during the accident that occurred on May 29, 2013. The accident histories, as documented by various medical providers over approximately three (3) months following the accident date, only mention an injury to the left shoulder. Petitioner first went to Winfield Moody Health Center on May 31, 2013, where a history is given of pain in the back of the left shoulder for two to three (2-3) days. There is no mention of injury or pain complaint for the right shoulder or cervical spine. Petitioner first saw Dr. Silver on June 6, 2013 and reported that he tripped on a conduit and "tried to stop his fall by grabbing a pole with his left arm and wrenched the left shoulder feeling his left shoulder pop and then fell to the ground on the shoulder". Again, there is no mention of any injury or pain complaint involving the right shoulder or cervical spine. Petitioner continued to follow-up with Dr. Silver; and the July 30, 2013 note again does not mention any injury to the right shoulder or cervical spine.

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

In order for an injury to be deemed compensable, Petitioner must establish it arose out of and in the course of the employment. "An injury 'arises out of' employment when it originates from some risk related to the employment, thereby establishing a causal connection between the injury and the occupation." *Wise v Industrial Commission,* 54 Ill.2d 138, 142 (1973); *Material Service Corp. v. Industrial Commission,* 53 Ill.2d 429, 292 N.E.2d 367; *Thurber v. Industrial Commission,* 49 Ill.2d 561, 276 N.E2d 316. "A compensable injury occurs 'in the course of' employment when it is sustained while Petitioner is at work or while he performs reasonable activities in conjunction with his employment." *Wise v Industrial Commission,* 54 Ill.2d 138, 142 (1973); *Hydro-Line Manufacturing Co. v. Industrial Commission,* 15 Ill.2d 156, 154 N.E.2d 234; *Associated Vendors, Inc. v. Industrial Commission,* 45 Ill.2d 203, 258 N.E.2d 354.

It is established law that at hearing, it is the employee's burden to establish the elements of his claim by a preponderance of credible evidence. *Illinois Bell Tel. Co. v. Industrial Comm'n.,* 265 Ill. App. 3d 681; 638 N.E. 2d 307 (1st Dist. 1994). This includes the issue of whether Petitioner's current state of ill-being is causally related to the alleged work accident. *Id.* A Petitioner must prove causal connection by evidence from which inferences can be fairly and reasonably drawn. *Caterpillar Tractor Co. v. Industrial Comm'n.,* 83 Ill. 2d 213; 414 N.E. 2d 740 (1980). Also, causal connection can be inferred. Proof of an employee's state of good health prior to the time of injury and the change immediately following the injury is competent as tending to establish that the impaired condition was due to the injury. *Westinghouse Electric Co. v. Industrial Comm'n,* 64 Ill. 2d 244, 356 N.E.2d 28 (1976). Furthermore, a causal connection between work duties and a condition may be established by a chain of events including Petitioner's ability to perform the duties before the date of the accident and inability to perform the same duties following that date. *Darling v. Industrial Comm'n,* 176 Ill.App.3d 186, 193 (1986).

The petitioner's initial visit to AthletiCo for physical therapy was on August 6 2013; and pain complaints were only noted for the left shoulder. It was not until his August 20, 2013 follow-up at AthletiCo, that there was any mention of a right shoulder issue. The first mention of right shoulder pain in Dr. Silver's records, is on August 29, 2013, wherein he states that the right shoulder is also troubling Petitioner, due to the overuse he has placed over the past few months. The doctor adds a postscript to that note stating that the petitioner fell on his right shoulder, so the symptoms are a combination of the original injury and overuse as well. The Arbitrator notes that that contention is contradicted by the testimonies of Dr. Silver and the petitioner.

The petitioner testified at hearing that he crashed into a cabinet, holding a laptop in his right hand; stating that he tried to catch himself and had pain in his left shoulder. Not only was there no report of right shoulder pain for three (3) months after the accident, but the histories given in the medical records state various mechanisms of injury. Dr. Silver's testimony as to accident history is also contradictory. In his evidence deposition, he stated that Petitioner fell to the ground on his right shoulder. Later in the deposition he testified that the initial note refers to falling on the left shoulder. He then proceeds to claim that the petitioner fell on both shoulders, hitting the ground on one shoulder and then rolling over on his other shoulder. Not only does that mechanism of injury seem

highly unlikely, it is also wholly unsupported by petitioner's testimony at hearing. Dr. Silver agreed that there is no mention of any injury or pain complaints to the right shoulder or cervical spine in his records for three (3) months following the date of accident. He also testified that it is his practice to take accurate notes. However, he then goes on to claim that he had a "personal recollection" that the petitioner had initially told him about the right shoulder. The Arbitrator does not find the testimony of Dr. Silver to be persuasive, regarding the mechanism of Petitioner's injury.

Dr. Forsythe provided an IME opinion that he would consider both alleged shoulder injuries to be causally related to the alleged work accident, "if in fact that patient's stated history is accurate". As has been pointed out, the accident histories are inconsistent and contradictory. Furthermore, the doctor opined that the petitioner sustained a contusion to the right shoulder which has since resolved. This is consistent with the objective testing; while the left shoulder MRI showed a partial thickness tear of the rotator cuff, the right shoulder MRI does not. He found both left and right shoulder examinations to be essentially normal, with Petitioner's subjective complaints not supported by objective findings. The Arbitrator also notes that the petitioner has returned to work as of April 8, 2015, despite his treating physicians stating that he could not work. This further supports the IME doctor's note of symptom magnification, inconsistent effort on strength testing; and non-physiological responses to provocative maneuvers. The Arbitrator finds the opinion of Dr. Forsythe to be more persuasive than that of Dr. Silver. Based on the inconsistent mechanisms of injury, gaps in treatment and reporting of right shoulder complaints, lack of objective findings; and Petitioner's ability to return to work, the Arbitrator does not find the right shoulder injury to be causally related to the work accident.

With respect to the alleged cervical injury, the records show there were no cervical complaints for over a year after the work accident. Petitioner saw Dr. Dasgupta at Elmwood Park Same Day Surgery Center on August 27, 2013 and noted an injury to the left shoulder on May 29, 2013. He notes he was improving with physical therapy for the left shoulder, but now has right-sided shoulder and arm pain.

In the October 28, 2013 follow-up visit, complaints are only noted in the shoulders. Indeed, the first injection done on November 12, 2013, is to the right shoulder. The Petitioner did not return to Elmwood Park until September 15, 2014, which is the first note of neck complaints. The cervical MRI on October 22, 2014 was limited and showed only disc bulging. On May 12, 2015, the petitioner noted that his neck pain is much improved, and an EMG was recommended. Dr. Mehta testified in his evidence deposition, that petitioner injured his left shoulder on the date of accident, and that he didn't fall or strike the right shoulder or neck. He further stated that there was no report of a cervical injury or pain complaints after the work accident. Dr. Mehta testified that the cervical complaints may not be related to the work accident, that the cervical MRI results may or may not correlate to the accident; and that he has not taken the petitioner off work, due to these alleged maladies. Due to the lack of cervical complaints for over a year after the accident, the lengthy gap in treatment and Dr. Mehta's equivocation as to causal connection, the Arbitrator finds that the cervical spine complaints are not causally connected to the work 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 expenses?

The Arbitrator finds that medical services provided to the petitioner for the left shoulder incurred through the December 29, 2014 IME date were reasonable and necessary. The Arbitrator further finds that the respondent has paid all charges incurred through December 29, 2014, the date to the IME. Because Petitioner has not proven, by a preponderance of the evidence, that his condition of ill-being with respect to the right shoulder and cervical spine are causally related to the work accident, the charges for those medical services subsequent to the December 29, 2014 are not awarded. Because the Arbitrator finds Dr. Forsythe's opinion persuasive with respect that no further treatment is required for the left shoulder; charges for medical services for the left shoulder, subsequent to the December 29, 2014, are also denied.

K. Is Petitioner entitled to any prospective medical care?

The petitioner has not proven, by a preponderance of the evidence, that he is entitled to prospective medical care, therefore it is not awarded.

L. What temporary benefits are in dispute?

The parties are in agreement that temporary partial disability ("TPD") is owed from June 8, 2013 through June 28, 2013. Temporary total disability benefits ("TTD") were properly paid from July 1, 2013 through January 21, 2015. The Arbitrator finds the opinion of Dr. Forsythe to be persuasive, with regards to Petitioner's ability to return to work after January 21, 2015. In addition, the Arbitrator concludes that Petitioner's condition of ill-being with respect to the right shoulder and cervical spine are not causally related to the work accident. As such, additional TPD and TTD benefits are denied.

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
13WC19605
SIGNATURE PAGE

Signature of Arbitrator

November 9, 2015
Date of Decision

NOV - 9 2015

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

PIJANOWSKI, DEREK Case# **13WC022059**
Employee/Petitioner

MARCIN ZUBRYCKI D/B/A ZUBRYCKI CONSTRUCTION
Employer/Respondent

On 11/9/2015, 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 0.28% 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:

4442 LAW OFFICE OF TIMOTHY TAKASH
111 W WASHINGTON ST
SUITE 1500
CHICAGO, IL 60602

0532 HOLECEK & ASSOCIATES
BARNALI ROY-MOHANTY
161 N CLARK ST SUITE 800
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Darek Pijanowski
Employee/Petitioner

Case # **13** WC **22059**

v.

Marcin Zubrycki D/B/A Zubrycki Construction
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 **David A. Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **9/29/2015 and 10/27/2015**. 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, **6/11/2013**, 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 $**52,000.00**; the average weekly wage was $**1,000.00**.

On the date of accident, Petitioner was **41** 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 $**80,381.35** for TTD, $-- for TPD, $-- for maintenance, and $-- for other benefits, for a total credit of $**80,381.35**.

The parties agreed that the issue of medical bills will be deferred to a future date and hearing.

ORDER

Medical benefits
Petitioner failed to prove that the treatment recommended by Dr. Gireesan, including fusion surgery at L5-S1 and L1-L2, is reasonable and necessary pursuant to Section 8 of the Act. Petitioner reached MMI on May 17, 2014. All benefits are denied.

Temporary Total Disability
Respondent shall pay Petitioner temporary total disability benefits of $666.67/week for 48 3/7 weeks, commencing 6/12/2013 through 5/17/2014, at which time Petitioner reached MMI, as provided in Section 8(b) of the Act.

Petitioner reached MMI on 5/17/2014. Respondent paid benefits from 6/12/2013 through 10/4/2015. Respondent shall be given a credit of $80,381.35 for TTD paid.

Maintenance
Petitioner failed to prove that he is entitled to maintenance benefits once he reached MMI on 5/17/2014. Benefits are hereby denied.

Credits
Respondent shall be given a credit of $80,381.35 for TTD paid.

Penalties
Petitioner withdrew his penalties petition. Accordingly, no penalties are awarded.

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.

David A. Kane
Signature of Arbitrator

November 9, 2015
Date

ICArbDec19(b)

NOV - 9 2015

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Darek Pijanowski,	)	
	)	
Petitioner,	)	
	)	
v.	)	No. 13 WC 22059
	)	
Marcin Zubrycki)		
D/B/A Zubrycki Construction	)	
	)	
Respondent.	)	

RIDER

An Application for Adjustment of Claim was filed in this matter. The case was heard by Honorable David Kane, Arbitrator of the Workers' Compensation Commission, in the city of Chicago, on a 19(b) hearing on September 29, 2015 and October 27, 2015. 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 moved to the United States in 1996. He testified that he does not speak, read or write English; however, has been able to maintain employment since 1996 through the date of the alleged accident. Based on Petitioner's testimony, there is no clear evidence that he is legally able to work in the United States.

On June 11, 2013, Petitioner, Darek Pijanowski, was employed as a Bricklayer for Respondent, Zubrycki Construction. He worked for Respondent for only two seasons. On that date, he alleges that he fell off scaffolding, sustaining injury to his back. Petitioner initially presented to Advocate Illinois Masonic and diagnostics taken revealed no abnormalities. (Px. 1; Illinois Masonic Records).

On July 8, 2013, MRI's taken at MRI Lincoln Imaging Center revealed disc bulges at L1-2 and L5-S1. Disc degeneration and spondylolysis was also found. (Px. 2, pg. 48-49; Dr. Nasilowski's Records). Petitioner subsequently underwent physical therapy and was eventually referred for an orthopedic consultation.

On September 6, 2013, Petitioner initially presents to Dr. Girresan who diagnoses him with discogenic low back pain (primary) and L1-L2 aggravated as a result of the work accident. The doctor further noted spondylolysis at L5-S1 but does not indicate that this condition was aggravated by the work accident. A review of the MRI revealed no evidence of disc herniations. On this initial evaluation, Dr. Gireesan recommended a FCE to determine his restrictions or second option to undergo fusion surgery. (Px. 4, pg. 2-4; Dr. Gireesan's Records).

On October 17, 2013, Petitioner presented for Respondent's Section 12 examination with Dr. Kornblatt, who is a board certified orthopedic surgeon. Dr. Kornblatt specializes in spine surgery, and has presented and published a number of topic and articles specific to spinal conditions. (Rx. 5; CV of Dr. Michael Kornblatt). The doctor diagnosed Petitioner with pre-existing L1-L2 degenerative disc disease and L5 spondylolysis. The doctor opined that Petitioner's condition was long standing and not a result of the work accident. The doctor diagnosed Petitioner with work-related thoracic and lumbar strain and contusion, as well as an occult fracture that would be related to the work accident. (Rx. 2; Respondent's Section 12 Examination Report).

On January 30, 2014, Dr. Kornblatt reviewed additional records from Dr. Nasilowski and Dr. Gireesan and diagnosed Petitioner with bilateral pars defect at L5 "suggesting either healed post-traumatic changes or pars defect" not secondary to trauma as it relates to the work accident. The doctor recommended a FCE. (Rx. 3; Respondent's Section 12 Report).

On May 17, 2014, Petitioner underwent a valid FCE, which found him capable of functioning at a medium to heavy demand level. (Rx. 1; FCE Report).

On May 20, 2014, Petitioner returned to Dr. Gireesan who recommended fusion surgery. (Px. 4, pg. 81). Since that time, he has had follow-up appoints on a monthly basis and other than pain medication and the recommendation for surgery, Dr. Gireesan has not prescribed active treatment. (Px. 4).

On June 26, 2014, Petitioner returned to Dr. Kornblatt for a repeat Section 12 examination and the physical examination revealed: straight spine, gait intact, negative straight leg raise, negative FABER and Patrick's

tests. At this time, Dr. Kornblatt opined that the work accident resulted on L2, L3 and L4 transverse process fracture and left 9th and 19th rib fractures. Petitioner's L5 spondylolisthesis was pre-existing, which was temporarily aggravated and resolved within six months of the date of accident. The doctor found no evidence of radiculopathy and opined that he was not a candidate for surgery. Petitioner at reached MMI and could return to work with restrictions within the FCE. (Rx. 4, Respondent's Section 12 Examination Report).

The parties agreed to obtain a third opinion from Dr. Edward Goldberg, who is a board certified orthopedic surgeon who specializes in spinal condition. The doctor is the Assistant Professor and Attending for orthopedic surgery at Rush University Medical Center. He has multiple awards, publications and presentations regarding spinal conditions. (Rx. 8; CV of Dr. Edward Goldberg).

On October 29, 2014, Petitioner presented to Dr. Goldberg for evaluation. The doctor had the opportunity to review the medical records from Dr. Nasilowski, Dr. Gireesan, Dr. Kornblatt, MRI films, and FCE. A Polish interpreter was present. On examination, Petitioner denied radicular pain. He was minimally tender at the lumbar and thoracic regions. Waddell's test was negative. Straight leg raise was negative. He presented with 5/5 motor strength. Dr. Goldberg diagnosed Petitioner with longstanding degenerative disc disease at L5-S1 with spondylolisthesis The doctor noted that spondylolisthesis arises at childhood and the bone scan did not indicate an acute process to suggest an acute fracture resulting in his condition. Dr. Goldberg did not recommend surgery; rather that Petitioner obtain a discography. Petitioner could return to work per the FCE. (Rx. 6; Respondent's Section 12 Examination Report).

On January 22, 2015, Dr. Goldberg was sent a copy of the discography for comment, in addition to updated medical records. Upon review of the discogram, the doctor found no reproduced concordant pain a L1-L2 and L5-S1. Dr. Goldberg opined that his isthmic spondylolisthesis was present since childhood and unrelated or aggravated by the work accident. The doctor further opined that he was not a surgical candidate. (Rx. 7; Respondent's Section 12 Addendum Report).

The evidence deposition of Dr. Goldberg was taken by agreement of the parties on July 29, 2015. Dr. Goldberg is a board certified orthopedic surgeon who is licensed to practice in Illinois. He has been practicing since 1990 and specializes in spinal condition and spinal surgery. During the deposition, the doctor credibly testified regarding diagnosis, causation, treatment and his rationale behind his opinions. (Rx. 9, Deposition Transcript).

In summary, relative to diagnosis, the doctor testified that Petitioner's conditions are pre-existing. Specifically, Petitioner has a condition known as pars defect of the lumbar spine, which is a condition that begins at childhood. Further, the bone scan correlates that this condition began in the early stages of Petitioner's life, well before the date of accident.

Based on the doctor's physical evaluation and review of the diagnostics, he opined that Petitioner's condition was not acute or traumatic. Additionally, the discograph found not reproduction of pain at the L1-2 and L5 disc levels. The doctor testified that Petitioner sustained a lumbar strain and transverse process due to the work accident. He opined that the pars defect and spondylolisthesis was unrelated to the work accident.

Relative to treatment, the doctor testified that Petitioner did not demonstrate any symptoms at L1-2 and L5, which was corroborated by the discography. Accordingly, the doctor opined that Petitioner is not a candidate for fusion surgery notwithstanding his opinion regarding causation.

Dr. Goldberg generally concurred with Dr. Kornblatt's opinions. He found the FCE to be valid. Based on the job description provided by the FCE, the doctor opined that Petitioner would be able to return to work within the medium/heavy demand level. The doctor opined that Petitioner had reached MMI.

On March 30, 2015, Petitioner presented for an initial vocational assessment with counselor Patricia Sharkey. Based on Petitioner's education, physical restrictions, language skills and transferable work skills, Ms. Sharkey opined that there was a stable labor market for him to return. Ms. Sharkey noted that Petitioner does not have a green card, permanent residency car or US citizenship; accordingly, Petitioner is not currently able to legally work in the United States. She noted that one of the barriers in Petitioner finding employment was his illegal working status. (Rx. 10; Initial Vocational Assessment).

On April 28, 2015, a labor market survey was obtained to identify employment opportunities based on Petitioner's education, physical restrictions, language skills and transferable work skills; notwithstanding his ability to legally work in the United States. Several occupations, including Deli Cutter Slicer, Production Laborer, Assembler, Delivery Driver, Window Cleaner, Linen Room Attendant, Cleaner Housekeeping and Cleaner I, were utilized in the survey. In summary, available jobs were found in the salary range of $8.25 to $10.00 per hour. Multiple employers showed

willingness to hire a Polish-only speaking applicant. (Rx. 11; Labor Market Survey).

Petitioner testified that he currently has low back pain and takes medication. Other than follow-up appointments with Dr. Gireesan, he has not actively treated since completing work conditioning on May 20, 2014. (Px. 4, pg. 81). He would like to undergo surgical intervention. He testified that Dr. Girreesan "guaranteed" that the surgery will improve his condition.

II. Conclusions of Law

In support of the Arbitrator's decision relating to issue (F), whether Petitioner's current condition is causally related to the injury, the Arbitrator finds the following:

The Arbitrator finds Dr. Kornblatt's and Dr. Goldberg's opinions more compelling. Based on the medical records, including the diagnostics, Petitioner's pars defect condition and spondylolisthesis is pre-existing and unrelated to the work accident. Petitioner sustained a temporary aggravation of a pre-existing condition consistent with transverse process. Petitioner's work-related condition has resolved and he has reached MMI as of the date of the FCE on May 17, 2014.

In support of the Arbitrator's decision relating to issue (J), whether the medical services provided to Petitioner were reasonable and necessary, and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

Respondent has paid for the reasonable and related medical treatment pursuant to the medical fee schedule or other negotiated agreement, whichever is less. Petitioner has reached MMI and is not entitled to additional medical treatment/benefits.

In support of the Arbitrator's decision relating to issue (K), whether Petitioner is entitled to any prospective medical care, the Arbitrator finds the following:

Section 8(a) of the Act limits the employer's liability to pay all *necessary* medical treatment, which is *reasonably required to cure or relieve* from the effects of the accidental injury (emphasis added).

On September 6, 2013, Petitioner initially treated with Dr. Gireesan and the doctor discussed surgery. The Arbitrator does not find Dr. Girreson's treatment protocol reasonable. Petitioner went for an evaluation with Dr. Kornblatt and Dr. Goldberg, and both doctors had similar opinions. All three doctor's did not find evidence of radicular symptoms and the diagnostics, including the discogram did not correlate any positive finding is the disc levels that Dr. Gireesan is recommending surgery. The Arbitrator finds Dr. Kornblatt's and Dr. Goldberg's opinions more convincing. Furthermore, Petitioner's reliance on the surgery, in that he believes it will guarantee improvement is misplaced.

It is the Arbitrator's duty to ensure that an injured worker is provided with reasonable and necessary medical treatment required to cure or relieve his condition. Based on the above, the Arbitrator is not convinced

that the surgical recommendation by Dr. Gireesan is reasonable and necessary. The Arbitrator finds the opinions of Dr. Kornblatt and Dr. Goldberg more credible.

Accordingly, the Arbitrator finds that Petitioner reached MMI on May 17, 2014 and prospective care is hereby denied. Although the Arbitrator views Petitioner's condition as having stabilized, the parties have not requested the Arbitrator to address permanency.

In support of the Arbitrator's decision relating to issue (L), whether Petitioner is entitled to TTD and/or maintenance benefits, the Arbitrator finds the following:

On May 17, 2014, Petitioner reached MMI. Petitioner is entitled to TTD benefits from June 12, 2013 through May 17, 2014. Respondent paid benefits through October 4, 2015. Accordingly, Respondent is due a credit for overpayment of TTD from May 17, 2014 through October 4, 2015.

Relative to maintenance benefits, Petitioner has not proven his burden that he is entitled to benefits. While an initial vocational assessment and labor market survey was obtained indicate that there was a stable labor market for Petitioner to return, he has not made a diligent job search and has no intention of returning to work. Furthermore, Petitioner's inability to legally work in the United States automatically takes Petitioner out of the workforce and he is not entitled to vocational rehabilitation. Accordingly, he is not entitled to maintenance benefits.

In support of the Arbitrator's decision relating to issue (N), whether Respondent is due any credit, the Arbitrator finds the following:

Respondent paid benefits from June 12, 2013 through October 4, 2015. Respondent shall be given a credit of $80,381.35 for TTD paid.

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BRZEZINSKI, MICHAEL
Employee/Petitioner

Case# **13WC037439**
14WC024746

CITY OF CHICAGO
Employer/Respondent

On 11/10/2015, 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 0.34% 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 60602

0113 CITY OF CHICAGO
MICHELLE BRYANT
30 N LASALLE ST 8TH FL
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

Michael Brzezinski
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **13** WC **37439**

Consolidated cases: **14 WC 24746**

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 **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **August 25, 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 _____

FINDINGS

On **October 28, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**69,296.24**; the average weekly wage was $**1,332.62**.

On the date of accident, Petitioner was **61** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**4060.94** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $4,060.94.

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 $888.41/week for 4 & 4/7 weeks, commencing October 31, 2013 through December 1, 2013, as provided in Section 8(b) of the Act.

Respondent shall pay to Petitioner reasonable and necessary medical services of $1,378.00 under Sections 8(a) and 8.2 of the Act for the following unpaid medical bills: Dr. Dennis Mess - $446.25, Midwest Diagnostic Pathology- $63.00, Advocate Medical Group - $599.00.

Respondent shall pay to Petitioner $337.00 reimbursement from the sum of the awarded bills for out-of-pocket payment for medical treatment related to this accident.

Respondent shall pay Petitioner permanent partial disability benefits of $721.66/week for 15.05 weeks, because the injuries sustained caused the Petitioner 7% loss of the left leg, as provided in Section 8(e) of the Act.

Respondent shall be given a credit of $4,060.94 for temporary total disability benefits paid to Petitioner.

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.

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

Michael Brzezinski
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **14** WC **24746**

Consolidated cases: **13 WC 37439**

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 **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **August 25, 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

B. ☐ 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 16, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**69,296.24**; the average weekly wage was $**1,332.62**.

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

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

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

ORDER

Respondent shall pay to Petitioner reasonable and necessary medical services of $1,378.00 under Sections 8(a) and 8.2 of the Act for the following unpaid medical bills; Weiss Memorial Hospital - $894.00; Dr. Khalid Malik - $309.00; and Advocate Medical Group - $175.00.

Respondent shall pay to Petitioner $175.00 reimbursement from the sum of the awarded bills for out-of-pocket payment for medical treatment related to this accident.

The Arbitrator finds and concludes that there is no permanent disability in this matter therefore no benefits are awarded pursuant to Section 8(b)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.

FINDINGS OF FACT

The disputed issues in 13 WC 37439 are: 1) causal connection; 2) medical bills; 3) temporary total disability; and 4) the nature and extent of the petitioner's injury. *See,* AX2.

The sole disputed issue in 14 WC 24746 is the nature and extent of the petitioner's injury. *See,* AX1.

13 WC 37439

At the time of accident Michael Brzezinski ("Petitioner") was a 61-year-old laborer employed by the City of Chicago ("Respondent") since 1993. Petitioner testified that on October 28, 2013, he was moving a heavy garbage bin when he stepped with his left foot onto an uneven part of the pavement. He immediately felt pain and a pop in his left knee.

The same day of the accident, Petitioner treated with Dr. Stephen Bunting at U.S. Healthworks. His left knee exhibited mild diffuse tenderness with a small amount of swelling around the left patella and no bruising. Both Lachman's and McMurray's tests were negative, but Ballottement test was positive for joint effusion. The left knee had 0 degrees of extension and decreased flexion versus the right knee. Petitioner was diagnosed with a left knee sprain and instructed to work full duty while using a knee brace. The left knee showed old injuries with a healed fibula neck fracture and healed tibia spine fracture. A small supra-patello bursal effusion was seen. Dr. Bunting did not anticipate any permanent disability as a result of this incident. PX3.

Petitioner followed up with Dr. Bunting on October 30, 2013, and there was still pain and swelling in the left knee. Dr. Bunting restricted Petitioner from working. On October 31, 2013, Petitioner called U.S. Healthworks and reported redness and swelling to his left calf. He felt it was due to wearing the brace on his left knee. PX3.

On November 1, 2013, Dr. Bunting noted swelling and tenderness in Petitioner's left calf. The diagnosis was left knee strain and left calf strain. Petitioner was instructed to remain off work and discharged to follow-up with orthopedic specialist. PX3.

On November 4, 2013, Petitioner was examined by Dr. Dennis Mess at Uptown Orthopedics. Petitioner reported pain and swelling in his left knee and calf. The left knee was positive for effusion and McMurray's test at the left medial line. The diagnosis was left medial meniscal tear and left gastrocnemius tear. Dr. Mess prescribed an MRI of Petitioner's left knee. PX4.

On November 5, 2013, Petitioner treated at Advocate Illinois Masonic Medical Center due to increased pain and swelling in his left calf. Petitioner's posterior left calf exhibited swelling and ecchymosis extending down to the left foot, as well as tenderness to palpation. A Doppler exam of the left leg did not show evidence of deep vein thrombosis; it did show a complex fluid collection in the left posterior

medial calf, most likely representing a complex hematoma. The diagnosis was left posterior calf hematoma with possible gastrocnemius tear. PX5.

On November 6, 2013, Dr. Mess again prescribed an MRI of Petitioner's left knee. On November 11, 2013, an MRI was performed on Petitioner's left knee at the University of Illinois Hospital. It revealed severe tri-compartmental osteoarthritis with high grade chondromalacia of the medial compartment; associated medial meniscus maceration with probable tear near the anterior road with adjacent meniscal fragment or osseous fragment; mild degenerative change with tiny tear of the posterior lateral meniscus; near complete tear of the ACL, probably chronic; joint effusion with synovitis, question underlying crystalline arthropathy; and a ruptured baker's cyst. PX4.

On November 13, 2013, Dr. Mess administered a cortisone injection to Petitioner's left knee and he was instructed to return to work full duty as of December 2, 2013. Petitioner followed up with Dr. Mess on November 20, 2013, who noted decreased pain and swelling in Petitioner's left knee and calf. Petitioner testified that he did return to work on December 2, 2013. Petitioner was off work from October 31, 2013 through December 1, 2013 and last treated with Dr. Mess on March 19, 2014. PX4.

At the time of hearing, Petitioner testified that he had not been having any problems with his left knee or calf prior to his accident on October 28, 2013. He currently experiences some stiffness and popping sensation in his left knee. Petitioner is currently still employed as a laborer with Respondent. He testified that he has to perform job duties including heavy lifting of trash bags, leaf bags, and other bulk items. He has to push and pull garbage bins to deposit garbage into trucks. He testified that he has to lift items more carefully now.

14 WC 24746

Petitioner testified that on August 16, 2013, he was working in an alley when he was bitten by a dog. City of Chicago EMS took petitioner to Weiss Memorial Hospital, where it was noted that he had a small circular wound on his right mid-posterior thigh. He received antibiotics and was released to return to work in a full duty capacity. Petitioner further testified that he followed up with his primary care physician on August 21, 2013 and was discharged from care and does not intend to seek further treatment for this incident. PXs 1 & 2.

CONCLUSIONS OF LAW

13 WC 37439

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

It is not enough that the petitioner is working when an injury is realized. The petitioner must show that the injury was due to some cause connected with the employment. *Board of Trustees of the*

University of Illinois v. Industrial Commission, 44 Ill.2d 207, 214, 254 N.E.2d 522 (1969); see also *Hansel & Gretel Day Care Center v Industrial Commission*, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991).

It is within the province of the Commission to determine the factual issues, to decide the weight to be given to the evidence and the reasonable inferences to be drawn there from; and to assess the credibility of witnesses. *See, Marathon Oil Co. v. Industrial Comm'n*, 203 Ill. App. 3d 809, 815-16 (1990). And it is the province of the Commission to decide questions of fact and causation; to judge the credibility of witnesses and to resolve conflicting medical evidence. *See, Steve Foley Cadillac v. Industrial Comm'n*, 283 Ill. App. 3d 607, 610 (1998).

It is established law that at hearing, it is the employee's burden to establish the elements of his claim by a preponderance of credible evidence. *See, Illinois Bell Tel. Co. v. Industrial Comm'n.*, 265 Ill. App. 3d 681; 638 N.E. 2d 307 (1st Dist. 1994). This includes the issue of whether Petitioner's current state of ill-being is causally related to the alleged work accident. *Id.* A claimant must prove causal connection by evidence from which inferences can be fairly and reasonably drawn. *See, Caterpillar Tractor Co. v. Industrial Comm'n.*, 83 Ill. 2d 213; 414 N.E. 2d 740 (1980). Also, causal connection can be inferred. Proof of an employee's state of good health prior to the time of injury and the change immediately following the injury is competent as tending to establish that the impaired condition was due to the injury. *See, Westinghouse Electric Co. v. Industrial Comm'n*, 64 Ill. 2d 244, 356 N.E.2d 28 (1976). Furthermore, a causal connection between work duties and a condition may be established by a chain of events including Petitioner's ability to perform the duties before the date of the accident and inability to perform the same duties following that date. *See, Darling v. Industrial Comm'n*, 176 Ill.App.3d 186, 193 (1986).

Petitioner testified in a credible and unrebutted manner that, prior to the accident on October 28, 2013; he was not having any problems with his left knee or calf. Immediately after he stepped onto uneven pavement while moving a garbage bin, he felt a pop and pain in his left knee. He was diagnosed that day by Dr. Bunting at U.S. Healthworks with a left knee sprain. Furthermore, Petitioner testified that his left calf muscle became swollen and discolored while treating for his left leg.

On November 5, 2013, a Doppler examination of Petitioner's left leg revealed a complex hematoma in the left posterior calf, diagnosed as suspected gastrocnemius tears. An MRI of the Petitioner's left knee on November 11, 2013 revealed tears in the meniscus and anterior cruciate ligament, as well as a ruptured Baker's cyst. This MRI also revealed mild degenerative changes of the lateral meniscus, with severe changes of the anterior horn near the root, with loose bodies. Patellofemoral degeneration changes with chondromalacia extending to the lateral femoral condyle, was identified as well as spurring with large osteophytes. "There is near-complete loss of the medial cartilage with subchondral edema."

The Arbitrator has had the opportunity to review the medical evidence and the testimony of the witness. And while there was an obvious degenerative condition in Petitioner's left leg, he was

apparently able to work with that condition until he stepped onto uneven ground and injured that leg. The Arbitrator finds a causal connection between Petitioner's present condition of ill-being in the left knee and calf and the work accident of October 28, 2013.

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

The medical records reflect that Petitioner was diagnosed with a left knee strain by Dr. Stephen Bunting with U.S. Healthworks on October 28, 2013. On November 1, 2013, Dr. Bunting referred Petitioner to see his own orthopedist, Dr. Dennis Mess. Petitioner treated with Dr. Dennis Mess from November 4, 2013 through March 19, 2014. On November 13, 2013, Dr. Mess diagnosed Petitioner with an acute left knee injury and ruptured Baker's cyst. As a result, Dr. Mess administered a cortisone injection to Petitioner's left knee. On November 5, 2013, Petitioner treated at the emergency department at Advocate Illinois Masonic Medical Center due to increased pain and swelling in his left calf muscle as a result of his left leg injury.

The Arbitrator finds all of the medical treatment to be reasonable and necessary.
Petitioner presented unpaid medical bills as part of Exhibit 6. Based on the Arbitrator's findings, the bills are awarded as follows:

1. Midwest Diagnostic Pathology– DOS 11/5/13: $63.00
2. Advocate Medical Group—DOS 11/5/13: $599.00
3. Dr. Dennis Mess – DOS 11/13/13: $446.25

The Arbitrator notes that Petitioner paid $337.00 out-of-pocket for his medical treatment related to this accident. That amount is to be reimbursed to him out of the sum of the awarded bills.

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

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

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

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

(i) The reported level of impairment;
(ii) The occupation of the injured employee;
(iii) The age of the employee at the time of injury;
(iv) The employee's future earning capacity; and

(v) Evidence of disability corroborated by medical records.

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

i. No physician has issued any permanent partial disability impairment report in this case.

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

ii. Petitioner is currently, and was at the time of injury, employed as a laborer with Respondent. This position involves heavy work and the Petitioner's permanent partial disability ("PPD") will be larger than an individual who performs lighter work.

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

iii. Petitioner is 62-years-old. The Arbitrator considers the Petitioner to be an older individual and concludes that Petitioner will likely have greater disability than a younger individual with the same injuries.

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

iv. Petitioner testified that he has to lift more cautiously now and still experiences popping in his left knee. He testified that high school graduate is his highest level of education. Petitioner's only employment has been in labor positions. He has no computer skills. He has no military experience and no licenses other than a driver's license.

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

Evidence of disability to the left leg in Petitioner's treating medical records finds that a November 5, 2013 Doppler exam showed a left posterior calf hematoma with suspected gastrocnemius tear. A November 11, 2013 MRI of Petitioner's left knee revealed severe tri-compartmental osteoarthritis with high grade chondromalacia of the medial compartment; associated medial meniscus maceration with probable tear near the anterior road with adjacent meniscal fragment or osseous fragment; mild degenerative change with tiny tear of the posterior lateral meniscus; near complete tear of the ACL, probably chronic; joint effusion with synovitis, question underlying crystalline arthropathy; and a ruptured baker's cyst. Petitioner underwent a cortisone injection to his left knee performed by Dr. Mess on November 13, 2013.

Petitioner testified that he currently experiences stiffness and a popping sensation in his left knee. He testified that he is more cautious now with lifting heavy objects. His job duties involve lifting heavy bags and moving heavy bins of trash and bulk items.

The determination of permanent partial disability ("PPD") is not simply a calculation, but an evaluation of all five factors as stated in the Act. In making this evaluation of PPD, consideration is not given to any single enumerated factor as the sole determinant. Therefore, after applying Section 8.1b of the Act, 820 ILCS 305/8.1b and considering the relevance and weight of all these factors, the Arbitrator concludes that Petitioner has sustained a 7% permanent loss of the left leg, or 15.05 weeks of PPD benefits.

14 WC 24746

The Arbitrator finds and concludes that there is not permanent disability in this case; therefore no benefits are awarded, pursuant to the Act. The respondent shall pay the accrued medical bills and out-of-pocket medical paid by the petitioner.

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
13WC37439 & 14WC24746
SIGNATURE PAGE

L Thompson

Signature of Arbitrator

November 9, 2015
Date of Decision

NOV 10 2015

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

WATROBA, STEFANIA Case# **13WC026400**

Employee/Petitioner

THOMAS ENGINEERING INC

Employer/Respondent

On 11/12/2015, 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 0.14% 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:

1938 BELCHER LAW OFFICE
MATTHEW J BELCHER
350 N LASALLE ST SUITE 750
CHICAGO, IL 60654

2461 NYHAN BAMBRICK KINZIE & LOWRY
MICAELA CASSIDY
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Stefania Watroba
Employee/Petitioner

Case # 13 WC 26400

v.

Thomas Engineering, 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 **Molly C. Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **September 15, 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, **Thomas Engineering, Inc.**, 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 right hand/wrist condition of ill-being ***is*** causally related to the accident. Petitioner also established causation as to the treatment rendered by Dr. Vitello.

In the year preceding the injury, Petitioner earned **$23,920**; the average weekly wage was **$460.00**.

On the date of accident, Petitioner was **53** years of age, ***single*** with **0** dependent children.

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

ORDER

Respondent shall pay Petitioner the following related medical expenses subject to the fee schedule: 1) Chicago Orthopaedic & Sports Medicine (PX 7A), with the exception of the occupational therapy charges from July and August 2015, which are not supported by treatment records; 2) St. Joseph Hospital (PX 8A); and 3) Golf Imaging Center (PX 12A)

Petitioner is awarded and Respondent shall authorize prospective right hand/wrist treatment as recommended by Dr. Vitello, Petitioner's surgeon.

For the reasons stated in the attached decision, the Arbitrator finds that the Petitioner was temporarily totally disabled from February 19, 2015 (the day after the first 19(b) hearing) through September 15, 2015 (the date of the second 19(b) hearing), a period of 30 weeks, as provided in Section 8(b) of the Act. The Arbitrator awards temporary total disability benefits at the rate of $306.67/week based on the stipulated average weekly wage.

The Arbitrator declines to award penalties and fees.

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

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

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

Molly C Mason

Signature of Arbitrator

NOV 12 2015

11/12/15

Date

Stefania Watroba v. Thomas Engineering, Inc.
13 WC 26400

Procedural History

The Arbitrator conducted a prior Section 19(b) hearing on February 18, 2015. On March 20, 2015, the Arbitrator issued a decision finding that Petitioner established a causal relationship between her undisputed accident of September 11, 2012 and her then-current bilateral hand, lower back and right foot conditions of ill-being. The Arbitrator awarded two medical bills, prospective care in the form of a diagnostic/therapeutic right wrist injection prescribed by Dr. Yaffe on February 16, 2015, and penalties and fees on one of the awarded bills. Respondent filed a review. To the Arbitrator's knowledge, this review remains pending as of the date of issuance of this decision. Respondent later filed a motion to re-open proofs concerning the bill on which the Arbitrator awarded penalties and fees. The Arbitrator denied the motion to re-open proofs on the basis of lack of jurisdiction, citing the pending review. The motion was then set for hearing before Commissioner Luskin.

Arbitrator's Findings of Fact Relative to Second 19(b) Hearing of September 15, 2015

Petitioner's native language is Polish but she testified primarily in English.

Petitioner testified she sought an award of a lumbar injection at the prior 19(b) hearing, held on February 18, 2015. She wanted Dr. Belcher to perform this injection. She tried to return to Dr. Belcher after the hearing but was unable to due to lack of authorization. T. 17-18.

On February 16, 2015, two days before the first 19(b) hearing, Petitioner saw Dr. Yaffe at Barrington Orthopedic Specialists. The doctor's note of that date reflects that Petitioner complained of right hand pain, numbness and weakness secondary to an acute injury at work three years earlier. The doctor indicated that Petitioner reported deriving only mild improvement from splint usage. He also noted that Petitioner denied any previous injury. He described Petitioner as right-handed. On right hand and wrist examination, he noted positive Phalen's, Tinel's and median nerve compression testing. He also noted 15 millimeter two point discrimination in all five fingers of the right hand.

Dr. Yaffe indicated he reviewed the October 15, 2014 EMG and found it "suggestive of carpal tunnel syndrome."

Dr. Yaffe described his sensory examination findings as "troubling/confusing," indicating that the 15 millimeter two point discrimination in all of the fingers could not be explained by carpal tunel syndrome. He further noted: "in addition, she has APB strength 5/5 and no FDP weakness, which I may anticipate in someone with profound sensory loss." He recommended a right carpal tunnel injection and imposed restrictions of no lifting over 10 pounds and no pushing/pulling or repetitive motion. PX 2A.

There is no evidence indicating Petitioner returned to Dr. Yaffe after February 16, 2015.

Petitioner testified that, in February and March of 2015, she was still experiencing back pain and foot numbness. She perceives her symptoms as traveling from her back to her foot. She was also experiencing worsening right hand pain. T. 19-20. Her back and foot symptoms made it difficult for her to bend, drive and clean her house. Her right wrist symptoms made it difficult for her to brush her teeth, fix her hair, lift items and open milk containers. She is right-handed. T. 21, 23.

Petitioner testified she looked for work after the first hearing. T. 21. Originally, her daughter wrote down her job contacts. T. 21. Later, she began recording the contacts on her own. After her surgery, her handwriting got very bad. T. 21. [Petitioner offered into evidence the job search records she testified are in her own handwriting. PX 9A.]

On May 13, 2015, Petitioner saw Dr. Vitello, a hand surgeon affiliated with Chicago Orthopaedics & Sports Medicine. Petitioner testified that her attorney referred her to Dr. Vitello. May 13, 2015 was the earliest appointment she could secure with the doctor. T. 18-19.

Dr. Vitello's initial note of May 13, 2015 reflects that Petitioner complained of right wrist pain on the volar side since an accident of September 11, 2012. The note also reflects that Petitioner "has had numbness of the hand in the past but that is now better." The doctor described the accident as follows: "while at work a metal cabinet was falling on her and she put her hands out to stop it."

Dr. Vitello also indicated that Petitioner "reported back pain and bilateral calf pain worse with walking." There is no indication that Dr. Vitello examined Petitioner's back or legs.

On wrist examination, the doctor noted a full range of motion, no swelling, tenderness on palpation of the dorsal aspect, tenderness on palpation of the flexor carpi radialis and normal motion.

Dr. Vitello obtained right wrist X-rays. He described the results as negative. He diagnosed arthralgia of the ulna, radius and wrist and synovitis and tenosynovitis of the right hand/wrist. He recommended a right wrist MRI. He imposed a restriction of no lifting over 10 pounds "until further notice." PX 7A.

The right wrist MRI, performed without contrast on May 19, 2015, showed extensor carpi ulnaris tendinopathy and volar radiocarpal ganglion cysts. PX 12A.

Petitioner returned to Dr. Vitello on May 27, 2015. On right wrist re-examination, the doctor noted no tenderness on palpation of the extensor carpi ulnaris, tenderness on palpation of the flexor carpi radialis and a positive ECU subluxation test. He reviewed the MRI and administered an injection at the point of maximal tenderness over the right wrist flexor carpi

radialis tendon. Petitioner testified that Dr. Vitello injected the inner part of her right wrist. The injection helped for a few days but the pain then came back. T. 27.

Petitioner returned to Dr. Vitello on June 24, 2015. On re-examination, he noted an area of maximal tenderness over the right volar wrist. He recommended surgery and scheduled it for July 14, 2015. PX 7A.

Petitioner testified she did not like the idea of surgery but felt she had no choice. She opted to have the surgery because she wants to get better and return to work. T. 28.

Petitioner underwent a pre-operative examination by Dr. Lodhi on July 2, 2015.

On July 14, 2015, Dr. Vitello operated on Petitioner's right wrist at Presence St. Joseph Hospital. He performed a flexor carpi radialis decompression. In his operative report, he indicated that the injection provided only temporary relief and that he recommended surgery in an attempt to relieve Petitioner's pain but could not guarantee success. He placed Petitioner's right wrist in a splint at the end of the surgery. PX 7A, PX 12A. At discharge, he prescribed Hydrocodone and recommended that Petitioner continue taking Celebrex. PX 12A, p. 35.

At the first post-operative visit, on July 20, 2015, Dr. Vitello noted that Petitioner described her pain as "better." He recommended occupational therapy and wound care. PX 7A. Petitioner testified she still had pain after the surgery but felt as if her hand was going to improve. By late July, her hand was still painful but much better. T. 30.

An itemized bill in PX 7A reflects that Petitioner underwent an occupational therapy evaluation at Chicago Orthopaedic & Sports Medicine on July 20, 2015 and attended therapy sessions on July 23, July 29, July 30, August 5, August 6, August 12 and August 13, 2015. No therapy records are in evidence.

At Respondent's request, Petitioner underwent a Section 12 examination by Dr. Michael Lewis on July 28, 2015. [Dr. Lewis previously examined Petitioner in this case on February 11, 2014, prior to the first 19(b) hearing.] Dr. Lewis is affiliated with the Illinois Bone & Joint Institute.

In his report of July 28, 2015, Dr. Lewis indicated that Petitioner was injured at work on September 11, 2012, when a cabinet fell forward toward her. The doctor indicated that Petitioner blocked the cabinet with her outstretched hands and "then fell backward," striking her back against a wall. He noted that Petitioner reported experiencing lower back pain as well as numbness on the dorsum of her right foot since the accident. He also noted that Petitioner also reported experiencing bilateral wrist pain after the accident but that her left wrist was now doing well. He indicated that Petitioner had recently undergone right wrist surgery and was currently undergoing therapy and taking Norco for the wrist. He stated that Petitioner denied numbness in either hand.

On right hand and wrist examination, Dr. Lewis noted full finger motion but pain at the extremes of wrist motion. He described the surgical incision as well-healed and "over the radial volar distal forearm with stitches in place." He indicated that two-point discrimination in both hands was within 6 millimeters. He did not test muscle strength in the right wrist due to the recent surgery.

On lumbar spine examination, Dr. Lewis noted no spasm, straight leg raising of 90 degrees, both sitting and lying down, and subjective decreased sensation over the dorsum of the right foot.

Dr. Lewis indicated he reviewed his previous examination report along with the EMG report, records from Barrington Orthopedic Specialists, the right wrist MRI report, Dr. Vitello's notes of May 13 and May 27, 2015 and Dr. Vitello's July 14, 2015 operative report.

Dr. Lewis diagnosed the following: 1) lumbar strain superimposed upon pre-existing degenerative disc disease, resolved; 2) left carpal tunnel syndrome, resolved; and 3) right hand and wrist, status post right wrist surgery. He indicated he described the lumbar strain as resolved based on the lack of objective evidence of orthopedic pathology on examination. He described the left carpal tunnel syndrome as resolved "based on [Petitioner] stating she has no symptoms concerning her left hand and wrist."

Dr. Lewis addressed causation as follows:

> "My opinion is that the conditions concerning her lumbar spine and left and right wrist are not work-related. The basis of my opinion is discussed in my independent medical evaluation performed on February 11, 2014 and my opinion has not changed based on additional review of records or my history and physical examination on July 28, 2015."

Dr. Lewis opined that "work restrictions related to recovering from [the recent] surgery are reasonable and necessary" but that, "for reasons previously discussed, these restrictions are not causally related to the September 2012 work injury." Dr. Lewis found Petitioner to be temporarily totally disabled, due to the recent right wrist surgery, but opined that this disability is not causally related to the work accident. He indicated that "the expected time for full recovery from the date of surgery would be eight weeks."

Dr. Lewis proceeded to address the issue of AMA impairment ratings, while reiterating that Petitioner's various conditions "are not work-related." He indicated it was too soon to rate the right wrist injury, since Petitioner was still recovering from the recent surgery. With respect to the lumbar spine condition, he arrived at a rating of 1% total body impairment. He rated the left wrist at 0% impairment. RX 1A.

Petitioner returned to Dr. Vitello on July 30, 2015. The doctor noted that Petitioner described her right wrist as "feeling better overall." On examination, he noted "good early" range of motion. He recommended that Petitioner return in two weeks and continue therapy. PX 7A.

An itemized bill in PX 7A reflects that Petitioner underwent a carpal injection at Chicago Orthopaedic & Sports Medicine on August 13, 2015.

At the September 15, 2015 hearing, Petitioner testified she last saw Dr. Vitello on September 3, 2015. In his note of that date, the doctor indicated that Petitioner told him "the numbness of the hand is gone since injection." On re-examination, the doctor noted mild sensitivity in the area of the incision, a good wrist range of motion, an improved grip and no numbness of the fingers. He recommended that Petitioner return to him in four weeks, undergoing additional therapy in the interim. He anticipated that Petitioner would reach maximum medical improvement at the next visit. He imposed restrictions of no lifting, pushing or pulling over 5 pounds and no forceful grasping, pulling or gripping with the right hand. PX 7A.

Petitioner testified she has looked for work within her restrictions but has not been successful. T. 33-34.

Petitioner denied having any new accident since the February 18, 2015, 19(b) hearing. T. 34.

Petitioner testified she still experiences a little pain in her right wrist. Her incision is sensitive and the skin feels tight. She wears a wrist brace when she goes outside. She has some difficulty flexing and extending her wrist. T. 34. Dr. Vitello recommended additional therapy when she saw him on September 3, 2015 but this has not been authorized. T. 36. She wants to undergo this therapy so that she can increase her activities and return to work. T. 33. Dr. Vitello also recommended that she return to him in four weeks.

Petitioner testified her medical bills remain unpaid. T. 44.

Under cross-examination, Petitioner testified that her attorney provided her with Dr. Vitello's telephone number. She called this number and made an appointment to see the doctor. T. 44-45. She brought her MRI to the initial appointment and told Dr. Vitello about the treatment she had undergone to date. T. 47. She does not know why the doctor's bill does not reflect any charges for the initial appointment. T. 46. She saw Dr. Vitello only for her right wrist. T. 48. She continues to smoke. When she saw Dr. Lodhi, in preparation for the right wrist surgery, he told her to quit smoking. She told Dr. Lodhi she still smokes half a pack of cigarettes per day. She also told Dr. Lewis, Respondent's examiner, that she continues to smoke. She is a current rather than former smoker but she has reduced her intake. T. 49. She never returned to Dr. Yaffe. T. 50. Dr. Vitello's office is far from her home. She has to drive to

Chicago in order to see Dr. Vitello. T. 50. Workers' compensation did not authorize the MRI, her visits to Dr. Vitello, the surgery or the therapy. T. 50-51. She has not undergone any therapy since mid-August 2015. She was able to undergo therapy for one month despite the lack of authorization. T. 51. She wants to finish the prescribed therapy before she returns to Dr. Vitello. T. 53. On September 3, 2015, Dr. Vitello recommended additional therapy and told her she would be "done" after she underwent this therapy. T. 54, 59. When she saw Dr. Lewis, on July 28, 2015, she told him about her lower back, foot and both hands. T. 55-56. She also told Dr. Vitello about her lower back but he deals only with hands. T. 56. She received unemployment benefits until July 2015. T. 57. Her job search records (PX 9A) end on June 19, 2015. Part of her reason for looking for work was to qualify for unemployment benefits. T. 57-58. She does not have any job logs for July 2015 through the hearing. She has not worked since Respondent laid her off in September 2014. T. 59. She lives with her daughter and her grandchildren, who are 3, 5 and 10 years old. She does not babysit her grandchildren. T. 60-61. Her daughter drives the children to daycare/school. T. 61. She is not subject to any restrictions relating to driving, sitting or walking. T. 61. When she saw Dr. Vitello, she told him her finger numbness was gone. T. 62. She continues to take the Norco that Dr. Vitello prescribed following the surgery but she only takes a half dose because the medication is strong. She last saw Dr. Belcher in January 2015. T. 63.

On redirect, Petitioner reiterated she wanted to return to Dr. Belcher after the first 19(b) hearing but no additional visits to this doctor were authorized. T. 64-65. She wants to see Dr. Belcher. T. 65. She had to change therapy providers because Dr. Vitello's office would not continue to provide therapy. T. 66.

Under re-cross, Petitioner testified she changed to ATI in Elk Grove Village. This therapy facility is closer to her home. T. 67. Dr. Vitello did not refer her to ATI. Her attorney helped her find ATI. She first underwent therapy at ATI the day before the hearing. T. 68.

On further redirect, Petitioner testified that Dr. Vitello is willing to provide additional therapy. T. 71.

No witnesses testified on behalf of Respondent at the hearing.

Following the hearing, and at the request of the Arbitrator, the parties entered into a stipulation supplementing the record with Dr. Lewis's previous examination report and deposition testimony. The Arbitrator summarized that report and testimony in her first 19(b) decision. Respondent's review of this decision is pending before the Commission.

Arbitrator's Credibility Assessment

As at the first hearing, Petitioner came across as an individual who wants to get better so that she can resume working. Respondent asserts Petitioner overstated her symptoms, using expressions such as "too much pain." The Arbitrator notes that Petitioner's English is neither fluent nor nuanced.

Arbitrator's Conclusions of Law

Did Petitioner establish a causal connection between the undisputed work accident of September 11, 2012 and her claimed current conditions of ill-being?

The Arbitrator finds that Petitioner established causation as to the need for the treatment rendered by Dr. Vitello, including the right wrist surgery of July 15, 2015, and as to her claimed current post-operative right wrist condition of ill-being.

The Arbitrator acknowledges that Petitioner's right wrist condition has been difficult to diagnose and that the condition Dr. Vitello addressed surgically is not identical to either the condition Dr. Yaffe suspected in February 2015 or the condition described by the radiologist who interpreted the right wrist MRI in May 2015. However, the Arbitrator finds it logical that using one's hands to support the weight of a heavy, leaning cabinet for several minutes could result in damage to the carpal tunnel ligament and/or tendons. The Arbitrator notes that Dr. Vitello administered a carpal tunnel injection in August 2015, after he operated on Petitioner's right wrist, and that Petitioner reported relief secondary to the injection on September 3, 2015. It appears to the Arbitrator that the work accident caused damage to more than one structure inside Petitioner's right wrist.

As in her first 19(b) decision, the Arbitrator declines to adopt the causation opinions of Respondent's examiner, Dr. Lewis. Dr. Lewis has never expressed an accurate understanding of the mechanism of Petitioner's accident. At his deposition, he testified it was his impression a cabinet fell onto Petitioner's back. He indicated he could not understand how this could have resulted in hand/wrist injuries. As the Arbitrator noted in her previous decision, there has never been any evidence suggesting that the falling cabinet struck Petitioner's back. The doctor's re-examination report of July 28, 2015 sets forth a different, but still inaccurate, account of the accident, with the doctor indicating Petitioner initially tried using her hands to block a falling cabinet but then fell backward. At the first 19(b) hearing, Petitioner testified a heavy cabinet fell toward her after she got down on one knee, facing the cabinet, and put items into a cabinet drawer. She further testified that she used both of her hands to support the weight of the cabinet for approximately three minutes before a co-worker came to her aid and righted the cabinet.

In finding causation as to Petitioner's current post-operative right hand/wrist condition of ill-being, the Arbitrator also relies on Petitioner's credible testimony that she has not worked or sustained any new injuries since the first 19(b) hearing.

The Arbitrator addressed causation vis-à-vis the lumbar spine and right foot in her first 19(b) decision. That decision is pending on review. Petitioner has not undergone any additional care for her lumbar spine or right foot since the first 19(b) hearing.

Is Petitioner entitled to temporary total disability benefits?

The Arbitrator finds that Petitioner was temporarily totally disabled from February 19, 2015 (the day after the first 19(b) hearing) through the hearing of September 15, 2015, a period of 30 weeks. In so finding, the Arbitrator primarily relies on Dr. Vitello's treatment records and work restrictions. When Petitioner last saw Dr. Vitello, on September 3, 2015, the doctor recommended therapy and imposed significant work restrictions relative to Petitioner's usage of her dominant right hand. The Arbitrator also notes that Respondent's examiner, Dr. Lewis, found Petitioner to be temporarily totally disabled when he saw her on July 28, 2015, although he did not causally link the disability to the work accident. Dr. Lewis did not question the reasonableness or necessity of the surgery Dr. Vitello performed. The Arbitrator has previously found that Petitioner established causation as to the need for that surgery. The Arbitrator views Petitioner's causally related right hand/wrist condition of ill-being as unstable as of the September 15, 2015 hearing. Interstate Scaffolding, Inc. v. IWCC, 236 Ill.2d 132 (2010).

The Arbitrator acknowledges that Petitioner changed physicians after the first 19(b) hearing and that there was some delay before she first saw Dr. Vitello, a hand surgeon recommended by her attorney. However, there is no indication that Respondent ever authorized the carpal tunnel injection recommended by Dr. Yaffe that the Arbitrator awarded in her first 19(b) decision, despite the fact that Dr. Lewis viewed this injection as "very reasonable." Instead, Respondent opted to review the Arbitrator's decision, as was its statutory right. The Arbitrator accepts that it took some time for Petitioner to establish care with a different provider.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims unpaid medical bills from three providers. The Arbitrator awards the bills from St. Joseph Hospital (PX 8A, pre-operative and surgery-related expenses) and Golf Imaging Center (PX 12A, right wrist MRI), subject to the fee schedule. The Arbitrator also awards the bill from Chicago Orthopaedic & Sports Medicine (PX 7A), subject to the fee schedule, with the exception of the charges relating to the therapy Petitioner underwent in July and August 2015. Petitioner did not offer any therapy records into evidence.

Is Petitioner entitled to prospective care?

The Arbitrator, having previously found that Petitioner established causation as to her claimed current right hand/wrist condition of ill-being, awards prospective care in the form of the additional treatment recommended by Dr. Vitello.

In her first 19(b) decision, the Arbitrator declined to award prospective care vis-à-vis the lumbar spine and right foot conditions, citing Dr. Belcher's note indicating that Petitioner described her back pain as "relatively tolerable." Only Respondent reviewed this decision. At the second 19(b) hearing, Petitioner did not introduce evidence of any new treatment recommendations regarding her back or right foot.

Is Respondent liable for penalties and fees?

While the Arbitrator finds the causation opinion of Respondent's examiner, Dr. Lewis, to be unpersuasive, the Arbitrator declines to award penalties and fees. On this record, with Petitioner's right hand/wrist diagnosis having expanded since the first hearing, the Arbitrator is unable to find that Respondent acted in an objectively unreasonable manner in denying benefits.

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CHAIDEZ, MANUEL Case# **09WC006490**

Employee/Petitioner

HISTORIC HOME & WINDOW RESTORATION
IWBF FRANK ROJAS

Employer/Respondent

On 10/27/2015, 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 0.15% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0243 JAMES E GUMBINER & ASSOCIATES
EDUARDO SALGADO
180 N MICHIGAN AVE SUITE 2100
CHICAGO, IL 60601

0000 HISTORIC HOME & WINDOW
RESTORATION INC
215 W PARK AVE
AURORA, IL 60506

5204 ASSISTANT ATTORNEY GENERAL
FLETCHER, CHRITOPHER
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Manuel Chaidez
Employee/Petitioner

Case # **09** WC **6490**

v.

Consolidated cases: _____

Historic Home And Window Resotoration, IWBF, Frank Rojas
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 **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **August 5, 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 **Was notice properly sent? Is the IWBF liable?**

FINDINGS

On **November 5, 2008**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**23,400.00**; the average weekly wage was $**450.00**.

On the date of accident, Petitioner was **42** years of age, ***married*** with **3** dependent children.

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

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

Respondent shall be given a credit of $**0.00** for TTD, $ for TPD, $ 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

Temporary Total Disability
Respondent shall pay Petitioner temporary total disability benefits of $320.00/week for 19.4 weeks, commencing 11/6/2008 through 03/20/2009, as provided in Section 8(b) of the Act.

MEDICAL BENEFITS:
Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, for all dates of services rendered at Mercy Medical Center $10,393.16 and $3,489.00 to Dreyer Medical Center, as provided in Sections 8(a) and 8.2 of the Act. ($13,882.16).

Permanent Partial Disability -Person as a whole:
Respondent shall pay Petitioner permanent partial disability benefits of $320.00/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 pay Petitioner permanent partial disability benefits of $320.00/week for 51.25 weeks, because the injuries sustained caused 25% loss of use of the Petitioner's right hand, as provided in 8(e) of the Act.

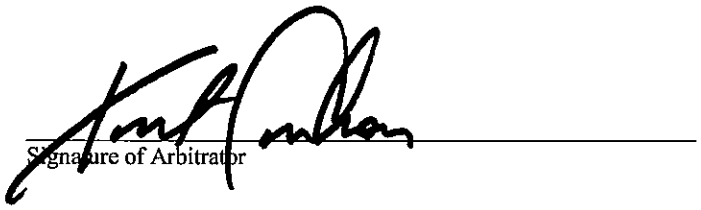
Injured Workers' Benefit Fund:
The Illinois State Treasurer, ex-officio custodian of the Injured Workers' Benefit Fund, was named as a co-respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act. In the event the Respondent/Employer/Owner/Officer fails to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing the Petitioner pursuant to Section 5(b) and 4(d) of this Act. Respondent/Employer/Owner/Officer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent/Employer/Owner/Officer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

RULES REGARDING APPEALS

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

STATEMENT OF INTEREST RATE

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



Signature of Arbitrator

10/21/2015
Date

OCT 2 7 2015

STATE OF ILLINOIS)
)
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MANUEL CHAIDEZ,	)	
	)	
Petitioner,	)	
	)	
	)	No. 09 WC 6490
	)	
vs.	)	
	)	
HISTORIC HOME & WINDOW RESTORATION, THE ILLINOIS STATE TREASURER , AS EX OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND, AND FRAN ROJAS,	)	
	)	
Respondent.	)	

FINDINGS OF FACT AND CONCLUSIONS OF LAW

I. FINDINGS OF FACT

Petitioner, Manuel Chaidez, through his attorneys, James Ellis Gumbiner and Associates, filed an application for adjustment of claims under the Illinois Workers' Compensation Act ("Act") seeking relief from the Respondent Historic Home and Window Restoration and the Injured Workers' Benefit Fund ("IWBF") for a work accident occurring on November 5, 2008. At the time of the reported accident Historic Home and Window Restoration did not maintain workers' compensation insurance. (Petitioner's Exhibit 2).

On August 5, 2015 the parties appeared before Arbitrator Kurt Carlson in order to try Petitioner's claim. Prior to the trial date on July 7, 2015, the parties, including Frank Rojas as representative for Historic Home and Window Restoration, met with the Arbitrator and were

personally provided with the August 5, 2015 trial date. On August 5, 2015 Frank Rojas appeared on behalf of Historic Home and Window Restoration but was not represented by an attorney. Attorney Eduardo Salgado from James Ellis Gumbiner and Associates appeared on behalf of the Petitioner and Christopher Fletcher with the Illinois Attorney General's office was present on behalf of the Illinois State Treasurer, as ex-officio custodian of the Injured Workers' Benefit Fund. Furthermore, a language translator was present at trial in order to assist the Petitioner with their testimony.

On November 5, 2015, Petitioner was 42 years old, married with 3 children all under the age of 18.

Petitioner began working for Historic Home and Window Restoration approximately 4 to 6 months before his accident on November 5, 2008. Petitioner further testified to walking by a project site of Historic Home and Window Restoration when he decided to inquire about a position. Petitioner testified to speaking with owner-president of Historic Home and Window Restoration Frank Rojas, regarding employment. Petitioner indicated that he was hired to provide assistance refurbishing and restoring windows for the Respondent. The kind of work Petitioner described consisted of climbing tall ladders, sanding window exteriors as well as fixing the inner workings of old and warn out windows. While working for Respondent, Petitioner was paid $450.00 a week. Petitioner was paid $450.00 a week regardless of whether or not he worked a 40-hour workweek. Petitioner was paid using business checks as evidence by Petitioner's exhibit 3. Historic Home and Window Restoration did not withhold taxes or provide any benefits.

According to the testimony provided by Frank Rojas, the Petitioner was instructed by either himself or a supervisor when and where to report for work. Furthermore, the Petitioner was told what tasks he was to perform while at work and when he was allowed to finish and leave for the

day. Moreover, when asked who procured all the business for Historic Home and Window Restoration Mr. Rojas indicated that he was responsible for obtaining all of the company's work projects.

On November 5, 2008, Petitioner informed the court that he was instructed to report to work at a commercial building in Illinois at approximately 10:00 a.m. Petitioner indicated that the days tasks required him to refurbish an exterior window located on the second floor of a commercial building. To accomplish said task, Petitioner placed one foot on the top step of a stepladder and the other on the windowsill. Petitioner then had to reach out to the outside of the building in order to sand the exterior of the window. While sanding said window, Petitioner testified he lost his balance and fell forward out of the second story window. On his way down, Petitioner stated that he first fell through the building's awning prior to striking the concrete floor below. Petitioner testified his coworkers including the project supervisor, Frank Rojas' sister, helped him off the ground and brought him inside. An ambulance was not called, but instead the Petitioner was driven home prior to finishing his shift.

Once home the Petitioner consulted with this wife and decided to seek emergency medical attention. Petitioner was admitted into Presence Mercy Medical Center on November 5, 2008 and hospitalized until November 7, 2008. (Petitioner's Exhibit 5). At that time the Petitioner was diagnosed with a right wrist fracture as well as a pubic rami fracture of Petitioner's pelvis. *Id.* In order to treat Petitioner's injuries Presence Mercy Medical Center hospitalized the Petitioner and conducted x-rays of Petitioner's right wrist and pelvis, prescribe various pain medications like morphine, as well as casted Petitioner's wrist. *Id.*

After being discharged from Presence Mercy Medical Center, the Petitioner sought treatment with Dreyer Medical Clinic. The Petitioner began his treatment on November 12, 2008.

(Petitioner's Exhibit 6). At this appointment the provider verified that the Petitioner was suffering from a loss of range of motion in the right wrist. *Id.* The medical records further indicate the Petitioner could ambulate even with the pelvis fracture, but could only do so with difficulty. *Id.* Petitioner's wrist/thumb was also immobilized with a spica splint. On Decmeber 31, 2008, Petitioner was again seen at Dreyer Medical Clinic. The medical provider indicated Petitioner's pelvis was healing well but Petitioner continued to suffer from right wrist pain. *Id.* At this time Petitioner's wrist was recasted and told to return for a follow up in one month. On January 30, 2009, Petitioner returned for a follow up. During Petitioner's appointment he was informed that the radiographs showed an acceptable alignment of his fractures. As a result he was recommended he start occupational therapy to help regain his range of motion in his wrist. *Id.* According to Petitioner's testimony, he began physical therapy with Dreyer Medical Center shortly thereafter on February 11, 2009. Petitioner underwent four formal sessions of Physical therapy before concluding his treatment with Dreyer Medical on March 20, 2009. *Id.* On said date, Dryer Medical Center indicated Petitioner's range of motion was nearly intact, but still lacked full range of motion. *Id.* Given these results, Petitioner was recommended to gradually increase his activity with the right hand as tolerated and could also begin to perform weight bearing exercises as tolerated. *Id.* As of March 20, 2009, Petitioner indicated that he has not continued with further medical treatment for either his right wrist or his pelvis. The Arbitrator notes that the medical records end on March 20, 2009.

Petitioner is claiming TTD benefits for November 6, 2008 to March 20, 2009 representing 19.4 weeks.

Petitioner testified that he never returned to work with Historic Home and Window Restoration. Petitioner said he was able to find new employment elsewhere at or around May of 2009 working for a roofing company at approximately the same rate of compensation.

II. CONCLUSIONS OF LAW

In deciding this matter the Arbitrator notes Petitioner has the burden of proving all disputed issues of his case by a preponderance of the evidence. Chicago Rotoprint v. Industrial Comm'n, 157 Ill.App.3d 996, 1000 (1987). Petitioner must prove each element of his claim without reliance on speculation or conjecture. Airlines v. Comm'n, 991 N.E.2d 458, 463 (2013).

Upon considering Frank Rojas' as well as the Petitioner's testimony and reviewing all the evidence, the Arbitrator finds no reason to question the credibility of the Petitioner. Accordingly, this decision relies heavily on Petitioner's credible testimony and the evidence provided in making the following conclusions of law:

a. Respondent was operating under and subject to the Illinois Workers' Compensation Act.

The Arbitrator finds the evidence tendered and both Petitioner's and Respondent's testimony to be credible and hereby holds Historic Home and Window Restoration was operating under and subject to the Illinois Workers' Compensation Act.

The Petitioner informed the court that he was injured on November 5, 2008, at a jobsite located in the state of Illinois. Petitioner further indicated that all subsequent medical care occurred within the state of Illinois. Moreover, Petitioner testified that he worked in an extra hazardous business that engaged in the maintaining, remodeling, and altering of historic homes and windows. Given that the Petitioner was engaged in construction work, which required him to climb ladders to reach tall heights and work in front of open windows, Section 3 of the Illinois

Workers Compensation Act shall be applied.

b. An Employee-Employer relationship does exist between Petitioner and Respondent –Employer.

The Arbitrator relies on the testimony of the Frank Rojas of Historic Home and Window Restoration in finding an Employee-Employer relationship existed on November 5, 2008 between the Petitioner and Historic Home and Window Restoration.

Frank Rojas, Owner/President of Historic Home and Window Restoration, testified to hiring the Petitioner to perform general carpentry work and other tasks as required. Mr. Rojas testified that he controlled all major aspects of Petitioner's employment with Historic Home and Window Restoration. In fact, Mr. Rojas indicated that he instructed the Petitioner what to do at the start of each individual job, controlled Petitioner's work schedule, instructed the Petitioner on when he was allowed to end for the day, and provided Petitioner's equipment to perform his tasks.

c-d. An accident occurred on November 5, 2008, which arose out of and in the course of Petitioner's employment.

The Arbitrator holds that Petitioner sustained an accident on November 5, 2008, which arose out of and in the course of Petitioner's employment. In reaching this conclusion the Arbitrator relies on Petitioner's credible description of the mechanism of injury, falling out of a second story window, and the medical evidence that was submitted into evidence. Furthermore, the Arbitrator notes that the testimony provided by Frank Rojas of Historic Home and Window Restoration did not refute the Petitioner's accident occurred.

e. Petitioner gave Respondent-Employee timely notice of the November 5, 2008 accident.

The Arbitrator finds that subsequent the work accident of November 5, 2008 Petitioner gave timely notice to both his supervisor as well as Frank Rojas, owner of Historic Home and Window Restoration.

On direct examination the Petitioner indicated that after falling out of the second story window on November 5, 2008, he was assisted by his coworkers and the project site supervisor inside the building where work was being done. Furthermore, Frank Rojas confirmed that at the time Petitioner was brought inside, he received a phone call from the project site supervisor notifying him of Petitioner's fall. After a review of this uncontested evidence, it is clear that Historic Home and Window Restoration was provided with immediate verbal notice of Petitioner's accident on the date of accident via the project site supervisor's call to Frank Rojas.

f. Petitioner's current condition of ill-being is casually related to his November 5, 2008 injury.

The Arbitrator finds that Petitioner's current condition of ill-being is related to the work accident of November 5, 2008.

According to the Petitioner, he sought medical attention with Presence Mercy Medical Center on November 5, 2008. The medical records from Presence Mercy Medical Center indicate that Petitioner suffered a right wrist fracture as well as a pubic rami fracture of Petitioner's pelvis. (Petitioner's Exhibit 5). Given that Petitioner's account of the mechanism of injury is well founded and given the medical treatment relates to said accident, Petitioner's current condition is related to the work accident of November 5, 2008.

g. Petitioner earned $450.00 per week during his employment with Historic Home and Window Restoration.

According to Petitioner's credible and uncontested testimony on direct examination, his yearly earnings preceding the injury were $23,400.00 with a corresponding average weekly wage of $450.00. Furthermore, when asked how he was compensated for his work, Petitioner stated that Historic Home and Window Restoration paid a total of $450.00 a week. Based on Petitioner's credible testimony, his average weekly wage is $450.00 with a corresponding rate of $320.00 for TTD and PPD based on the state minimum rate for four claimed dependents.

h-i. Petitioner was Petitioner was 42 years old, married with 3 children all under the age of 18.

At trial the Petitioner testified to being 42 years of age on November 5, 2008, when he was injured while working for Historic Home and Window Restoration. Petitioner further testified that at the time of the accident he had three minor children all under the age of 18. (Petitioner's Exhibit 4).

j. Any and all medical services provided by Presence Mercy Medical Center and Dreyer Medical Center were reasonable and necessary.

The medical records submitted into evidence are consistent in showing the care and treatment provided to the Petitioner was reasonable and necessary. Not only do the records adequately document the mechanism of injury, but they also provide a clear causal connection between Petitioner's treatment and his accident at Historic Home and Window Restoration. Furthermore, a review of the records show that the Petitioner had x-rays taken, prescribed pain medication, and performed several sessions of physical therapy for a well-documented wrist fracture prior to being released from care.

Regarding payment of the aforementioned treatment, the Petitioner testified credibly that the Respondent, Historic Home and Window Restoration, did not pay any of his medical bills. Rather the Petitioner was forced to make out of pocket payments for all of his necessary medical

treatment. Accordingly, the Arbitrator awards all medical bills entered into evidence, which includes bills from Presence Mercy Medical Center and Dreyer Medical Center, and orders the Respondent pay said bills in accordance with section 8.2 of the "Act". (Petitioner's Exhibit 5, 6).

k. Respondent owes Petitioner TTD benefits as a result of the injuries sustained on November 5, 2008.

After reviewing the medical records in evidence and considering Petitioner's testimony, the Arbitrator finds the Respondent owes Petitioner 19.4 weeks in TTD benefits. The medical records reviewed indicate the Petitioner was off work or provided with restrictions that the Respondent failed to accommodate from November 6, 2008 through March 20, 2009. It is important to note that Frank Rojas, Owner/President of Historic Home and Window Restoration, did not dispute the Petitioner was unable to work as a result of his accident on November 5, 2008. As a result the Petitioner is awarded $6,208.00 representing 19.4 weeks of TTD at a rate of $320.00.

l. Petitioner has sustained partial and permanent disability due to the injuries sustained at work.

Based upon the evidenced presented the Arbitrator finds that the Petitioner is permanently partially disabled to the extent of 5% person as a whole, under Section: 8(d)2 of the "Act" for Petitioner's undisplaced pelvic fracture and an additional 25% loss of the use of the Petitioner's hand for his right wrist and navicular fracture.

o. Notice to the Respondent was proper and the Respondent IWBF liable for all awarded workers' compensation benefits to the Petitioner.

A review of the facts indicate that the Respondent was properly provided with notice of the November 5, 2008.

In the case at hand, Respondent was present on the July 7, 2015 trial date. At that time Mr. Frank Rojas as well as a representative of from the Attorney General's office met with the Arbitrator and were

provided with the final August 5, 2015 trial date. On August 5, 2015 all parties were present before the Arbitrator; including Frank Rojas from Historic Home and Window Restoration.

Given that the record clearly shows that Frank Rojas as representative of Historic Home and Window Restoration attended the trial date of August 5, 2015, this court finds that the Respondent was provided with proper notice and required under the "Act".

With regards to the liability of Illinois Worker's Benefit Fund, a review of the record shows that a certificate from the National Council on Compensation Insurance was tendered into evidence (Petitioner's Exhibit 2). A review of the certification shows that on November 5, 2008 Historic Home and Window Restoration, Inc. was operating without worker's compensation insurance as required by the state of Illinois [Petitioner's Exhibit 2]. As a result of Respondent's lack of insurance coverage, James Ellis Gumbiner & Associates named the IWBF as a named party to Petitioner's filed Application for Adjustment of Claims.

Given that IWBF was properly named on Petitioner's filed Application for Adjustment of Claims for date of accident November 5, 2008, and given the lack of worker's compensation insurance coverage by Historic Home and Window Restoration, Inc. at the time of the accident, this court finds the IWBF liable for providing Petitioner with workers' compensation benefits.

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LIZON, JOHN Case# **09WC043267**
Employee/Petitioner

POST GENERAL CONTRACTORS LLC
Employer/Respondent

On 11/6/2015, 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 0.28% 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:

1993 ROMANUCCI & BLANDIN LLC
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ERIC MONTOYA
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

John Lizon
Employee/Petitioner

Case # 09 WC 43267

v.
Post General Contractors, LLC
Employer/Respondent

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Arbitrator Lynette Thompson-Smith, Arbitrator of the Commission, in the city of Chicago, on 8/21/15. 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 05-14-2009, 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.

In the year preceding the injury, Petitioner earned $62,400.00; the average weekly wage was $1,200.00 .

On the date of accident, Petitioner was 38 years of age, married , with 2 children under 18.

Respondent shall be given a credit of $148,457.14 for TTD, $ 0 for TPD, $100,571.45 for maintenance, and $7,200 (PPD advance) for other benefits, for a total credit of $256,228.59 .

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

ORDER

Respondent shall pay Petitioner maintenance benefits from December 4, 2012 to August 21, 2015.

The Respondent shall pay Petitioner permanent partial disability benefits of $664.72/week for 250 weeks (less PPD credit of $7,200), because the injuries sustained resulted in permanent partial disability of 50% loss of the man as a whole, as provided in Section 8(d)(2) of the Act.

Respondent shall be given a credit of $148,457.14 for temporary total disability benefits, $100,571.45 for maintenance, and $7,200 (PPD advance) for other benefits, for a total credit of $256,228.59.

Respondent shall pay Petitioner penalties of $1,000.00, pursuant to Section 19(k) of the Act, penalties of $10,000.00, pursuant to section 19(l) of the Act, and attorney's fees of $2,548.57, pursuant to 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 of 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.

FINDINGS OF FACT

The disputed issues in this matter are: 1) causal connection; 2) maintenance; 3) penalties; 4) attorney's fees; and 5) the nature and extent of Petitioner's injuries. *See*, AX1.

Mr. John Lizon, ("Petitioner") was employed by Post General Contractors, LLC. ("Respondent") as a superintendent/project manager. Petitioner testified that his job required him to "run all the trades, take care of job conditions and anything else that was not covered by the subcontractors". Petitioner was hired in October of 2008 and supervised a renovation project at the Shrine Nightclub in Chicago. Petitioner was required to move material including concrete bags, wood and metal studs. Petitioner was also responsible for supervising all the subcontractors, working with plumbing, masonry and ventilation.

On May 14, 2009, the petitioner was working on a ladder when it collapsed. Petitioner fell to the ground and landed on his left shoulder and "smashed" his left hand. Petitioner was taken via ambulance to Mercy Hospital. The admitting diagnosis was left shoulder arm pain and Petitioner complained of pain in his left shoulder, arm and hand. X-rays of the left shoulder and elbow did not reveal any fractures. An x-ray of the left wrist revealed a non-displaced fracture. Petitioner was advised to remain off work and was referred to an orthopedist for further evaluation. PX1.

On May 15, 2009, the petitioner presented to OAD Orthopedics. He was evaluated with respect to his left wrist complaints by Dr. Anup Bendre, an orthopedic surgeon. Dr. Bendre diagnosed the petitioner with a distal, radius fracture and a median nerve injury and recommended surgery. PX2.

On that same day, Petitioner was evaluated by Dr. Aaron Bare, regarding his left shoulder complaints. Updated x-rays of the left shoulder did not reveal any fractures. Range of motion testing in the cervical spine did not reproduce shoulder pain. Dr. Bare diagnosed petitioner with a left shoulder contusion with possible internal derangement. Dr. Bare kept the petitioner off work and advised him to rest his shoulder for three (3) weeks.

On May 19, 2009, Dr. Bendre performed an open reduction and internal fixation of the left distal radius fracture. Petitioner was kept off work and advised to begin physical therapy. On June 5, 2009, the petitioner returned to Dr. Bare for an evaluation of his left shoulder. Petitioner reported that his pain complaints were no better however; he denied any neck pain or radicular symptoms. On May 29, 2009, Dr. Bendre performed new x-rays of the left wrist and advised the petitioner that he could return to work, with restrictions. Ultracet and physical therapy were prescribed.

On June 5, 2009, Dr. Bare ordered an MRI of the left shoulder and on June 9, 2009, the petitioner began physical therapy.

On June 26, 2009, after reviewing the MRI films, Dr. Bare diagnosed Petitioner as having a non-displaced fracture of the acromial end of the distal clavicle. Dr. Bare released the petitioner to return to work with a fifty (50) pound lifting restriction and advised him to continue physical therapy.

Petitioner returned to Dr. Bendre on August 21, 2009, reporting "puffiness"/soreness in the palmar aspect of his index finger, with gripping. Dr. Bendre performed a carpal tunnel injection and advised him to continue therapy and to remain off work. PX2.

Petitioner returned to Dr. Bare on August 21, 2009. Petitioner was pleased with his progress regarding the left shoulder, as he had a full range of motion with intact strength. Petitioner had minimal pain with cross arm adduction. Dr. Bare placed the petitioner at MMI and released him to full duty, with respect to the left shoulder.

Petitioner returned to Dr. Bendre on September 21, 2009, who noted that Petitioner's fracture had healed without complications. Petitioner complained of persistent pain in the volar radial aspect of his wrist brought on/aggravated by holding a bowling ball and pushing a stroller. Dr. Bendre recommended hardware removal surgery, which was performed on October 19, 2009. Dr. Bendre prescribed additional therapy and light duty work restrictions. PX2.

On October 26, 2009, Petitioner sought a second opinion regarding his left shoulder, with Dr. Howard Freedberg of Suburban Orthopedics. Dr. Freedberg diagnosed Petitioner with left shoulder impingement and x-rays revealed a healed distal clavicle fracture. Dr. Freedberg injected Petitioner's left shoulder and recommended additional physical therapy. PX4.

Petitioner continued to treat with Dr. Bendre for his left wrist. On October 30, 2009, additional physical therapy was ordered and Petitioner's light duty restrictions were continued. Petitioner returned to Dr. Bendre on December 7, 2009, who recommended an updated MRI of his left wrist. PX3.

On December 15, 2009, an MRI of the left wrist was read to show post-operative changes of the distal radius, a mild strain of the pronator quadratus muscle and mild degenerative arthritis of the radial clavicle joint. Petitioner stopped therapy for his left wrist on January 5, 2010.

On December 18, 2009, Petitioner was examined by Dr. Sandeep Jejurikar, by request of Respondent. Dr. Jejurikar diagnosed the petitioner as having flexor tenosynovitis which was causally related to his work injury. He also stated that the medical treatment, to date, was reasonable and necessary, that the petitioner required light duty restrictions and would benefits from either more injections or possible surgery. PX12.

On January 5, 2010, Petitioner completed physical therapy on his left wrist and on January 8, 2010, Dr. Bendre reviewed the MRI of the left wrist and discussed the Section 12 exam report with him and the nurse case manager. The doctor offered to either do another surgery or the petitioner could try work conditioning and then a functional capacity evaluation, ("FCE"). Petitioner chose to think about it and in the meantime, Dr. Bendre prescribed work conditioning. PX3, p. 77-79.

On January 11, 2010, petitioner returned to Dr. Freedberg, who diagnosed him with a cervical strain and posterior nerve root irritation. This is noted to be approximately eight (8) months after the accident. Petitioner was advised to continue therapy and remain off work. PX4.

After three days of work conditioning, the petitioner self-terminated the program due to pain complaints. Petitioner returned to Dr. Bendre on January 22, 2010, complaining of pain at the base of his thumb joint. Dr. Bendre opined that Petitioner's pain may be related to flexor tendon adhesions and/or tenosynovitis at the level of the carpal tunnel. Dr. Bendre recommended a tenosynovectomy of the flexor tendons and a carpal tunnel release. PX3.

Petitioner returned to Dr. Freedberg on February 22, 2010, and was released to return to work full duty for his left shoulder. On February 25, 2010, the petitioner underwent a tenosynovectomy of the digital flexor tendon as well as a carpal tunnel release. On March 2, 2010, Petitioner restarted physical therapy at OAD Orthopedics.

On April 19, 2010, Petitioner returned to Dr. Freedberg, reporting that he was feeling 85-90% overall improved. Petitioner was released to return work full duty for his left shoulder. Petitioner completed physical therapy for his left wrist on May 13, 2010 and returned to Dr. Bendre on May 17, 2010 reporting that his complaints were no better after surgery. Dr. Bendre recommended a second opinion or an FCE.

On May 13, 2010, he completed physical therapy on the left wrist at OAD and on May 17, 2010, Dr. Bendre recommended a second opinion or repeat IME and an FCE. Petitioner advised Respondent that he then wanted a second opinion with Dr. Charles Carroll at Northwestern for his left wrist. On May 21, 2010, nurse case manager Linda Savage of Alaris Group was placed on the file by Respondent. Petitioner testified that the respondent did not authorize the FCE or the second opinion with Dr. Carroll. On June 3, 2010, Dr. Freedberg released him at MMI for the left shoulder. PX3, pp. 22-24.

Petitioner returned to Dr. Freedberg on June 3, 2010, complaining of periodic discomfort when holding something or laying down. Petitioner reported that he was not taking medication or undergoing therapy. Dr. Freedberg released the petitioner to return to work in a full duty capacity and placed him at MMI for his left shoulder.

Petitioner underwent an IME with Dr. Sandeep Jejurikar on June 8, 2010 regarding his left wrist. Dr. Jejurikar recommended additional work hardening and an FCE. Dr. Jejurikar believed that the petitioner may require some level of permanent restrictions.

Petitioner returned to Dr. Bendre on June 18, 2010. Work conditioning and a second functional capacity evaluation were ordered. On July 6, 2010, petitioner began work conditioning at AthletiCo. PX3 & 7.

Petitioner testified that on July 8, 2010, a 19(b)/8(a) emergency and penalty petition had to be filed for August 17, 2010, before then Arbitrator Peterson, to reinstate TTD that had not been paid since June 27, 2010. On August 1, 2010, Adjuster Ladonna Allen issued a check in the amount of $3,200.00, for four (4) weeks of TTD arrearage. PX17.

The petitioner completed an FCE on August 5, 2010, which was determined to be valid and stated that the petitioner could function at the "light-medium" (up to 40 pounds) physical demand level. It was recommended that Petitioner have additional work conditioning in order to attain the medium level ability, required by his job duties.

On August 9, 2010, Petitioner returned to Dr. Bendre, complaining of pain in his thumb and index finger. Dr. Bendre released the petitioner to return to work with permanent restrictions of no lifting greater than forty (40) pounds with either extremity and he was placed at maximum medical improvement ("MMI"). PX3.

Petitioner testified that the respondent did not take him back with his restrictions and he did not receive any TTD. Petitioner states that on August 30, 2010, his attorney appeared before then Arbitrator Peterson, where Respondent's attorney advised that he was awaiting a response from the adjuster, as to status of TTD issuance, thus Arbitrator Peterson continued the case to September 2, 2010 for status on the issuance of TTD. Petitioner's attorney also states that on September 2, 2010, respondent's attorney advised that the TTD check was issued and that the adjuster would authorize the second opinion with Dr. Carroll so Arbitrator Peterson returned the case to the call. On September 5, 2010, Petitioner received the TTD that was owed from August 9, 2010. Petitioner testified that he was aware that on October 11, 2010, another 19(b) and penalty petition was filed for October 19, 2010 before Arbitrator Peterson because the adjuster still had not sent written authorization for him to see Dr. Carroll. Petitioner also testified that the respondent was no longer in business and that he could not perform his former job as a project manager, with his current, permanent restrictions. PX17.

Petitioner finally presented to Dr. Charles Carroll IV of NorthShore Orthopedics on November 22, 2010. Petitioner complained of numbness and tingling in his thumb and index finger along with pain

in his index, long and small fingers. Dr. Carroll diagnosed petitioner with carpal tunnel syndrome and recommended an EMG study of Petitioner's left upper extremity. PX9.

Petitioner testified that in late December 2010, there was another delay in TTD payment. He had not been paid since December 19, 2010 and the adjuster had not authorized the EMG, so he was aware that another 19(b) and penalty petition was filed on January 18, 2011 for February 17, 2011 before Arbitrator Peterson. On March 7, 2011, Petitioner received his TTD check for December 20, 2010 through March 7, 2011, in the amount of $8,800.00 which was eleven weeks of benefits. Petitioner testified that at least eleven (11) 19(b) and penalty petitions had to be filed during the course of the case because Respondent continuously did not pay TTD or authorize treatment timely, sometimes for periods of up to eleven (11) weeks at a time. Tr. pp. 49-50, 53; PX17.

Petitioner testified that on April 11, 2011, he received a bill from Respondent's Section 12 examiner, Dr. Jejurikar because the adjuster did not pay the bill. Petitioner testified that in April 2011, there was another issue with TTD being paid timely since April 4, 2011 so another 19(b) and penalty petition was filed on April 21, 2011 for May 17, 2011 before Arbitrator Peterson. On May 2, 2011, petitioner underwent the EMG that Dr. Carroll prescribed on November 22, 2010, almost seven months prior. On May 23, 2011, Petitioner received TTD owed from April 19, 2011 through May 30, 2011, in the amount of $4,800.00. Petitioner testified that on May 24, 2011, the adjuster began sending the TTD checks directly to his attorney so that the attorney could monitor when TTD was late. Tr. pp. 51-54; PX17; PX9, pp. 55, 231-235; PX17.

Petitioner testified that in September of 2011, he was still awaiting written authorization to be sent to Dr. Carroll, to be seen in follow-up after the EMG, so another 19(b) and penalty petition was filed on September 19, 2011 for October 18, 2011 before Arbitrator Dollison. Petitioner testified that he was finally able to see Dr. Carroll on November 29, 2011, who after his review of the May 2, 2011 EMG, which was done six months earlier. He diagnosed him with a median nerve compression, prescribed surgery and continued his work restrictions.

Petitioner testified that in October 2011, there was another issue of TTD not being paid. Another 19(b) and penalty petition was filed on November 30, 2011 for December 15, 2011 before Arbitrator Thompson-Smith because TTD had not been paid since October 10, 2011. Petitioner testified that on December 7, 2011, he finally received TTD from October 11, 2011 through December 7, 2011, in the amount of $6,400.00. On December 27, 2011, the case was returned to the call by Arbitrator Thompson-Smith because Respondent's attorney advised that TTD was paid through December 21, 2011 and that adjuster was awaiting the full November 29, 2011 report of Dr. Carroll, to determine if surgery would be authorized. Tr. pp. 54-56; PX9, pp. 54, 237-238; PX17.

On February 21, 2012, another 19(b) and penalty petition was filed for March 15, 2012 before Arbitrator Thompson-Smith because TTD was not paid since February 1, 2012 and surgery still was

not authorized. On March 27, 2012, a new adjuster named Myrna Castaneda was placed on the file and the case was continued by Arbitrator Thompson-Smith because respondent's attorney advised that TTD was issued by new adjuster and that TTD would be paid timely from now on. Later in the day on March 27, 2012, Petitioner received his TTD check for February 20, 2012 through March 20, 2012, in the amount of $5,371.45.

On May 15, 2012, a new case manager named Marianne Drafkey was placed on the file to procure authorization for Dr. Carroll to perform surgery. On June 11, 2012, Petitioner was able to see Dr. Carroll in a follow-up since his November 29, 2011 visit, and schedule surgery for July 17, 2012. On June 29, 2012, Petitioner had his pre-operation testing, and on July 17, 2012, Dr. Carroll performed surgery, consisting of revision, exploration and decompression of left median nerve at carpal tunnel, hand and forearm and microneuroplasty of median nerve. On July 30, 2012, Dr. Carroll prescribed physical therapy and on August 1, 2012, Petitioner began physical therapy at AthletiCo. Tr. pp. 35-58; PX10, pp. 25-27; PX9, pp. 28-31, PX17.

On September 10, 2012, Dr. Carroll advised him to continue in physical therapy, which Petitioner completed on October 25, 2012. On October 29, 2012, Dr. Carroll prescribed an FCE. On November 14, 2012, petitioner underwent the FCE at AthletiCo which was noted to be valid; and recommended that he could return to work in a sedentary to light physical demand level job with a twenty (20) pound maximum occasional lifting restriction on the left extremity. On December 3, 2012, Dr. Carroll advised him to continue home exercise program and released him at MMI, with permanent restrictions per the November 14, 2012 FCE.

Petitioner testified that his employer did not take him back to work with the restrictions so Respondent began paying maintenance benefits as of December 4, 2012, but did not immediately commence vocational rehabilitation. Tr. pp. 60-64; AX1.

Petitioner testified that on December 11, 2012, he still had pain for both the left shoulder and left wrist. He wanted to see Dr. Freedberg for the left shoulder but needed authorization to be seen and to get another second opinion doctor regarding the left wrist. On March 4, 2013, Arbitrator Thompson-Smith returned the case to the call, since respondent's attorney advised that maintenance was being paid and that he was awaiting a response from the adjuster as to whether they would authorize the appointment with Dr. Freedberg for the left shoulder; and authorize a second opinion doctor for the left wrist. They also needed to do another Section 12 exam or commence vocational rehabilitation.

Petitioner testified that there was another issue with his TTD/maintenance benefits not being paid in late March 2013 so on April 5, 2013, another 19(b) and penalty petition was filed for May 15, 2013 before Arbitrator Thompson-Smith in order to get respondent to authorize appointments, commence vocational rehabilitation, and pay TTD/maintenance.. On April 30, 2013, Petitioner received his TTD/maintenance for March 27, 2013 through April 23, 2013, in the amount of $3,200.00 from the

new adjuster, Jeff Mazich. On June 4, 2013, Arbitrator Thompson-Smith returned the case to the call because respondent's attorney advised that TTD/maintenance was again being paid and that Ms. Mary Schmit of Triune would be contacting Petitioner's attorney to schedule an initial vocational rehabilitation meeting. PX17.

On May 2, 2011, Petitioner underwent the EMG study, which findings suggested the presence of median neuropathy. Petitioner returned to Dr. Carroll on November 29, 2011 to review the EMG study results and Dr. Carroll diagnosed him as having median nerve compression and recommended a left median nerve exploration and release. He released the petitioner to return to work with a forty (40) pound lifting restriction. PX9.

Petitioner returned to Dr. Carroll on June 11, 2012, complaining of pain in his left hand. Dr. Carroll examined Petitioner's left shoulder and did not find any abnormalities. Petitioner had positive Phalen's and Tinel's tests and was diagnosed with carpal tunnel syndrome. Dr. Carroll recommended a left carpal tunnel revision and release. On July 17, 2012, petitioner underwent a left median nerve decompression and carpal tunnel release and remained off work.

On August 1, 2012 Petitioner began physical therapy at AthletiCo. Petitioner returned to Dr. Carroll on September 10, 2012 complaining of ulnar numbness since the last surgery. Petitioner was advised to continue physical therapy, which he completed. Petitioner returned to Dr. Carroll on October 29, 2012, who recommended work conditioning and an FCE.

On November 29, 2012, Petitioner underwent an FCE at AthletiCo. The examiner noted that the petitioner's physical demands of his pre-injury job as a carpenter were identified as "very heavy" per the Department of Transportation ("DOT"). The examiner did not have a functional job description from the employer. The FCE determined that Petitioner could function at the sedentary to light level of work and he had no limitations with respect to standing, walking, sitting, balancing, stooping, crouching, or climbing. Petitioner was limited to lifting 20 pounds from floor to 31 inches and 10 pounds from floor to 61 inches. Petitioner was able to carry 20 pounds up to 100 feet, push and pull 25 to 35 pounds and climb a ladder up to 8 feet. The test results were deemed valid. PX8.

Petitioner returned to Dr. Carroll on December 3, 2012, who determined that he had reached maximum medical improvement. The doctor released the petitioner to return to work with permanent restrictions per the functional capacity evaluation. PX9.

Petitioner testified that after his release from care, he did not begin searching for work. Petitioner testified that he could not return to respondent's employ as they had ceased operations in 2010. He further testified that several months later, he met with Ms. Mary Schmit, a certified rehabilitation counselor with Triune Health Group. The initial vocational assessment took place on May 13, 2013. According to the initial vocational assessment, the petitioner had worked as a

construction/superintendent for Post General Contractors for eight months before the accident. Petitioner previously worked as a project manager/construction superintendent for another company known as Single Site Solutions for approximately ten (10) years. Petitioner also ran his own home remodeling business for seven (7) years. RX1.

A transferable skills analysis was performed and determined that Petitioner was employable at the sedentary to light physical demand level, based upon his previous work experiences and skills. Ms. Schmit identified positions within that demand level that Petitioner would be qualified to perform. She targeted positions such as construction supervisor, foreman, maintenance manager, construction inspection, lumber estimator and a construction estimator. According to Ms. Schmit's initial assessment, the plan was to have him apply for positions within the construction trade that were within his permanent restrictions.

Petitioner returned to Dr. Howard Freedberg on June 17, 2013, complaining of left shoulder and left wrist pain. Petitioner stated that his left shoulder pain had worsened and complained of pain behind his left shoulder blade. Petitioner reported that his left wrist pain was worse than before surgery with Dr. Carroll. Petitioner had a normal physical examination except for positive tenderness to palpation in the cervical spine. X-rays of the left shoulder were normal. Cervical spine x-rays revealed C4 osteophytes. Petitioner was diagnosed with left shoulder bursitis/tendonitis and cervical referred rhomboid pain. Petitioner was referred to Dr. Dmitry Novoseletsky, a pain management physician, for further evaluation. PX5.

On June 25, 2013, the petitioner was evaluated by Dr. Novoseletsky, complaining of constant pain in his shoulder blade area. Dr. Novoseletsky performed a left subscapular injection. Petitioner was instructed to return in two weeks. Petitioner returned to Dr. Novoseletsky on July 9, 2013, stating that the injection helped for three to four days. Petitioner was diagnosed with cervical spondylosis and scapular pain. Petitioner was recommended to have injections at the C3, C4 and C5 level.

Petitioner testified that he began searching for work in the construction industry in July of 2013, contacting 20 to 30 potential employers a week. Petitioner obtained interviews within the first few weeks of searching for work however; he never received a job offer. On cross-examination, Petitioner admitted that he received one job offer from a demolition company. He testified that he did not accept the position as the job required him to help load trucks in addition to his superintendent duties.

Petitioner continued to search for work as a project manager/construction superintendent for the remainder of 2013 and into 2014. The petitioner's job search is documented in the vocational reports. The reports indicate that petitioner received approximately one interview a month for positions in construction/project management field. RXs 2–11.

On July 28, 2014, the petitioner accepted a volunteer position with Projx Construction. Petitioner volunteered from July 28 through August 4, 2014 as a project manager. Petitioner testified that he was not paid. Petitioner testified that the purpose of the volunteer position was to determine if he could physically perform the work that was required. Petitioner testified that he qualified bids, put together schedules and "did stuff on permitting". He testified that he performed all the duties of a project manager.

According to the vocational progress report, the petitioner was not offered a position after the volunteer period ended. Petitioner was told that if the company's business increased, he would be considered for a job. RX12.

Petitioner continued his job search throughout the remainder of 2014. He received several interviews for project management positions. Petitioner did not receive any job offers at this time. RXs 12–15.

On January 16, 2015, the petitioner returned to Dr. Carroll. Petitioner complained of pain in his palm with forceful gripping along with pain and stiffness radiating to the index and small finger. Petitioner's left wrist examination revealed pain with flexion. Petitioner had a normal left shoulder examination. Petitioner was diagnosed with pain from the radioscaphoid joint and an old fracture. Dr. Carroll released Petitioner to return to work, with permanent restrictions of sedentary to light duty. Petitioner told Dr. Carroll that he wanted a referral for a different opinion. Dr. Carroll provided Petitioner with a referral to Dr. Michael Vender. PX10.

Petitioner testified that he continued to search for work in the project management/construction superintendent field. The vocational progress reports document several more interviews for project manager positions. RXs 16-18.

On April 28, 2015, the petitioner underwent an IME with Dr. Kevin Walsh, who determined that the petitioner had a relatively normal physical examination. Petitioner had a negative Tinel's and Phalen's test and good range of motion in his wrist. Petitioner had full strength and range of motion in his shoulders. Dr. Walsh also reviewed a surveillance video and noted that the petitioner was participating in activities of daily living without any obvious restrictions. Dr. Walsh opined that petitioner's pain complaints were disproportionate to his injury, given the healed fracture. Dr. Walsh felt the FCE restrictions were far too limiting for the petitioner's diagnosis and physical examination. Dr. Walsh determined that Petitioner had reached MMI and was capable of returning to work full duty. In his April 28, 2015 Section 12 exam report, Dr. Walsh opined that his diagnoses were consistent with the diagnoses of the prior Section 12 examiners, but that all of Petitioner's current subjective complaints were not related to his May 14, 2009 accident, based on the length of time. Petitioner testified that his appointment was set for 9:00am but when he got there, he was told it was not till 2:00 p.m. so he had to leave and come back. He further testified that once he was seen by Dr. Walsh, the appointment lasted between 5-10 minutes.

On April 30, 2015, Arbitrator Thompson-Smith continued the case because Respondent's attorney advised that he was awaiting receipt of the April 28, 2015 Section 12 exam report. Tr. p. 83; RX21.

Petitioner testified that on May 21, 2015, he received a fax from respondent's counsel that no further maintenance would be paid, based on the Section 12 exam report of Dr. Walsh. On May 28, 2015, Arbitrator Thompson-Smith continued the case for trial to August 21, 2015 and recommended that respondent make an advance permanent partial disability payment.

On June 18, 2015, another 19(b) and penalty petition was filed for July 7, 2015 before Arbitrator Thompson-Smith because Respondent had neither paid the PPD advance or maintenance since May 7, 2015. Petitioner testified that on June 25, 2015, he finally received the December 27, 2013 Section 12 exam report of Dr. Wysocki; and on June 30, 2015, Petitioner and Ms. Schmidt were advised that vocational rehabilitation was being terminated by the respondent.

On June 30, 2015, formal vocational rehabilitation ceased and the petitioner testified that he continued to search for work on his own. He testified that he had a few job interviews but no offers of employment.

Petitioner testified that on July 24, 2015, he received the $7,200.00 PPD advance check. On July 29, 2015, Arbitrator Thompson-Smith noted that the case was already set for trial on August 21, 2015 and continued the pending penalty petition. Tr. p. 86; PX 17; RX 19.

Petitioner testified that he continued to look for jobs after he was advised that the vocational rehabilitation process was being terminated up through the trial date but still did not find any jobs or receive any job offers. Petitioner did not offer any job search logs into evidence from June 30, 2015 to the date of trial. Petitioner testified throughout the case, he would receive unpaid medical bills, several times before they were paid by the adjuster, but that now all medical bills have been paid or are being processed for payment by respondent. Tr. pp. 86-87; PX17; RX12.

Petitioner testified that he was paid TTD from May 15, 2009 through December 3, 2012; and maintenance from December 4, 2012 through May 7, 2015 and that at least eleven (11) 19(b)s and penalty petitions had to be filed during the course of the case because Respondent continuously refused to pay benefits or timely approve medical treatment.

Petitioner testified that he applied for social security disability, but did not remember when he applied. Petitioner believed that Ms. Schmit had recommended that he apply for SSDI. Petitioner also testified that he was denied benefits by the Social Security Administration and has not appealed the decision. Petitioner did not offer the denial letter into evidence.

Regarding his current left shoulder complaints, Petitioner testified that his left shoulder is "a big nuisance" but that he is "not in a great deal of pain". He testified that he experiences left shoulder pain if he sits too long or sleeps on his shoulder and when he drives. He testified that he is not really restricted with doing anything and testified that his strength is "fine" in his left shoulder.

Regarding his left wrist, Petitioner testified that he is in constant pain. He testified that he experiences pain in his index finger and thumb and numbness in his ring and pinky finger. Petitioner testified that he has decreased grip strength in his left hand, although he is not taking any narcotic pain medication for either his left shoulder or wrist. Petitioner testified that he takes non-prescription strength Aleve on a daily basis.

Regarding his current medical treatment, petitioner testified that he still wishes to see Dr. Michael Vender. He testified that he wants his left hand "fixed". Petitioner testified that he wishes to have further medical treatment as he "wants to return to the job he had before".

Petitioner testified that he feels he complied with vocational rehabilitation and that his earning capacity has been diminished, as he can no longer perform his usual and customary trade. Petitioner testified that no doctor has told him that it would be detrimental to his health or safety if he returned to work. Petitioner agreed that he did not have any restrictions on the amount of hours in a day that he could work and no restrictions with respect to sitting, standing or walking or with respect to his right upper extremity.

Petitioner testified that he bowls on a regular basis and that no doctor has told him that he cannot bowl. He testified that he primarily uses his right arm to bowl as he is right-handed. Petitioner admitted that he uses his left hand to stabilize the ball. He testified that he experiences pain when he bowls and drinks more while bowling, due to his pain complaints.

Petitioner believed that he is not physically capable of working and does not believe he can return to work in any capacity. Petitioner testified that he had applied for over 2000 positions and has been on "countless interviews" and "no one will hire me". Petitioner testified that he believes his problem is his education, as he does not have a college degree and the "big contractors" will not hire him.

Petitioner testified that he does not believe he is physically capable of performing a less physically demanding job in a different industry. Petitioner admitted that he only targeted jobs exclusively within the construction industry. These included jobs as a project manager, construction superintendent and construction sales. Petitioner testified that he never applied for any entry level unskilled jobs.

Petitioner denied ever working for Projx Construction. He denied having any contact with Projx prior to his volunteer period from July 28, 2014 to August 4, 2014. Petitioner was asked, on cross-

examination, whether he had ever been to a building located at 657 W. Lake Street in Chicago. Petitioner testified that he has been to that building numerous times as he "has a friend who works there" that he would visit from time to time.

Petitioner acknowledged that his name appeared on several documents, including records from the City of Chicago listing him as the point of contact for Projx Construction. The project was for a renovation at 657 W. Lake Street. Petitioner had no explanation for why he was listed as the main point of contact for Projx. Petitioner denied that he ever did anything more than volunteer for Projx Construction.

Respondent's first witness

Ms. Mary Schmit testified that she is a certified rehabilitation counselor and has worked as such since 2001. She often works with claimants that previously worked in the construction industry. Ms. Schmit testified that she has served as an expert witness in both workers' compensation cases and social security disability hearings. She testified that an individual typically must prove that they are unemployable for gainful wage in any occupation in order to receive social security disability.

Ms. Schmit testified regarding her initial vocational assessment of the petitioner, which was consistent with her report. Based upon Petitioner's skills, age and experiences, Ms. Schmit targeted positions within the construction trade; i.e., construction manager, superintendent, maintenance manager and lumber estimator. RX1.

Ms. Schmit testified that the goal of vocational rehabilitation is to return someone at the best and most appropriate occupation for that individual, provided those jobs are available. She makes every attempt to pursue positions that do not demean her clients and that provide her clients with the most income so that they can recapture the lifestyle they had prior to the injury. RX19.

Ms. Schmit further testified that Petitioner immediately generated interest from employers when he began his job search. He generated his own interviews within the first couple of months of searching for work and had a number of job interviews and second interviews. She testified that all the jobs were within the construction trade and that the petitioner was never encouraged to look for unskilled, entry level, minimum wage positions. She also testified that the petitioner never searched for work in a different industry.

Ms. Schmit testified regarding her opinion letter dated July 19, 2015, stating that Petitioner is employable to a reasonable degree of vocational certainty and that he is employable in a reasonably stable labor market. Ms. Schmit believed that he was still employable in the areas that they targeted, including construction management/supervisor.

Ms. Schmit explained that many jobs were lost in the construction market in Chicago and that over the last five or six years, the availability of construction jobs is only about half of what they were in 2000. She testified that the petitioner presents well and has a good work history and that his project list garnered a lot of attention from employers. She testified that petitioner was one of the final candidates in several of the jobs to which he applied however, he has not received a job offer, to date, due to the significant amount of competition for construction jobs.

Regarding the competition, Ms. Schmit cited to Bureau of Labor Statistics, which demonstrated that the loss of jobs and recovery of those jobs in the construction industry over the last several years has been less strong for construction management positions. She testified that the construction industry has not rebounded from the economic recession as compared to other industries and based upon these statistics, the competition, for construction management jobs, is significant.

Ms. Schmit testified that the petitioner may be a little bit more employable had he obtained a degree, and that it would benefit the petitioner to continue to look for work, as he is a young man and cannot afford to retire. Ms. Schmit testified that the petitioner could find work in the construction industry and that the range of pay would be between $50,000.00 and $75,000.00; based her statistics from the Department of Transportation as well as the Bureau of Labor Statistics for 2014. RX19.

She recommended junior college courses in construction estimating as those jobs were typically less physically demanding although she also testified that she was not instructed to enroll Petitioner in college level courses. She testified that many of those positions are commission only jobs. And finally she testified that the petitioner had performed a diligent job but unsuccessful job search and did everything she asked of him.

Respondent's second witness

Investigator Kevin Knop testified that he has been an investigator for twenty-six (26) years and works as a private investigator for Combined Investigations. He further testified that he was assigned to watch and record the petitioner in October and November of 2013. Mr. Knop's report along with a surveillance videotape, were admitted into evidence. The video showed the petitioner bowling at Fox Bowl on October 11, 2013. Petitioner's name was listed on a scoreboard as he is part of a bowling league for Stella's Pub. The video from November 1, 2013 showed the petitioner retrieving a bowling bag from his car and entering the same building. Petitioner played six games on two different lames. He used his right hand to bowl and left hand to hold the ball. He also used his left hand will drinking, leaning on a table and conducting celebratory high-fives. Mr. Knop personally identified the petitioner as the individual he watched on those days. RX23.

Respondent's third witness
Mr. Kyle Landes also testified that he was working as an investigator with PhotoFax, Inc., in July 2014 and that he was assigned to watch and record the petitioner on July 24, 2014. Mr. Landes' report and video was admitted into evidence. According to the video, the petitioner is seen leaving his house in Wheaton at 7:01 a.m., walking with a folder in his left hand as he entered his vehicle. At 8:18 am, the petitioner arrived at a vacant storefront located at 657 West Lake Street in Chicago and was observed entering an alley. The building was noted to be vacant and unfinished inside.

At 8:41 am, the petitioner was filmed walking to the driver side of his car and grabbing blueprint paper and a water bottle with his left hand. Petitioner then carried the blueprints and entered the building through the back alley entrance. Over the next several hours, petitioner was observed entering and exiting the back alley entrance of the building located at 657 West Lake. Petitioner was filmed conversing with individuals that arrived in the alley throughout that morning. Petitioner was observed entering and exiting the vacant storefront with a folder in his left hand. At 1:30 pm, petitioner was observed exiting the back alley with blueprint paper in his left arm. Petitioner placed the prints into his truck and returned inside the building. Petitioner eventually departed the area at 2:01 pm. RX24.

CONCLUSIONS OF LAW

F. Is Petitioner's current condition of ill-being causally related to the injury?
A decision by the Commission cannot be based upon speculation or conjecture. *Deere and Company v Industrial Commission*, 47 Ill.2d 144, 265 N.E. 2d 129 (1970). A petitioner seeking an award before the Commission must prove by a preponderance of credible evidence each element of the claim. *Illinois Institute of Technology v. Industrial Commission*, 68 Ill.2d 236, 369 N.E.2d 853 (1977). Where a petitioner fails to prove by a preponderance of the evidence that there exists a causal connection between work and the alleged condition of ill-being, compensation is to be denied. Id. The facts of each case must be closely analyzed to be fair to the employee, the employer, and to the employer's workers' compensation carrier. *Three "D" Discount Store v Industrial Commission*, 198 Ill.App. 3d 43, 556 N.E.2d 261, 144 Ill.Dec. 794 (4th Dist. 1989).

It is not enough that the petitioner is working when an injury is realized. The petitioner must show that the injury was due to some cause connected with the employment. *Board of Trustees of the University of Illinois v. Industrial Commission*, 44 Ill.2d 207, 214, 254 N.E.2d 522 (1969); see also *Hansel & Gretel Day Care Center v Industrial Commission*, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991).
Based upon the facts and medical evidence, the Arbitrator finds that the petitioner's current condition with respect to his left wrist and left shoulder is causally related to the accident of May 14, 2009. The

Arbitrator finds that petitioner's cervical spine complaints are not causally related to the accident of May 14, 2009. The petitioner did not testify to any current complaints with respect to his neck. His testimony was limited to his left wrist and left shoulder. The ER records from Mercy Hospital indicate that petitioner only sustained injuries to his left shoulder and wrist.

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 parties agreed, on the record, that the bills indicated on Arbitrator's Exhibit 1, have been paid or will be paid directly to the providers pursuant to the fee schedule. Based upon the parties' agreement on the record, the Arbitrator finds that there are no disputed issues regarding medical bills.

K. What temporary benefits are in dispute?

The petitioner was paid maintenance benefits from December 4, 2012 to May 7, 2015. Maintenance benefits were stopped after the petitioner was evaluated by Dr. Kevin Walsh. Petitioner seeks fifteen (15) additional weeks of maintenance benefits from May 8, 2015 through the date of trial, August 21, 2015. Petitioner testified that he continued to search for work after May 8, 2015. However, Petitioner did not offer any job search logs into evidence documenting a self-direct job search from May 8, 2015 to August 21, 2015. Petitioner testified that he believes he cannot return to work in any physical capacity. Based upon this, the Arbitrator finds that the petitioner has failed to meet his burden of proof for an award of maintenance benefits from May 8, 2015 to the date of Arbitration.

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

Petitioner claims that as a result of the work accident, he is permanently, totally disabled. For the reasons set forth, the Arbitrator finds Petitioner has failed to prove he is permanently, totally disabled as a result of the May 14, 2009 work accident.

There was no credible medical evidence presented by Petitioner indicating that Petitioner is medically permanently, totally disabled. The Arbitrator also finds that the petitioner failed to prove that he is permanently and totally disabled under an odd-lot theory.

An employee is totally and permanently disabled when he is unable to make some contribution to industry sufficient to justify payment of wages to him. *A.M.T.C. of Illinois v. Industrial Commission*, 77 Ill.2d 482, 487 (1979). The employee, however, need not be reduced to total physical incapacity before a permanent total disability award may be granted. *Ceco Corp. v. Industrial Commission*, 95 Ill.2d 278, 286-87 (1983). Rather, the employee must show that he is unable to perform services except those that are so limited in quantity, dependability, or quality that there is no reasonably stable market for them. *Alano v. Industrial Commission*, 282 Ill.App.3d 531, 534 (1996).

If the employee's disability is limited in nature so that he is not obviously unemployable, or if there is no medical evidence to support a claim of total disability, he may qualify for "odd lot" status. *Valley*

Mould & Iron Co. v. Industrial Commission, 84 Ill.2d 538,546-47 (1981). An odd-lot employee is one who, though not altogether incapacitated to work, is so handicapped that he will not be employed regularly in any well-known branch of the labor market. *Valley Mould*, 84 Ill.2d at 547. The burden is upon the claimant to establish the unavailability of employment to a person in his circumstances. Valley Mould at 546-547 (Ill., 1981).

If employees fail to make out a prima facie case that they fall into the "odd lot" category, then it remains incumbent upon them to demonstrate that, given their present condition and in light of their age, training, experience, and education, they are permanently and totally disabled. *ABB C-E Services v. Industrial Commission*, 316 Ill.App.3d 745 (Ill.App. 5 Dist. 2000); citing *Valley Mould*, 84 Ill.2d at 547. They may accomplish this by a showing of diligent but unsuccessful attempts to find work or by proof that because of the above mentioned qualities they are unfit to perform any but the most menial tasks for which no stable market exists. *ABB C-E Services*, 737 N.E.2d at 685.

There are three ways by which employees can demonstrate that they are permanently and totally disabled: (1) by a preponderance of the medical evidence, (2) by showing a diligent but unsuccessful job search, or (3) by demonstrating that because of their age, training, education, experience, and condition, no jobs are available to a person in their circumstances. *Id*, at 686.

The claimant must establish by the preponderance of the evidence that they fall into the odd-lot category. *Meadows v. Industrial Comm'n*, 262 Ill.App.3d 650, 653-654 (holding that "claimant has the burden of proving that he fits into the 'odd lot' category of section 8(f) of the Act"). Applying the analytic framework of the case law, the Arbitrator does not find that the petitioner has established, by a preponderance of the evidence that he falls into the odd-lot category. The Arbitrator finds it significant that the petitioner received a number of interviews during his search for work in the construction industry. In petitioner's own words, he received "countless job interviews" and no offers. On cross-examination, the petitioner testified to one job offer at a demolition company. The job required him to unload trucks in addition to his superintendent duties. Petitioner declined the offer because of the unloading requirement. There was no evidence presented as to the required lifting capabilities for that job.

Petitioner also testified that he volunteered with a company known as Projx Construction. Petitioner testified that he performed all the duties required of a project manager. According to the vocational report from August of 2014, Projx did not have work for the petitioner at that time and advised that they would contact him should their business increase. Petitioner testified that he still maintains contact with Projx Construction, to date.

In reviewing petitioner's job search logs, the Arbitrator finds that the positions targeted were almost exclusively with the construction/project management industry. Both Petitioner and Ms. Schmit agreed that these were the only positions targeted.

The Arbitrator understands that the goal of the vocational rehabilitation process is to return the individual to work at the highest wage possible so the individual can continue his pre-injury lifestyle. The Arbitrator also acknowledges that it is not always possible to return an individual to work in their usual and customary area of employment.

There is no evidence that Petitioner's job search was ever expanded to include other industries and positions. The Arbitrator notes that this case was tried on all issues. Petitioner also testified that he does not believe he can return to work "in any physical capacity". A claimant may prove by the preponderance of the evidence that they fall into the odd-lot category by demonstrating a diligent but unsuccessful job search. The Arbitrator finds that petitioner's job search was only limited to the construction trade and therefore not considered to be diligent. The Arbitrator finds the evidence to be insufficient to prove that the petitioner falls within the odd-lot category.

Furthermore, Ms. Schmit, the only vocational expert to testify, concluded that Petitioner is employable. She testified credibly and in an unrebutted manner, that the petitioner presented well to employers and garnered significant interest. She testified that Petitioner is motivated and that he is a younger individual (44 years old at the time of hearing). The job search logs revealed that Petitioner received interviews almost monthly and in some cases, petitioner was one of the final candidates to be selected for a position. Based upon this evidence and testimony, the Arbitrator cannot conclude that the petitioner is unemployable.

Even if the Arbitrator were to find that petitioner proved by a preponderance of the evidence that he falls into the odd-lot category, expert to testify and offer opinions on petitioner's employability as well as his skills and experience. Her testimony was unrebutted.

Ms. Schmit testified credibly that the petitioner is employable in a reasonably stable labor market. She testified credibly regarding petitioner's skills, age and work experience. Ms. Schmit testified that petitioner's age (44 years old) would not have a negative impact upon his ability to find work. The Arbitrator notes that the petitioner has many skills, including supervisory experience. Petitioner also ran his own business for several years. He was required to supervise all of the trades at a job site, maintain schedules, order supplies, document payroll and other duties of a business owner. The Arbitrator adopts Ms. Schmit's opinion that the petitioner is employable in a reasonably stable and well-known sector of the labor market.

The Arbitrator also relies upon the surveillance video taken on July 24, 2014. The video shows the petitioner entering and exiting a vacant building located at 657 W. Lake Street in Chicago over the course of several hours. Petitioner is seen carrying blueprints in and out of the building. Petitioner admitted that he has been to that address several times in order to "visit a friend". The Arbitrator notes that this video was taken before the petitioner began his volunteer period with Projx construction. After the investigator testified and the video was played, the petitioner did not offer any rebuttal testimony to explain his activities on that day. The Arbitrator questions what the petitioner

was doing at the vacant building with blueprints prior to the volunteer period with Projx and considers this in her evaluation of the petitioner's credibility.

Since petitioner has failed to prove that he is permanently and totally disabled, the Arbitrator must consider whether Petitioner qualifies for an wage differential award under Section 8(d)1. The Arbitrator finds insufficient evidence to award a wage differential under Section 8(d)1. The Arbitrator finds that the petitioner has likely lost access to his usual and customary employment. However, there was no credible evidence to establish what petitioner is capable of earning in some suitable employment. The Arbitrator cannot base a wage differential award on speculation. Without credible evidence to establish an appropriate wage in some suitable employment, the Arbitrator declines to award a wage differential under Section 8(d)1.

Petitioner sustained injuries to his left wrist and shoulder. Petitioner does not have any permanent disability with respect to his left shoulder. He testified that his pain is more of a "nuisance" and that he has no issues with his shoulder strength or range of motion. Petitioner has not had treatment for his left shoulder in several years. Petitioner has a significant disability with respect to his left wrist, which resulted in permanent lifting restrictions.

Based upon the medical evidence and testimony, the Arbitrator finds that petitioner has sustained a loss of trade or profession. The Arbitrator finds that the petitioner sustained permanent, partial disability to the extent of 50% loss of use of person as a whole representing a loss of trade or profession.

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

Illinois courts have refused to assess penalties under sections 19(k) and (l) of the Act where the evidence indicates that the employer reasonably could have believed that the employee was not entitled to the compensation withheld. *See, Board of Education v. Industrial Commission*, 93 Ill.2d 1, 442 N.E.2d 861 (1982); *See also, Avon Products, Inc. v. Industrial Commission,* 82 Ill. 2d 297 (1980) and *Brinkmann v. Industrial Commission*, 82 Ill. 2d 462 (1980). "Where a delay has occurred in payment of workmen's compensation benefits, the employer bears the burden of justifying the delay, and the standard we hold him to is one of objective reasonableness in his belief." *Id. See also, City of Chicago v. Industrial Commission*, 63 Ill. 2d 99 (1976).

The Illinois Supreme Court has explicitly found an obligation on the part of Respondents to diligently obtain information regarding a Petitioner's claim in *Board of Educ. v. Industrial Comm'n*, 93 Ill. 2d 1, 66 Ill. Dec. 300, 442 N.E.2d 861 (1982). In *Board of Educ.*, the court found that the Chicago Board of Education "had or should reasonably have had in its possession" sufficient evidence, that "would have disclosed that the grounds for challenging temporary total disability liability were insubstantial at best," and therefore fees and penalties were warranted. The Supreme Court also found that the Board's "failure to obtain that information did not entitle the Board to assert later that it acted in good

faith because it was ignorant of the evidence in favor of the employee." *See, Board of Educ. v. Industrial Comm'n*, 93 Ill. 2d 1, 66 Ill. Dec. 300, 442 N.E.2d 861 (1982).

The petitioner has requested penalties and fees to be awarded. While the respondent argues that the petitioner's three paragraph penalty petition does not specify the time periods in which penalties and fees were being claimed for a delay in payment of TTD or maintenance; the petitioner testified to the necessity of his attorney filing 19(b)'s and penalty petitions, for such delays. The 19(b) petitions were included as an exhibit at trial. The Arbitrator notes that the 19(b)'s do not indicate the time periods in which TTD or maintenance was delayed. Although Petitioner could not testify with any specificity as to all of the time periods in which his TTD or maintenance checks were delayed, he did testify sufficiently and in an unrebutted manner, to prove the chronic delays in payment of his benefits and authorization to necessary medical treatment, by the respondent. The Arbitrator finds that the petitioner has met his burden of proving entitlement to penalties with respect to the Act.

The Arbitrator finds that penalties of $1,000.00 pursuant to Section 19(k) of the Act, penalties of $10,000.00, pursuant to section 19(l) of the Act, and fees of $2,548.57, pursuant to section 16 of the Act, should be imposed upon the Respondent. The Arbitrator does not find Dr. Walsh's opinion to be persuasive and that the respondent's reliance on Walsh's opinion, to terminate Petitioner's benefits was misplaced. The respondent has previously utilized several other doctors for its Section 12 examinations of Petitioner, who offered credible, professional opinions regarding his medical condition and the Arbitrator finds that the respondent's chronic delays in paying Petitioner's temporary total disability payments rises to the level of arbitrary and capricious and acts in bad faith, on the part of the respondent, therefore penalties and attorney's fees are awarded.

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
09WC43267
SIGNATURE PAGE

L Thompson Smith
Signature of Arbitrator

November 6, 2015
Date of Decision

NOV - 6 2015

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PEVRIL, ROBERT
Employee/Petitioner

Case# **09WC052079**

JOHN H STROGER JR HOSPITAL OF COOK COUNTY
Employer/Respondent

On 11/5/2015, 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 0.28% 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:

0533 ROSS TYRRELL LTD
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CHICAGO, IL 60602

0132 STATES ATTORNEY OF COOK COUNTY
STEPHEN L GARCIA
500 RICHARD J DALEY CENTER
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
REVISED ARBITRATION DECISION BASED ON COMMISSION REMAND ORDER

Robert Pevril
Employee/Petitioner

v.

John H. Stroger, Jr. Hospital of Cook County
Employer/Respondent

Case # **09** WC **52079**

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 **12/04/2012**. The Arbitrator previously issued a decision in this case on December 27, 2012, with the Commission affirming and adopting the decision on December 11, 2013. Petitioner filed a Circuit Court review thereafter, with the Circuit Court reversing the Commission and remanding. On May 28, 2015, the Commission reversed its previous decision and remanded the case to the Arbitrator with directions. The Arbitrator has taken no additional evidence, noting the Commission's finding as to the adequacy of the existing arbitration record. The Arbitrator adopts the Commission's implied findings as to credibility and accident and makes additional findings as directed by the Commission. Those findings are attached hereto.

DISPUTED ISSUES

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

FINDINGS

On **10/22/2009**, 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 the claimed accident ***was*** given to Respondent. Arb Exh 1.

In the year preceding the injury, Petitioner earned $**61,127.56**; the average weekly wage was $**1,175.23**.

On the date of the claimed accident, Petitioner was **39** years of age, ***married*** with **1** dependent child.

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

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

ORDER

The Arbitrator adopts the Commission's implied findings that Petitioner was credible and sustained an accident arising out of and in the course of his employment on October 22, 2009.

The Arbitrator finds that the accident resulted in a temporary aggravation of a significant, pre-existing spinal condition of ill-being, with that aggravation resolving as of April 17, 2010. The Arbitrator finds that Petitioner was temporarily totally disabled from October 23, 2009 through April 17, 2010, a period of 25 2/7weeks, and awards temporary total disability benefits at the rate of $783.48 per week during that period. The Arbitrator further awards any claimed medical expenses for treatment rendered from October 22, 2009 through April 17, 2010 (PX 1), subject to the fee schedule. The Arbitrator awards no permanency benefits.

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

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

Molly C Mason

Signature of Arbitrator

11/5/15
Date

NOV 5 - 2015

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert Pevril,

Petitioner,

vs. No. 09 WC 52079

John H. Stroger, Jr. Hospital of Cook County,

Respondent.

ARBITRATOR'S REVISED DECISION ON REMAND FROM COMMISSION

Procedural History

The Arbitrator originally heard this case on December 4, 2012. At that hearing, the parties placed the following issues in dispute: accident, causal connection, medical services, temporary total disability and nature and extent of the injury. Petitioner testified as did his former co-worker, Raeesa Ali. Petitioner called Ali to testify on his behalf. No witnesses testified on behalf of Respondent.

On December 27, 2012, the Arbitrator issued a decision finding that Petitioner was not credible and failed to prove a compensable work accident. The Arbitrator found the remaining disputed issues to be moot and denied compensation.

Petitioner filed a Petition for Review. The Commission heard oral arguments on December 5, 2013. On December 11, 2013, the Commission issued a Decision and Opinion on Review affirming and adopting the Decision of the Arbitrator.

Petitioner filed a Circuit Court review thereafter. On September 30, 2014, the Circuit Court issued an order finding that the Commission's decision was against the manifest weight of the evidence. The Circuit Court reversed the Commission and remanded the case, utilizing the following language:

> "The Arbitrator's decision finding Plaintiff's [sic] testimony not credible and that Plaintiff [sic] failed to prove a compensable work accident occurred, is against the manifest weight of the evidence. The Arbitrator did not address the remaining issues as she found them moot. The Board [sic] affirmed and adopted the Arbitrator's decision. Therefore, the Court reverses the Board's [sic] decision and remands it for further determination of the remaining issues."

On May 28, 2015, the Commission issued a Decision and Opinion on Remand, reversing its previous decision and "remand[ing] the matter back to the Arbitrator to address all outstanding issues regarding Petitioner's claim." The Commission noted that, while the Arbitrator "did not address certain issues in her decision due to her finding of no accident . . . evidence was taken at arbitration regarding the issues of accident, causal connection, temporary total disability benefits, medical expenses and permanent disability benefits." The Commission found the existing arbitration record "sufficient to

address any and all outstanding issues" but "nonetheless . . . remand[ed] the matter back to the Arbitrator as ordered by the Circuit Court."

The Arbitrator respectfully disagrees with the Commission's interpretation of the Circuit Court's directive. The Circuit Court did not order the Commission to send the case back to the Arbitrator. The Circuit Court remanded the case for further determination of the remaining issues. If the existing arbitration record is sufficient to resolve those issues, as the Commission concedes, it should be the Commission that resolves them. To simply "reverse" and send the case back to an arbitrator who found the claimant not credible as to accident and other matters, with directions to make new findings based on the existing record, undermines the arbitrator's role in the decision-making process. For the Arbitrator, everything in this case hinged on whether Petitioner's account of his pre-accident state of health and the mechanics of his claimed accident was to be believed. Petitioner's account as to the former was undermined by his own medical records and his account as to the latter was undermined by the credible testimony of his own witness.

The Arbitrator interprets the Commission's "reversal" as meaning that it has found Petitioner to be credible and to have proved a compensable lifting-related accident of October 22, 2009, based on the Circuit Court's reasoning and decision. The Arbitrator adopts those implied findings. The Arbitrator further finds that the accident resulted in a temporary aggravation of a significantly disabling pre-existing spinal condition for which Petitioner was actively treating (with Dr. Candido) as of the accident, with that aggravation ending as of April 17, 2010, the date on which Dr. Melnick noted that Petitioner reported having made a "dry run" at working (for some employer other than Respondent) and requested a formal release to work with no restrictions. Dr. Melnick complied with this request. PX 4, pp. 53-54. The Arbitrator views the need for the treatment that occurred after April 17, 2010 as stemming from the pre-accident thoracic spine condition and/or the post-accident fall of June 23, 2010 and lifting incident of October 23, 2010.

In so finding, the Arbitrator relies on the following: 1) the pre-accident records, which show that Petitioner was regularly taking Hydrocodone and undergoing active treatment for spinal and radicular pain, with that treatment including medical branch blocks administered on October 6, 2009, about two weeks before the accident; 2) the radiographic studies performed at Advocate Lutheran General Hospital on October 23, 2009, which showed no disruption of the previous fusion and no new structural injury, according to both the radiologist, Dr. Geremia, and orthopedist, Dr. Spencer (PX 3); and 3) Dr. Melnick's December 6, 2009 characterization of the work accident as "an acute episode of mid-back pain on top of a picture of chronic radicular thoracic pain" (PX 3, p. 30). On December 29, 2009, Dr. Davis interpreted another study as showing an annular tear that "might be new" but he did not believe this tear was the cause of Petitioner's symptoms. The Arbitrator assigns no weight to the causation-related opinions of Petitioner's examiner, Dr. Chmell, since the doctor based those opinions on the assumption that Petitioner's pain syndrome was "under control" and Petitioner was "doing well" before the work accident. PX 7. That assumption is belied by the pre-accident records (PX 5) and Petitioner's admission that the treatment Dr. Candido provided before the work accident resulted only in "so-so" relief of his chronic pain.

In accordance with the foregoing, the Arbitrator finds that Petitioner was temporarily totally disabled from October 23, 2009 through April 17, 2010, a period of 25 2/7 weeks, and that Petitioner is entitled to the claimed medical expenses in PX 1 relating to the treatment rendered from October 22, 2009 through April 17, 2010, subject to the fee schedule. A print-out in PX 1 makes clear that some or

all of these expenses were paid by Blue Cross Blue Shield, Petitioner's wife's group carrier. Respondent did not claim, and is not entitled to, Section 8(j) credit for any such payments.

Having previously found that the accident caused only a temporary aggravation that resolved, the Arbitrator declines to award any permanency benefits.

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BUSHUR, DANIEL Case# **10WC022467**

Employee/Petitioner

J & V PROBST PORK INC

Employer/Respondent

On 11/5/2015, 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 0.28% 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
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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

Daniel Bushur
Employee/Petitioner

v.

J & V Probst Pork, Inc.
Employer/Respondent

Case # 10 WC 22467

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 Urbana, on September 10, 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 _____

FINDINGS

On January 28, 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, in part, causally related to the accident.

In the year preceding the injury, Petitioner earned $37,700.00; the average weekly wage was $725.00.

On the date of accident, Petitioner was 49 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 $102,266.81 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $102,266.81. At trial, the parties stipulated that TTD benefits were overpaid by $8,806.03, and that Respondent is entitled to a credit for same.

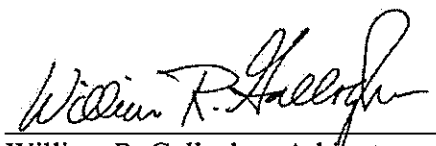
Respondent is entitled to a credit of $0.00 under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $169.20 per week commencing November 6, 2014, for the duration of the disability, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.

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

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



William R. Gallagher, Arbitrator

October 30, 2015
Date

NOV 5 - 2015

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on January 20, 2010. According to the Application, Petitioner sustained injuries to the right shoulder and right knee as a result of a "Corn bin collapse" (Arbitrator's Exhibit 2). At trial, Petitioner and Respondent stipulated that medical and temporary total disability benefits had been paid in full. Further, Petitioner and Respondent stipulated that there was an overpayment of temporary total disability benefits of $8,806.03 and that Respondent was entitled to a credit for same. Respondent disputed liability for Petitioner's left shoulder condition on the basis of causal relationship (Arbitrator's Exhibit 1).

Petitioner worked for Respondent primarily as a truck driver and he would haul grain, manure, etc. Petitioner's job duties also included cleaning out grain bins. Petitioner testified that, on January 28, 2010, he and several co-employees were inside a grain bin. At that time, a wall that held corn in place gave way which caused Petitioner and his co-employees to be buried in corn. Petitioner stated that he and one other employee were buried up to their necks in corn. Another employee was buried in corn and died as a result. Petitioner was able to use his cell phone and call for help and he and the other employee were rescued.

As a result of the accident, Petitioner sustained injuries to his right shoulder and right knee. Petitioner initially sought medical treatment from Dr. Eugene Dust, his family physician, who referred him to Dr. Joseph Williams, an orthopedic surgeon (Petitioner's Exhibit 1).

Dr. Williams initially evaluated Petitioner on March 16, 2010. Dr. Williams ordered MRIs of both the right shoulder and right knee which were performed on March 23, 2010. The MRI of the right shoulder revealed some inflammation of the AC joint and bone spurs, but no evidence of a rotator cuff tear. The MRI of the right knee revealed a tear of the medial meniscus and a medial collateral ligament strain (Petitioner's Exhibit 1).

Dr. Williams treated both conditions conservatively for several months. Petitioner's conditions did not improve to any significant degree, and Dr. Williams recommended both right shoulder and right knee surgeries (Petitioner's Exhibit 1).

Dr. Williams performed arthroscopic surgery on Petitioner's right knee on January 12, 2011. The procedure consisted of a partial medial meniscectomy, chondroplasty of the medial femoral condyle, synovectomy/excision of the medial patellar shelf and supra patellar plica and chondroplasty of the patella. Following the surgery, Dr. Williams saw Petitioner on January 27, 2011, and ordered an MRI/arthrogram of Petitioner's right shoulder (Petitioner's Exhibit 1).

The MRI/arthrogram was performed on January 31, 2011. Dr. Williams saw Petitioner on February 2, 2011, and reviewed the MRI/arthrogram. He opined that its findings were consistent with the prior MRI. He opined Petitioner had impingement syndrome of the right shoulder and renewed his surgical recommendation (Petitioner's Exhibit 1).

Dr. Williams performed arthroscopic surgery on Petitioner's right shoulder on March 9, 2011. The procedure consisted of a subacromial decompression and excision of the subacromial bursa, coracoacromial ligament and distal clavicle (Petitioner's Exhibit 1).

Following the right shoulder surgery, Dr. Williams ordered physical therapy and, on August 9, 2011, Dr. Williams ordered a functional capacity evaluation (FCE). The FCE was performed on August 29, 2011, and Petitioner was authorized to return to work with a restriction of occasional lifting of no more than 45 pounds. Petitioner was also limited to steering and driving occasionally (Petitioner's Exhibit 1).

Petitioner continued to be treated by Dr. Williams, primarily for his right shoulder. Dr. Williams ordered another MRI/arthrogram which was performed on September 15, 2011. This diagnostic study revealed possible tears of the supraspinatus and subscapularis tendons. On November 1, 2011, Dr. Williams evaluated Petitioner and recommended that he receive periodic cortisone injections or have another arthroscopic surgery performed (Petitioner's Exhibit 1).

Petitioner subsequently sought medical treatment from Dr. Jay Keener, an orthopedic surgeon. Dr. Keener initially evaluated Petitioner on December 21, 2011. Dr. Keener also recommended Petitioner have another arthroscopic surgery performed on his right shoulder. On March 1, 2012, Dr. Keener performed right shoulder surgery which consisted of a rotator cuff repair and biceps tenodesis (Petitioner's Exhibit 3).

Following surgery, Dr. Keener ordered physical therapy. When he saw Petitioner on September 12, 2012, he opined that Petitioner was at MMI but did not impose any specific work restrictions. Petitioner continued to be treated by Dr. Keener because of severe right shoulder symptoms. Dr. Keener performed another arthroscopic right shoulder surgery on January 10, 2013, for a recurrent rotator cuff tear (Petitioner's Exhibit 3).

Subsequent to the surgery of January 10, 2013, Dr. Keener again ordered physical therapy. When he saw Petitioner on September 13, 2013, he ordered an FCE. When Dr. Keener saw Petitioner on October 21, 2013, he reviewed the FCE and imposed permanent work restrictions in regard to the right upper extremity. He also opined Petitioner was at MMI (Petitioner's Exhibit 3).

On December 9, 2013, Petitioner was evaluated by Dr. Keener because of left shoulder symptoms. On February 27, 2014, Dr. Keener performed arthroscopic surgery on Petitioner's left shoulder that consisted of a rotator cuff repair, biceps tenodesis and subacromial decompression (Petitioner's Exhibit 3). In a letter directed to Petitioner's counsel dated April 11, 2014, Dr. Keener opined that Petitioner's left shoulder condition was not related to his right shoulder injury and/or recovery (Petitioner's Exhibit 4).

Respondent obtained the services of Med Voc Rehabilitation in June, 2014. A letter from Med Voc to Petitioner dated June 12, 2014, was received into evidence at trial. The letter stated, among other things, that a vocational consultant would meet with Petitioner for the purpose of formulating a vocational rehabilitation plan (Respondent's Exhibit 1).

In a subsequent letter from Med Voc to Petitioner dated November 6, 2014, Petitioner was informed that the rehabilitation consultant had attempted to contact him on multiple occasions, without success. Petitioner was directed to contact the vocational consultant on her cell phone (Respondent's Exhibit 3). At trial, Petitioner denied that he failed to return calls to Med Voc; however, he agreed that he was unable to participate in vocational rehabilitation efforts because of a right foot fracture.

At trial, Petitioner testified that he had attempted to find a job and believed he may have submitted five or six applications. Petitioner did not have any specific information regarding the positions for which he applied other than the fact that they were all minimum wage jobs.

Med Voc conducted two labor market surveys dated November 6, 2013, and May 4, 2015. The labor market survey of May 4, 2015, was received into evidence at trial. According to the survey, there were jobs available within Petitioner's work restrictions that paid $10.78 per hour to $12.78 per hour. The mean wage was $11.78 per hour (Respondent's Exhibit 2).

Conclusions of Law

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

The Arbitrator concludes that Petitioner's current conditions of ill-being in regard to Petitioner's right shoulder and right knee are related to the accident of January 20, 2010, but that Petitioner's current condition of ill-being in regard to Petitioner's left shoulder is not related to the accident of January 20, 2010.

In support of this conclusion the Arbitrator notes the following:

There was no dispute that Petitioner's right shoulder and right knee conditions were related to the accident of January 20, 2010.

In regard to Petitioner's left shoulder, Dr. Keener, one of Petitioner's treating physicians, opined that the left shoulder condition was not related to Petitioner's right shoulder injury and/or recovery. There was no opinion to the contrary.

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

The Arbitrator concludes that Petitioner is entitled to a wage differential benefit of $169.20 per week commencing November 7, 2014, and continuing for the rest of his life.

In support of this conclusion the Arbitrator notes the following:

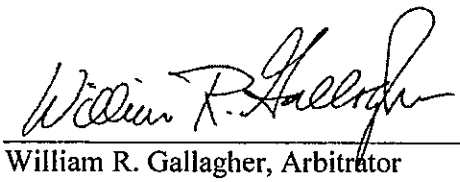
Petitioner agreed that he did not participate in the vocational rehabilitation process because of his right foot fracture.

Petitioner was contacted on multiple occasions by the rehabilitation consultant and failed to respond to same. This was confirmed in a letter to Petitioner dated November 6, 2014.

The labor market survey indicated that there were work opportunities available to Petitioner that conformed to his restrictions. These jobs paid from $10.78 per hour to $12.78 per hour with the mean wage of $11.78 per hour.

Based on the preceding, the Arbitrator concludes that Petitioner's entitlement to a wage differential award commenced on November 6, 2014, the date of the letter from Med Voc Rehabilitation confirming that Petitioner was not participating in vocational rehabilitation.

The Arbitrator also concludes that Petitioner's likely starting wage would be the mean of $11.78 per hour. Based upon a 40 hour work week, Petitioner would thereby earn $471.20 per week. Had Petitioner not been injured, he would have been making $725.00 per week, a difference of $253.80 per week. The wage differential amount is two-thirds of $253.80 or $169.20 per week.



William R. Gallagher, Arbitrator

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BROWN, JANET L Case# **11WC013623**
Employee/Petitioner

JOHN DEERE HARVESTER
Employer/Respondent

On 11/5/2015, 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 0.28% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0347 MARSZALEK AND MARSZALEK
STEVEN A GLOBIS
221 N LASALLE ST SUITE 400
CHICAGO, IL 60601

2119 CALIFF & HARPER PC
STEVEN NELSON
506 15TH ST SUITE 600
MOLINE, IL 61266

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

Janet L. Brown
Employee/Petitioner
v.
John Deere Harvester
Employer/Respondent

Case # **11** WC **13623**

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, 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 **Was petitioner exposed to the hazards of an occupational disease.**

FINDINGS

On **April 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 **$73,661.99**; the average weekly wage was **$1,416.57**.

On the date of accident, Petitioner was **66** 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.

ORDER

Respondent shall pay reasonable and necessary medical services of $5,076.45, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent and total disability benefits of **$944.38**/week for life, commencing **11/06/13**, as provided in Section 8(f) of the Act.

Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment Fund***, as provided in Section 8(g) of the Act.

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

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

Arbitrator Anthony C. Erbacci

November 3, 2015
Date

NOV 5 - 2015

FACTS:

On April 30, 2010 the Petitioner was a 36 year employee of the Respondent. The Petitioner testified that she began working for the Respondent on July 22, 1974 as an assembler, and that she worked five days per week, eight hours per day for the next 36 years. She testified that she worked as an assembler in the V Building for approximately one year, and that her work area was full of dust and smoke. She testified that she then started working as a material handler in the M Building and that her job duties included sweeping dirt, dust and cigarette butts from a road way on the Respondent's premises, hauling hoppers filled with slag (metal shavings and oil) three hours per day, cleaning out the basement, which was full of dust and dirt, every four to six months and painting stripes on the floor one time per year for about a week. The Petitioner testified that for two to three months in 1989 she worked as a welder in the M Building which she described as an environment filled with welding fumes, dust and smoke. She testified that for the next 20 years, she worked as an assembler in Department 982 in the VI Building which she described as dusty, dirty and full of fumes from forklifts operating in the building as well as second-hand smoke.

The Petitioner testified that she retired from her employment with the Respondent on April 30, 2010 and that that was the last day that she worked for the Respondent. The Petitioner testified that throughout the period of her employment with the Respondent, she was never provided with any type of respirator or breathing protection.

The Petitioner testified that in the early 1990s she began to notice she was having "breathing problems" and that, in the mid-1990s, she sought treatment for her complaints with Dr. Felipe Enriquez. The Petitioner testified that Dr. Enriquez sent her for a pulmonary function test and prescribed medications, a nebulizer, and oxygen. The Petitioner testified that she used the nebulizer at work two to three times per day and that her foreman, Craig Freebern, saw her using the nebulizer at work. The Petitioner also testified that sometime in 2005, a hopper caught fire inside the building and the building had to be evacuated. The Petitioner testified that, at that time, she told her foreman, Craig Freebern, that she had to go home because she could not breathe. The Petitioner testified that she has never smoked and that she has no family history of asthma.

The Petitioner testified that she currently notices difficulty breathing and shortness of breath three to four times per day. She testified that she uses oxygen at night and a nebulizer every three to four hours and that her current medications include Prednisone, Daliresp, Advair and Albuteral.

The records of Dr. Felipe Enriquez were admitted into the record as Petitioner's Exhibit 1 and Respondent's Exhibit 2. The records indicate that the Petitioner began seeing Dr. Enriquez on June 17, 1996 complaining of shortness of breath, dyspnea and wheezing. The Petitioner reported a history of asthma for the last five to six years and "this recent problem for the last eight weeks now." It was noted that the Petitioner also reported that "She works at John Deere, and according to her, there are a lot of people are smoking at work." She was diagnosed with asthma with rhinitis and post nasal drip. The post nasal drip was felt to be most likely allergic in nature.

The Petitioner returned to Dr. Enriquez on February 10, 2003 and was diagnosed with acute bronchitis and chronic obstructive pulmonary disease. Thereafter, the Petitioner continued to follow up with Dr. Enriquez on a fairly regular basis and continued to complain of coughing, wheezing and

difficulty breathing. Dr. Enriquez continued to diagnose the Petitioner as having chronic obstructive pulmonary disease and asthma. On April 6, 2008 the Petitioner reported that she was feeling good and not having any breathing problems. On May 4, 2009, it was noted that the Petitioner reported that "she is the only one in her family to have asthma, and she thinks she gets this from exposure to dust and fumes at work. She states that she is exposed to paint fumes at the plant and also has been exposed to welding fumes, dust and smoke in that her co-workers used to be able to smoke up until recently, at which time it was banned."

On September 12, 2011 the Petitioner saw Dr. Enriquez complaining of an increase in shortness of breath and coughing. It was noted that "She has been told that certainly some of her problem could be occupational given she is a non-smoker. She appears to have pulmonary functions which show an obstructive lung disease suggestive of chronic obstructive pulmonary disease, but we cannot exclude the possibility this could be occupationally related as well given that she was a welder." The Petitioner then underwent a pulmonary function test on October 7, 2011.

On December 15, 2011, Dr. Enriquez noted that the Petitioner's pulmonary function test showed moderate chronic obstructive pulmonary disease with hyperinflation consistent with emphysematous changes. Dr. Enriquez noted that the Petitioner's diffusing capacity was moderately reduced and there was worsening of lung function compared to a 2007 pulmonary function test. It was also noted that the Petitioner claimed that she was exposed to dust and fumes at work and that she "felt that the worsening of her breathing capacity has been contributed partly by her working in dust and exposure to fumes at the machine shop at John Deere."

On November 26, 2012 the Petitioner complained of chest congestion, and bronchospasm and frequent attacks of asthma flare up. Dr. Enriquez noted that "this is most likely related to her workplace." Dr. Enriquez also noted that "Most likely the work place has contributed somehow with worsening of her COPD." On March 18, 2003, Dr. Enriquez noted the Petitioner's description of her workplace as having a lot of dust and paint fumes and he opined; "Based on these exposure to the dust and fumes its most likely the cause of her asthma and COPD as she has no known history of smoking."

On November 6, 2013, Dr. Enriquez assessed the Petitioner as having acute bronchitis, exacerbation of COPD, moderate to severe persistent asthma and a history of atrial fibrillations and he indicated that "In view of the above findings, plus the presence of comorbidities including rheumatoid arthritis, plus her age of 70 and due to frequent exacerbation of her COPD and asthma, it is my opinion that the patient will not be able to go back to work anyplace."

The Respondent offered into evidence John Deere Medical Department record which show on October 15, 1980, Dr. J.F. Green wrote to Dr. Lewis Wok about the Petitioner's absence from work for an asthma allergy condition. Other records show a diagnosis of asthma in April of 1994, as do duty disposition reports dated December 6, 1999, December 8, 1999, February 15, 2002 (asthma with RAD resolving), February 18, 2002, (asthma improved) and February 19, 2003. On December 15, 1999, it is noted she is restricted to, "No exposure to welding fumes." Clinic progress notes reflect a virus affecting her asthma from February 28, 2005 to March 11, 2005. On February 22, 2010 she reported a vacation day because of breathing problems.

Craig Freeberg testified that he was the Petitioner's supervisor from March 2007 to September of 2009. He testified that in all that time, the Petitioner never complained to him about her breathing difficulties, and that he never saw her use a Nebulizer at work. Mr. Freeberg testified that had the Petitioner complained to him about difficulty breathing, he would have sent her to the Medical Department.

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 (O.), was Petitioner exposed to the hazards of an occupational disease, the Arbitrator finds and concludes as follows:

Pursuant to Section 1(d) of the Occupational Disease Act, "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."

The Petitioner's unrebutted testimony indicates that during the term of her employment with the Respondent from July 22, 1974 through her last day of work on April 30, 2011, she was exposed to dirt, dust, paint fumes, slag fumes, welding fumes, forklift exhaust, and second hand smoke in the Respondent's plant. Her treating physician, Dr. Felipe Enriquez is of the opinion that her work exposure has caused or aggravated her chronic obstructive pulmonary disease and asthma.

The Petitioner's testimony further established that her last day of working in this environment was April 30, 2010.

The Respondent presented no evidence or testimony to rebut or contradict the Petitioner's testimony as to her work environment and, similarly, presented no medical evidence or opinion which questioned, contradicted, or rebutted the opinions of Dr. Enriquez.

Consequently, the Arbitrator finds that the Petitioner was exposed to the hazards of an occupational disease with the date of last exposure of April 30, 2010.

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

Under Section 6(c) of the Occupational Disease Act, notice shall be given to the employer of the disablement, "as soon as practicable after the date of disablement." That section further states, "no defect or inaccuracy of such notice shall be bar to the maintenance of proceedings on arbitration or otherwise by the employee unless the employer proves that he or she is unduly prejudiced in such proceedings by such a defect or inaccuracy."

During the course of her employment with the Respondent the Respondent received notice that the Petitioner was experiencing breathing difficulties which constitute disablement on multiple occasions. On March 15, 2005, Dr. Enriquez's office notes indicate he checked with JDH (John Deere Harvester) and Petitioner was OK'd for coverage for a portable nebulizer. The records from the Respondent's medical department also demonstrate that the Petitioner reported breathing problems, asthma, or treatment with Dr. Enriquez on several occasions and that she missed time from work due to those complaints and was on restricted work from time to time as a result of those complaints.

The Act requires the employee to place the employer in possession of the known facts within the statutory period, but allows that a defect or an inaccuracy in the notice is not a bar unless the employer is unduly prejudiced by the inaccurate notice. Because the Respondent was aware of the Petitioner's job duties and environment and the fact that she was experiencing breathing problems and saw Dr. Enriquez during the term of her employment with the Respondent, it can be fairly said that the Respondent was in possession of the necessary known facts to put them on notice pursuant to Section 6(c) of the Occupational Disease Act. Furthermore there was no evidence of any undue prejudice to the Respondent.

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

According to Section 1(d) of the Occupational Disease Act, "A disease shall be deemed to arise out of the employment if it is apparent to the rational mind, upon consideration of all the circumstances, a causal connection between the conditions under which the work was performed and the occupational disease. The disease need not to have been foreseen or expected but after its contraction it must appear to have had its origin or aggravation in a risk connected with the employment and to have flowed from that source as a rational consequence."

The Petitioner's unrebutted testimony established that she has been a long time employee for the Respondent working in an environment which included dust, dirt, smoke, slag fumes, welding fumes, paint fumes, fork lift exhaust and second hand smoke from co-workers using cigarettes. It was during the term of the Petitioner's employment with the Respondent that she began developing difficulty breathing.

The Petitioner's primary treating physician has been Dr. Felipe Enriquez who is Board Certified in Internal Medicine and Pulmonary Disease. He diagnosed the Petitioner with chronic obstructive pulmonary disease and asthma. The medical records demonstrate that the Petitioner reported to Dr. Enriquez the fact that she was exposed to dust, dirt, smoke and fumes at work. On September 12, 2011, Dr. Enriquez commented that; "She has been told that certainly some of her problems could be occupational given she is a non-smoker. She appears to have pulmonary functions which are suggestive of chronic obstructive pulmonary disease, we cannot exclude the possibility this could be occupationally related as well given that she was a welder." On November 26, 2013, Dr. Enriquez commented that; "Her COPD is up a little bit after she has been retired compared to when she was working. Most likely the workplace has contributed somehow with worsening of COPD." On March 18, 2003, Dr. Enriquez again commented that; "Based on these (sic) exposure to dust and fumes it is

most likely the cause of her asthma and COPD as she has no known history of smoking. She also claimed that she had no family members at all with asthma."

The Respondent presented no evidence or testimony to rebut or contradict the Petitioner's testimony as to her work environment and, similarly, presented no medical evidence or opinion which questioned, contradicted, or rebutted the opinions of Dr. Enriquez.

Based upon the above, the Arbitrator concludes that the Petitioner's chronic obstructive pulmonary disease and asthma had its origin or aggravation in a risk connected with her employment and these conditions have flowed from that source as a rational consequence.

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 Respondent disputed their liability for the Petitioner's medical bills based upon defenses relating to causal connection, exposure to hazards of an occupational disease and notice. Having found for the Petitioner regarding these disputed matters, the Arbitrator finds the Respondent liable for the following medical expenses:

Petitioner's Exhibit #3	Apria Health Care	$5,049.47
Petitioner's Exhibit #4	Advanced Radiology	$26.98
	Total Medical Awarded	$5,076.45

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 testified that she worked for the Respondent from July 22, 1974 through April 30, 2010 when she retired. The Petitioner was not under any work restrictions when she retired and she testified that she has not worked at all since April 30, 2010. During the course of her employment with the Respondent the Petitioner began to notice breathing difficulties for which she sought medical treatment. The Petitioner continues to receive follow up medical treatment for her condition and she has been prescribed various medications including Prednisone, a nebulizer, Advair and oxygen to be used at night. The Petitioner testified that she has difficulty breathing and notices shortness of breath three to four times per day. Her primary treating physician has been Dr. Felipe Enriquez.

Dr. Enriquez' records demonstrate that the Petitioner has been under his care from June 17, 1996 through the present and that the Petitioner's diagnoses include chronic obstructive pulmonary disease and asthma. On November 6, 2013, Dr. Enriquez assessed the Petitioner as having acute bronchitis, exacerbation of COPD, moderate to severe persistent asthma and a history of atrial fibrillations and he indicated that "In view of the above findings, plus the presence of comorbidities

including rheumatoid arthritis, plus her age of 70 and due to frequent exacerbation of her COPD and asthma, it is my opinion that the patient will not be able to go back to work anyplace."

No evidence was offered into the record which questioned, contradicted, rebutted or discredited the opinions of Dr. Enriquez.

Based upon the above, the Arbitrator concludes that the Petitioner is permanently and totally disabled from November 6, 2013 through the present.

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

SMITH, ANDREW Case# **11WC024617**

Employee/Petitioner

NATIONAL FREIGHT

Employer/Respondent

On 11/5/2015, 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 0.28% 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
LESLIE N COLLINS
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EAST ALTON, IL 62024

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

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)

Andrew Smith
Employee/Petitioner

Case # 11 WC 24617

v.

Consolidated cases: n/a

National Freight
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 September 11, 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, May 25, 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 $53,220.96; the average weekly wage was $1,023.48.

On the date of accident, Petitioner was 45 years of age, married with 0 dependent child(ren).

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

Respondent shall be given a credit of $1,364.64 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $1,364.64.

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 in the amount of $4,902.03 as identified in Petitioner's Exhibit 7 for medical services provided to Petitioner as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall pay Petitioner prospective medical treatment including, but not limited to, the surgery recommended by Dr. Kennedy.

Respondent shall pay Petitioner temporary total disability benefits of $682.32 per week for 160 2/7 weeks commencing August 14, 2012, through September 11, 2015, as provided in Section 8(a) of the Act.

Petitioner's Petition for penalties and attorneys' fees is denied.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, 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 4, 2015
Date

NOV 5 - 2015

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on May 25, 2011. According to the Application, Petitioner sustained an injury to the man as a whole when a truck was blown over by a 60 mile per hour wind (Arbitrator's Exhibit 2).

This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of temporary total disability benefits and medical bills. Petitioner also filed a Petition for Section 19 (k) and 19(l) penalties as well as Section 16 Attorneys' Fees. Respondent disputed liability on the basis of causal relationship (Arbitrator's Exhibit 1). Petitioner's entitlement to prospective medical treatment was not specifically indicated on the Request for Hearing as a disputed issue; however, given the procedural history of this case as discussed herein, Petitioner was apparently seeking an order for this as well.

This case was previously tried in a 19(b) proceeding before Arbitrator Douglas McCarthy on August 14, 2012. At that time, Petitioner sought an order for payment of temporary total disability benefits and medical bills as well as prospective medical treatment. Respondent disputed liability on the basis of accident and causal relationship. Arbitrator McCarthy's Decision was filed with the Commission on October 1, 2012, and he ruled in favor of Petitioner and ordered Respondent to pay temporary total disability benefits from June 15, 2011, through August 14, 2012, and medical bills. He also ordered Respondent to "...pay the prospective medical as proposed by Dr. Kennedy." (Arbitrator's Exhibit 4; p 3).

In regard to Dr. Kennedy's surgical recommendation, Arbitrator McCarthy noted in his findings of fact that Dr. Kennedy recommended Petitioner have his prior instrumentation removed, have a decompression at L2-L3 and be re-instrumented from L2 to L5 (Arbitrator's Exhibit 4; p 6). The prior instrumentation was from a back surgery that Dr. Kennedy previously performed at L3-L4 and L4-L5.

Respondent filed a review of Arbitrator McCarthy's Decision with the Commission. In a Decision and Opinion on Review filed on April 26, 2013, the Commission affirmed and adopted Arbitrator McCarthy's Decision (Petitioner's Exhibit 5).

Respondent subsequently appealed the Decision of the Commission to the Circuit Court of Montgomery County and then to the Appellate Court. When this case was before the Appellate Court, Respondent argued that the Commission's determination that Petitioner's condition of ill-being and need for surgery was contrary to the law and manifest weight of the evidence. Specifically, Respondent argued that Petitioner's back condition was, in fact, related to a prior work-related injury that occurred in December, 2008. The Appellate Court ruled against Respondent and found that the Commission's Decision was not against the manifest weight of the evidence and affirmed and remanded same (Petitioner's Exhibit 6).

In its review of the record, the Appellate Court noted the conflicting opinions regarding causality of Petitioner's treating physician, Dr. David Kennedy, and employer's examiner, Dr. David Lange, and noted that the Commission had found the opinion of Dr. Kennedy to be more persuasive. The

Appellate Court noted that the employer was requesting that the Court "... reweigh the evidence presented, which is not the appropriate function of this court on review." (Petitioner's Exhibit 6; p 13).

In the current 19(b) proceeding, Petitioner testified that he was employed as a truck driver by Respondent and that, on May 25, 2011, a tornado picked up the truck he was driving and threw at approximately 116 feet. Petitioner has been treating with Dr. Kennedy since shortly after the accident and Dr. Kennedy has authorized him to remain off work. In regard to the surgery recommended by Dr. Kennedy, Petitioner agreed that this procedure was delayed because of some heart issues that he had.

At trial, Petitioner introduced into evidence Dr. Kennedy's records/notes for treatment and office visits provided by him to Petitioner from October 29, 2012, through May 21, 2015. This record also included an office note dated September 8, 2015, but the admission of this particular office note was objected to by Respondent's counsel and said objection was sustained by the Arbitrator. In these various office notes, Dr. Kennedy continued to authorize the Petitioner to remain off work pending surgery. Several of the office notes made reference to the date of accident as being 11/6/06; however, the office notes dated March 25, 2015, and May 21, 2015, reference the date of accident as being 5/25/11 (Petitioner's Exhibit 2).

In Dr. Kennedy's office note dated August 6, 2013, Dr. Kennedy stated: "I attribute his need for surgical intervention to the prior fusion which is a result of the work related injury on December 3, 2008." (Petitioner's Exhibit 2; p 23) (Respondent's Exhibit 4). In that same report, Dr. Kennedy's surgical recommendation was that Petitioner undergo a lumbar decompression and fusion at L2-L3. Dr. Kennedy did not make any reference to either removal of old instrumentation or re-implanting new instrumentation as he had previously.

The evidence depositions of Dr. Kennedy and Dr. Lange taken on April 10, 2012, and April 17, 2012, respectively, were received into evidence at trial. These depositions were also tendered into evidence at the time of the prior 19(b) hearing before Arbitrator McCarthy. As was noted in Arbitrator McCarthy's Decision, and affirmed by the Commission, Circuit Court, and Appellate Court, Dr. Kennedy's opinion that there was a causal relationship between Petitioner's condition of ill-being and the accident of May 25, 2011, was found to be more persuasive than that of Dr. Lange who opined that there was not such a causal relationship.

Petitioner's position was that Respondent's disputing causal relationship between the accident of May 25, 2011, and Petitioner's current condition of ill-being was not one that can be raised by Respondent at this time because this issue was previously adjudicated by the Appellate Court. Specifically, Petitioner argues that the Court's determination is the "law of the case" and cites Irizarry v. Industrial Commission, 786 N.E. 2d 218 (Ill. App. 2nd Dist. 2003), as authority.

Respondent's position was that the second 19(b) proceeding involved different legal and factual issues than the first 19(b) proceeding. Because of the preceding, Respondent asserts that the prior finding of a causal relationship is not binding in this proceeding as a result of the "law of the case" doctrine. Respondent cited Weyer v. Illinois Workers' Compensation Commission, 900 N.E. 2d 360 (Ill. App. 1st Dist. 2008), as authority.

Conclusions of Law

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

The Arbitrator concludes that Petitioner's current condition of ill-being is causally related to the accident of May 25, 2011.

In support of this conclusion the Arbitrator notes the following:

The Arbitrator concludes that this issue was previously adjudicated and is the "law of the case" and cannot be retried in this proceeding.

In the Irizarry case, the case was initially tried in a 19(b) proceeding in which the Petitioner alleged injuries to multiple body parts including his left knee. The Arbitrator awarded Petitioner benefits and found that he had sustained injuries to the left knee, neck, right shoulder and lower back. Neither side took a review and it became final. In a subsequent 19(b) proceeding, another Arbitrator found that there was no causal relationship between Petitioner's head, neck, low back and right shoulder. The Arbitrator's Decision in the second 19(b) proceeding was confirmed by the Commission but reversed by the Appellate Court. The Court found that once the Arbitrator's Decision in regard to the first 19(b) proceeding became final, that Decision became the "law of the case" and could not be revisited with the singular exception of the head injury because the first Decision did not make a finding of causal relationship for that part of the anatomy. Irizarry at 224-225.

In the Weyer case, there was a 19(b) proceeding in which the Arbitrator determined that Petitioner's left shoulder injury was causally related to the work-related accident and awarded temporary total disability benefits and medical. In a subsequent 19(b) Decision, the same Arbitrator found that Petitioner failed to prove that his left shoulder condition, as it existed at the time of the second 19(b) proceeding. The Court held that the Arbitrator's first Decision was not binding and that the "law of the case" doctrine did not apply. However, there was a significant difference in the pathology of the left shoulder between the time of the first and second 19(b) proceedings. Specifically, at the time of the second 19(b) proceeding, Petitioner was diagnosed with a SLAP lesion which was not diagnosed prior to the first 19(b) proceeding and was diagnosed approximately two years post accident. Weyer at 369.

In the instant case, there has been no change in the pathology regarding Petitioner's low back. Dr. Kennedy has consistently recommended Petitioner undergo back surgery. The Arbitrator notes that in Arbitrator McCarthy's 19(b) Decision, Dr. Kennedy recommended that Petitioner have prior instrumentation removed, a decompression at L2-L3, and new instrumentation at L2 to L5. His more recent surgical recommendation is different, namely, that Petitioner have a lumbar decompression and fusion at L2-L3.

The Arbitrator does not view Dr. Kennedy's modified surgical recommendation to be analogous with the separate shoulder pathology as was diagnosed in the Weyer case.

The Arbitrator does note that Dr. Kennedy made a statement in one medical record that attributed the need for surgery to the accident of December 3, 2008, and a number of other notes that referenced the date of accident as being 11/6/2006. The preceding appears to be erroneous as it was contrary to what Dr. Kennedy testified to as well as Arbitrator McCarthy's prior 19(b) Decision. In spite of what appears to be a contradiction, the Arbitrator cannot find a basis to overrule the "law of the case" doctrine as it applies to this case.

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

The Arbitrator concludes that Respondent is liable for all of the medical bills for services rendered to Petitioner and that Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services of $4,902.03 as identified in Petitioner's Exhibit 7, 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 surgery recommended by Dr. Kennedy.

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

The Arbitrator concludes Petitioner is entitled to payment of temporary total disability benefits of 160 2/7 weeks commencing August 14, 2012, through September 11, 2015.

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) and Section 19(l) penalties or Section 16 Attorneys' Fees.

In support of this conclusion the Arbitrator notes the following:

Even though the Arbitrator has ruled that the "law of the case" doctrine is applicable and that Petitioner's current condition of ill-being is causally related to the accident of May 25, 2011, the Arbitrator does not find Respondent's actions to be either vexatious or in bad faith.

The holding in the Weyer case provided a basis for Respondent to assert that the law of the case doctrine was not applicable. Further, Dr. Kennedy's medical record of August, 2013, purported to relate Petitioner's current condition to a prior accident which, as noted herein, was inconsistent with his prior testimony.

William R. Gallagher, Arbitrator

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LOWE, LISA
Employee/Petitioner

Case# **12WC013391**

STATE OF ILLINOIS DEPT OF CORRECTIONS
Employer/Respondent

On 11/5/2015, 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 0.28% 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 62794-9208

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

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

NOV 5 2015

RONALD A. RASCIA, 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

LISA LOWE
Employee/Petitioner

v.

STATE OF ILLINOIS DEPARTMENT OF CORRECTIONS
Employer/Respondent

Case # **12** WC **13391**

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 **Gerald Granada**, Arbitrator of the Commission, in the city of **New Lenox**, on **October 14, 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 _____

FINDINGS

On **4/1/12**, 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 in part*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**86,366.80**; the average weekly wage was $**1,660.90**.

On the date of accident, Petitioner was **45** 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 $**43,342.93** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $**43,342.93**.

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

ORDER

The Respondent shall pay the Petitioner temporary total disability benefits of $1,107.27/week for 39 2/7 weeks ($43,499.89), commencing from 4/2/12 through 1/2/13, as provided in Section 8(b) of the Act. Respondent is entitled to a credit of $43,342.93.

Respondent shall pay the Petitioner permanent partial disability benefits of $695.78/week for 37.5 weeks ($695.78/week x 37.5 weeks = $26,091.75), as provided in Section 8(d)(2) of the Act, because the physical injuries sustained caused 7.5% loss of use of person as a whole.

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

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

Signature of Arbitrator

11/6/15
Date

NOV 5 - 2015

FINDINGS OF FACT

Lisa Lowe (the "Petitioner") seeks relief from the Respondent-Employer, the State of Illinois, Stateville Correctional Center (the "Respondent"), for the Petitioner's alleged work-related accident on April 1, 2012, pursuant to the Illinois Workers' Compensation Act (the "Act"). On October 14, 2015, a hearing on the disputed issues was held in New Lenox, Illinois. The disputed issues are: causation, medical expenses, temporary total disability, and nature and extent. [Arb. Ex. 1]. The parties stipulated that on April 1, 2012, the date of the alleged work-related accident, the Petitioner was 45 years old and married with one dependent child. [Arb. Ex. 1].

The Petitioner testified she worked for the State of Illinois at Stateville Correctional Center as a Nurse Supervisor. She testified that prior to the accident in question, she was working in that capacity for less than a year. She is no longer employed by the State of Illinois and currently resides out of state.

On October 4, 2011, prior to the work related accident, Petitioner fell and injured her back and neck. She reported to Ingalls Occupational Health on October 7, 2011 and reported pain to her back and neck. [Resp. Ex. 2]. She had limited range of motion in the lumbar spine. [Resp. Ex. 2]. On October 12, 2011, she returned to Ingalls. [Resp. Ex. 2]. Her primary problem was pain located in the neck and lower back. [Resp. Ex. 2]. Petitioner missed about a week of work for this injury.

Petitioner testified that on April 1, 2012, the date of the alleged accident, she slipped and fell on a wet floor while performing her duties as a nurse supervisor. [See also, Pet. Ex. 11]. She hit her head and body during the fall. An inmate noticed her fall and ran to help her. However, he also slipped on the same water and slid into Petitioner. Petitioner testified that she was knocked unconscious after the inmate struck her.

After the accident, Petitioner presented to St. Joseph Medical Center. [Pet. Ex. 1 at 9]. A CT of her head without contrast was normal. [Pet. Ex. 1 at 28]. A CT of her cervical spine showed no acute osseous abnormality. [Pet. Ex. 1 at 26]. Minimal spondylotic change is identified at C5-C6 without associated degenerative disc disease. [Pet. Ex. 1 at 26]. An X-ray of her lumbar spine showed minimal facet hypertrophic; otherwise it was unremarkable. [Pet. Ex. 1 at 30]. The hospital records indicate that she did not lose consciousness. [Pet. Ex. 1 at 32]. She denied any tingling or numbness in her extremities. [Pet. Ex. 1 at 32].

That same day, Petitioner met with Dr. Watson of Health Benefits Pain Management Services. [Pet. Ex. 3 at 2]. She reported that she hit her head three times. [Pet. Ex. 3 at 2]. Dr. Watson referred her to a neurology specialist and an MRI for her cervical and lumbar spine. [Pet. Ex. 3 at 3]. She was instructed to refrain from work. [Pet. Ex. 3 at 3].

On April 16, 2012 Petitioner's MRI of the cervical spine revealed straightening of the cervical spine, may be due to myospasm; at C5-C6, mild bilateral foraminal stenosis due to mild predominantly left central disc fragment extrusion pointing caudally; at C4-C5, subtle focal central disc bulge, that indents the thecal sac. [Pet. Ex. 5 at 6].

An MRI of the lumber spine revealed transitional vertebra at lumbosacral junction; at L5-S1 level, mild bilateral forminal stenosis due to mild predominantly central disc bulge, hypertrophy of facet joints and ligament flava; at L4-L5 level, subtle disc bulge that abuts the thecal sac. [Pet. Ex. 5 at 4].

Petitioner returned to Dr. Watson on May 9, 2012. [Pet. Ex. 3 at 8]. He recommended Petitioner meet with Dr. Kelly, a neurologist, and to start physical therapy. [Pet. Ex. 3 at 8]. They discussed how she would benefit from epidural steroid injections if her pain does not improve. [Pet. Ex. 3 at 8].

Petitioner began physical therapy at Maximum Rehab on May 22, 2012. [Pet. Ex. 6]. On July 3, 2012, she transferred but continued physical therapy at ATI. [Pet. Ex. 7].

Petitioner returned to Dr. Watson on June 6, 2012. [Pet. Ex. 3 at 14]. Petitioner had attended six sessions of physical therapy with success. [Pet. Ex. 3 at 14]. Petitioner stated that she does not wish to undergo the nerve block at this time. [Pet. Ex. 3 at 14]. Accordingly, Dr. Watson recommended she continue with physical therapy. [Pet. Ex. 3 at 14].

On June 27, 2012, Petitioner presented to Dr. Kelly. [Pet. Ex. 3 at 16]. Dr. Kelly noted that the physical therapy was helping quite considerably. [Pet. Ex. 3 at 16]. Dr. Kelly recommended an epidural steroid injection, but Petitioner opted to wait to have this done just before she would go back to work to try to maximize the duration of benefits during her time of working. [Pet. Ex. 3 at 16].

Petitioner returned to Dr. Kelly on August 29, 2012. [Pet. Ex. 3 at 23]. Dr. Kelly noted that Petitioner opted not to pursue the epidural steroid injections. [Pet. Ex 3 at 23]. Instead the patient would like to continue to just pursue the physical therapy for now until December 2012 and then have the injections performed before returning to work at that time. [Pet. Ex. 3 at 23]. Dr. Kelly informed Petitioner that there was no need to wait. [Pet. Ex. 3 at 23]. Petitioner reported that she was not hesitant to receive the injection, but would like to postpone it until just before she returns to work in December. [Pet. Ex. 3 at 23]. Dr. Kelly informed Petitioner that she would thus be at MMI but Petitioner was not happy with this. [Pet. Ex. 3 at 23]. Dr. Kelly noted that Petitioner wanted to wait to return to work until December, but putting off the appropriate interventional treatment until December 2012 is just delaying the process inappropriately. [Pet. Ex. 3 at 23]. Dr. Kelly noted that she was giving a number of excuses that Dr. Kelly told her were not medically appropriate. [Pet. Ex. 3 at 23]. Petitioner did not schedule a follow-up with Dr. Kelly. [Pet. Ex. 3 at 25].

On October 4, 2012, Petitioner underwent an FCE which placed her functioning at the light capacity. [Pet. Ex. 8]. Petitioner began work hardening.

On November 27, 2012, Petitioner underwent an IME with Dr. Daniel Troy. [Resp. Ex. 1]. Dr. Troy diagnosed Petitioner with a left shoulder strain, lumbosacral strain, and cervical strain. [Resp. Ex. 1]. He believed her condition had long resolved. [Resp. Ex. 1]. Dr. Troy based his opinion on Petitioner's August 29, 2012 visit with Dr. Kelly in which it was revealed that Petitioner was purposely extended her care to remain off of work. [Resp. Ex. 1. See also, Pet. Ex. 3 at 23]. Dr. Troy found her treatment excessive. [Resp. Ex. 1]. He recommended finishing the work hardening and then report to work full duty. [Resp. Ex. 1].

On January 2, 2013, Petitioner returned to Dr. Watson. [Pet. Ex. 3 at 35]. Petitioner reported to Dr. Watson that her headaches have resolved. [Pet. Ex. 3 at 35]. Dr. Watson noted that Petitioner completed work hardening and she is able to lift 50 pounds. [Pet. Ex. 3 at 35]. This allowed the Petitioner to return to work in the medium physical demand level. [Pet. Ex. 3 at 35]. Dr. Watson found Petitioner to be at MMI and to return to work. [Pet. Ex. 3 at 35]. Petitioner did not return to work at this time. Instead, Petitioner returned to Dr. Watson on January 30, 2013. [Pet. Ex. 3 at 37]. Petitioner complained of knee pain, left arm pain, and left hand numbness. [Pet. Ex. 3 at 37]. Dr. Watson reiterated that she should return to work. [Pet. Ex. 3 at 37].

Petitioner again returned to Dr. Watson on February 27, 2013. [Pet. Ex. 3 at 39]. Petitioner told Dr. Watson that she never returned to work due to a fear of passing out. [Pet. Ex. 3 at 39]. She complained of continued headaches and pain to her left knee and left arm. [Pet. Ex. 3 at 39]. Dr. Watson referred her to a neurologist. [Pet. Ex. 3at 39]. Petitioner returned to Dr. Watson on March 27, 2013. [Pet. Ex. 3 at 39]. She had not yet seen the neurologist. [Pet. Ex. 3 at 39].

Petitioner presented to Dr. Marquess Wilson on April 4, 2013. [Pet. Ex. 1 at 38]. He gave her a prescription for physical therapy and Zanaflex. [Pet. Ex. 1 at 39]. Petitioner was to follow-up in 3 weeks. [Pet. Ex. 1 at 39]. Petitioner returned to Dr. Wilson on May 6, 2013. [Pet. Ex. 1 at 41]. Petitioner reported that she no longer is experiencing headaches, she denied numbness and tingling in her extremities, and she currently had no complaints. [Pet. Ex. 1 at 41].

On May 8, 2013, Petitioner returned to Dr. Watson. [Pet. Ex. 3 at 43]. Dr. Watson instructed her to return to work on May 13, 2013. [Pet. Ex. 3 at 43].

On September 6, 2014, Petitioner underwent an exam with Dr. Coe, at the request of her attorney. [Pet. Ex. 12]. Petitioner denied a history of significant injuries to her back or neck. [Pet. Ex. 12]. On July 9, 2015, the parties took the evidence deposition of Dr. Coe. [Pet. Ex. 14]. Dr. Coe did not review any medical records concerning Petitioner's pre-existing injury. [Pet. Ex. 14 at 70]. Dr. Coe explained that when he asked Petitioner if she suffered any previous injuries, he explained that this did not just involve bumps and bruises, which is typical for someone her age. [Pet. Ex. 14 at 71]. He clearly explained to her that he was referring to anything that required medical treatment. [Pet. Ex. 14 at 71]. Petitioner continued to deny a history of pain that required medical treatment. [Pet. Ex. 14 at 71]. Dr. Coe opined that the Petitioner suffered a contusion and strain type injuries in the accident of April 1, 2012 with a head injury and post concussion syndrome, a neck injury with C5-6 disc protrusion, herniation and some aggravation of the pre-existing cervical degenerative changes causing chronic neck pain and then some aggravation of degenerative changes in her lumbar spine-L4 – S1 – with now chronic lumbar pain of multiple origins, disc and facet joints as well as soft tissue muscular pain [Pet. Ex. 14. at 39].

Petitioner testified that she returned to work full duty with the Respondent from May 12, 2013 through July 20, 2013. In July, 2013, she moved to North Carolina to work for the federal government at the VA, where she was making the same amount of money as her job with the Respondent. In August, 2015, Petitioner began a new job in Los Angeles, as a labor and delivery nurse. At that time, she began noticing numbness in her fingers and arms, along with the experience of headaches. She then sought treatment at Cedars-Sinai, where she received treatment from Dr. Levesque who noted Petitioenr had chronic neck pain and low back pain without sciatica. [Pet. Ex. 20] Dr. Levesque ordered an MRI, which indicated Petitioner had degenerative changes in her cervical spine, mild to moderate spinal canal stenosis at C5-6, small left paracentral disc herniatation at C3-4 without cord compression, and mild degenerative changes at L5-S1.

The Petitioner broke down in tears as she testified that she could no longer work two jobs following her accident on April 1, 2012. Petitioner testified that she has to be careful in her current job and does not do house chores. She has pain with sitting for long periods of time and takes over the counter medication for her pain. She still complains of constant lower back pain.

CONCLUSIONS OF LAW

1. With regard to the issue of causation as to her neck and back condition, the Arbitrator finds that the Petitioner has met her burden of proof. In support of this finding, the Arbitrator relies on both the Petitioner's

testimony and the medical evidence. While Respondent disputes this issue based on the fact that the Petitioner sustained a prior injury on October 4, 2011 resulting in pain to her upper and lower back - there was relatively little medical treatment following that incident, after which the Petitioner continued to work fully duty until April 1, 2012. With regard to the Petitioner's complaints to her hands and arms, and her complaints of headaches for which she is most recently seeking treatment in Los Angeles, the Arbitrator finds these conditions are not causally related. In support of this finding, the Arbitrator relies on the medical records showing the Petitioner had reached MMI in May, 2013.

2. With regard to the issue of medical expenses, the Arbitrator finds that the Petitioner's medical treatment through January 2, 2013 was reasonable and necessary to alleviate Petitioner's work related conditions. The records from Dr. Watson show that as early as January, 2013, Petitioner was placed at MMI and instructed to return to work. However, Petitioner did not return to work and went back to the doctor complaining of headaches, knee pain, left arm pain, and left hand numbness. Petitioner continued to see Dr. Wilson and Dr. Watson, who later released her full duty as of May 13, 2013. In reviewing the medical records, the Arbitrator is persuaded by Respondent's IME, Dr. Troy that the Petitioner continued to unnecessarily prolong her treatment to remain off work. Therefore, the Petitioner's medical treatment following her release on January 2, 2013 do not appear to be reasonable and necessary. Accordingly, the Arbitrator awards Petitioner all related medical expenses through January 2, 2013 subject to the fee schedule, with Respondent receiving credit for any and all related medical expenses it has paid to thus far.

3. Regarding the issue of TTD, the Arbitrator finds that the Petitioner was temporarily totally disabled from April 2, 2012 through January 2, 2013. Under section 19(d), the Commission may, in its discretion, reduce an award in whole or in part if it finds that a claimant is doing things to retard his or her recovery. A claimant's refusal to undergo medical treatment must be reasonable. Keystone Steel & Wire Company v. IWCC, 72 Ill.2d 474 (1978). In this case, Petitioner purposefully prolonged her treatment, as documented by Dr. Kelly's records. On August 29, 2012, Petitioner indicated to Dr. Kelly that she was interested in a series of epidural steroid injections but preferred to wait until her return to work. Petitioner explicitly told Dr. Kelly that she was not hesitant to undergo the injections. It is clear that under section 19(d), Petitioner purposely retarded her recovery to stay off of work. She had no real treatment after she was released from work hardening. In fact, an FCE indicated, and Dr. Watson confirmed, that she could return to work as of January 2, 2013. This date is also corroborated by Respondent's doctor, who stated she could return to work after she completed her work hardening. Petitioner is trying to confuse the evidence to indicate why she did not return to work when instructed to by both her own physician and Respondent's physician. Petitioner's statement at trial that Respondent did not want her back is in complete contrast to her statement to her doctor that she did not return to work because she was afraid of "passing out." Both her treating doctor and Respondent's doctor told Petitioner to go back to work. She chose not to return. Therefore, Petitioner is entitled to temporary total disability until the date of her release to work, which was January 2, 2013. Accordingly, the Respondent shall pay the Petitioner temporary total disability benefits of $1,107.27/week for 39 2/7 weeks ($43,499.89), commencing from 4/2/12 through 1/2/13, as provided in Section 8(b) of the Act. Respondent will be given a credit of $43,342.93.

4. Pursuant to Section 8.1b of the Act, for accidental injuries occurring after September 1, 2011, permanent partial disability shall be established using five enumerated criteria, with no single factor being the sole determinant of disability. Per 820 ILCS 305/8.1b(b), the criteria to be considered are as follows: (i) the reported level of impairment pursuant to subsection (a) [AMA "Guides to the Evaluation of Permanent Impairment"]; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. Applying this standard to this claim, the Arbitrator notes the following…

(i) Level of Impairment – there was no reported level of impairment offered into evidence and therefore the Arbitrator places no weight on this factor.

(ii) Occupation - . Petitioner was employed as a nurse supervisor, she returned to work shortly after the accident in that capacity, and has continued to work as a nurse since the injury; the Arbitrator places great weight on this factor.

(iii) Age – Petitioner was was 45 years old at the time of the accident and the Arbitrator places some weight on this factor.

(iv) Future Earning Capacity – there was no credible evidence presented at the hearing proving the Petitioner's future earning capacity has been affected by her accident, other than the Petitioner's tearful description of her inability to work a second job, since the medical evidence show that the Petitioner was able to return to her previous job with no medical restrictions and has since been able to obtain employment in other parts of the country as a nurse. The Arbitrator places significant weight on this factor.

(v) Evidence of Disability – there was evidence of Petitioner's disability corroborated by the medical evidence showing that as a result of the Petitioner's April 1, 2012 work accident, she sustained cervical and lumbar strains and underwent physical therapy. Petitioner did not undergo any other treatment other than physical therapy as she refused epidural steroid injections. She returned to work full duty. Petitioner's complaints of hand, arm, and finger numbness are not corroborated by the medical records. Petitioner continues to complain of back pain for which she takes over the counter pain medication and does home exercises.

Based on all these factors, the Arbitrator finds that the Petitioner has sustained 7.5% loss of use to the person as a whole, pursuant to Section 8(d)(2) of the Illinois Workers' Compensation Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BONASORTE, JOSEPH Case# **12WC018561**

Employee/Petitioner

VILLAGE OF ADDISON

Employer/Respondent

On 11/5/2015, 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 0.28% 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:

1404 KETTER, BARRY A
111 W WASHINGTON ST
SUITE 920
CHICAGO, IL 60602

2542 BRYCE DOWNEY & LENKOV LLC
EDWARD A JORDAN
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

STATE OF ILLINOIS)

)SS.

COUNTY OF DuPAGE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JOSEPH BONASORTE
Employee/Petitioner

v.

VILLAGE OF ADDISON
Employer/Respondent

Case # **12** WC **018561**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Wheaton**, on **07/24/2015**. 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 **§8a medical remains open**

FINDINGS

On **02/23/2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$59,934.16**; the average weekly wage was **$1,162.59**.

On the date of accident, Petitioner was **31** 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 **$8,414.52** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$8,414.52**.

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

ORDER

PERMANENT PARTIAL DISABILITY:
The Arbitrator finds that Petitioner sustained a permanent partial disability to the extent of **30%** loss of use of the right leg, and that Respondent shall pay Petitioner permanent partial disability benefits of **$695.78**/week for **64.5** weeks, as provided in §8(b)2, §8(e), and §8.1b(b) of the Act.

MEDICAL BENEFITS:
Respondent shall pay **$235.00** to Elmhurst Orthopedics, subject to the fee schedule, in accord with §8.2 of the Act. Further, medical benefits under § 8(a) shall be remain open and Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, provided in §8(a) and §8.2 of the Act.

CREDITS:
Respondent shall be given a credit of $8,414.52 for TTD. Respondent shall be given a credit for medical 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

November 4, 2015
Date

ICArbDec p. 2

NOV 5 - 2015

Joseph Bonasorte v. Village of Addison
12 WC 18561

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth on July 24, 2015. Disputed Issues were: ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***L:*** What is the nature and extent of the injury?

Petitioner testified at the hearing. Exhibits offered in evidence by the parties were admitted without objections.

STATEMENT OF FACTS

Petitioner testified that he was working for Respondent as an arborist on February 23, 2012. He was removing a tree with a coworker and as they were carrying a log to a wood chipper, the log fell on Petitioner's right leg. Petitioner reported the injury to his supervisor and sought medical treatment with Dr. John Nikoleit at Elmhurst Orthopedics. (PX #1 - #5)

Following the accident Petitioner first treated with Dr. Nikoleit on February 29, 2012. Petitioner reported that he injured his right knee at work. He had a prior right knee injury 10 years before with ACL reconstruction surgery. Examination found tenderness at the medial joint line, clicking sensation, pain with McMurray test, pain with valgus stressing, minimal effusion, and no ACL instability. Dr. Nikoleit diagnosed a possible torn meniscus or medial collateral ligament strain of the right knee. Petitioner was fitted with a hinged brace, placed on light duty, and sent for an MRI.

Petitioner had the MRI of his right knee on March 7, 2012. No obvious meniscal tear was noted. There was mild joint effusion and grade 2 myxoid degeneration of the lateral meniscus. On March 14 Dr. Nikoleit thought there was a questionable tear of the meniscus. He continued Petitioner on light duty. Petitioner began physical therapy for his knee. Petitioner continued to have pain and popping in his knee. On April 25, 2012 Dr. Nikoleit recommended a right knee injection and surgery.

Dr. Nikoleit performed a right knee arthroscopy on May 8, 2012, involving a partial medial meniscectomy and a trochlear chondroplasty. The post-operative diagnoses were torn medial meniscus and chondromalacia of the trochlear. Petitioner had physical therapy after surgery at Physico Sports and Rehabilitation Center through July 13, 2012, at which time Petitioner had achieved his goals. Dr. Nikoleit prescribed Synvisc injections. Petitioner followed up with Dr. Nikoleit on July 10, 2012 and reported that he was doing much better with less pain. Dr. Nikoleit recommended

Petitioner to return to full duty work. Petitioner testified that he returned to regular duty work on July 23, 2012.

Petitioner testified to continuing complaints of pain and swelling in his right knee. Although he is working full time without work restrictions he wears a brace to support his knee. His knee will lock or give out on occasion. His pain is worse when he stands for a long time. He testified that each step is painful. He still trims trees, which requires lifting and carrying tree limbs and branches. He works out of a lift bucket rather than climbs ladders.

Petitioner acknowledged that he had sustained a right ACL injury in 2002 which required surgery. He testified that he was able to work without problems up to his 2012 accident. His doctor did not tell him then that he might have ongoing problems.

Petitioner has remained under care with Dr. Nikoleit. Petitioner has a routine of treatment with injections of cortisone and Synvisc in his right knee: November 19, 2012; January 16, April 10, August 23, and December 27, 2013; February 7, March 27, May 22, November 5, and December 3, 2014; and March 11 and June 12, 2015. (PX # 2 & 5) A new MRI on March 14, 2014 showed an abnormal signal in the posterior horn and body of the medial meniscus but it was uncertain if that represented a new tear of post-operative changes. Dr. Nikoleit injects his knee twice a year, at intervals of about 6 months, with Synvisc. Dr. Nikoleit will inject cortisone periodically between the Synvisc injections. Petitioner testified that the injections give temporary but not lasting relief. Dr. Nikoleit has not modified Petitioner's work status despite the ongoing medical treatment. He has not had physical therapy since his discharge in July 2012.

Petitioner followed up with Dr. Nikoleit on March 11, 2015 with continued right knee pain. Dr. Nikoleit administered a cortisone injection and refilled Petitioner's medications. Petitioner was also seen on June 12, 2015. (PX #5) Dr. Nikoleit diagnosed right knee degenerative joint disease and gave Petitioner another Synvisc injection. Petitioner was also given a toxicology screen based upon continuing use of prescription medications.

Petitioner testified that he is still employed by Respondent as an arborist, which is the job he had at the time of the injury. He is making the same hourly pay rate as at the time of his injury. Petitioner testified that he has to lift and cut tree branches and place branches in wood chippers.

Dr. Nikoleit authored a narrative report to Petitioner's counsel dated August 13, 2014. (PX #3, #4 & #5) Dr. Nikoleit noted that he was managing Petitioner's knee complaints with conservative measures, including injections and prescriptive medication. Dr. Nikoleit opined that Petitioner's diagnosis is right knee patellofemoral degenerative joint disease and medial compartment degenerative joint disease that is related to the work injury. He also opined that Petitioner will require ongoing injections and a greater than 50% likelihood of a knee replacement.

Petitioner was examined pursuant to § 12 of the Act by Dr. Ira Kornblatt, a board certified orthopedic surgeon, on June 27, 2013 and on October 23, 2014. (RX #1 & #2)

At the first exam Dr. Kornblatt reviewed Petitioner's medical records, performed a physical examination of Petitioner's right knee, and drafted an impairment rating report. On exam Dr. Kornblatt observed Petitioner's normal gait. Petitioner was able to squat. Petitioner had reduced flexion in the knee along with crepitance. The knee was stable. Also, meniscal signs were negative. Dr. Kornblatt opined that Petitioner's injury equates to an impairment of 2% of the lower extremity. (RX #1)

Dr. Kornblatt also drafted an addendum IME and Impairment Rating Report dated October 23, 2014. (RX #2) Dr. Kornblatt took x-rays of Petitioner's right knee which he stated revealed no changes from the June 2013 x-rays and well-maintained joint spaces. Dr. Kornblatt opined that his diagnosis for Petitioner's right knee is status-post ACL reconstruction with a work related medial meniscus tear with ongoing symptomatic patellofemoral pain and medial compartment arthritis. Dr. Kornblatt also opined that Petitioner was at MMI, but would require ongoing injections and may require a total knee replacement. Dr. Kornblatt modified Petitioner's impairment rating to a class 2 modifier, but continued with his opinion that Petitioner's impairment rating is 2% of the lower extremity or 1% of the whole person.

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner's current condition of ill-being regarding his right knee is causally related to his workplace accident. The Arbitrator notes that Dr. Nikoleit and Dr. Kornblatt, Respondent's IME physician, both opined that Petitioner sustained a right knee injury caused by his workplace accident on February 23, 2012 and that his current condition was causally related to the accident. Although Petitioner had a pre-existing right knee injury, there was no evidence that he was under medical care at the time of the injury or had ongoing disability or restrictions prior to the work injury.

Therefore, the Arbitrator finds that Petitioner's right knee condition is causally related to the February 23, 2012 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?

The Arbitrator finds that Respondent has not paid all appropriate charges for all reasonable and necessary medical services. Petitioner presented medical bills totaling $235.00 from Elmhurst Orthopedics and Dr. Nikoleit for an office visit and a urine toxicology screening tests. Prior to trial, Respondent's counsel stated that Respondent will agree to pay these medical bills pursuant to the fee schedule. Therefore, the Arbitrator finds Respondent liable for these medical charges, pursuant to the fee

schedule, and that said bills are to be paid directly to the medical providers per Respondent's statement at trial.

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

Petitioner's injury occurred after September 1, 2011 and therefore, permanent partial disability is determined pursuant to §8.1b of the Act. Based on the following, the Arbitrator finds that Petitioner sustained a 30% loss of use of the right leg pursuant to §8.1b(b), based on the following factors:

(i) Petitioner's impairment was evaluated twice by Respondent's retained expert, Dr. Ira Kornblatt. Dr. Kornblatt's assessments were based on his reviews of Petitioner's medical records and clinical examinations of Petitioner. In applying American Medical Association Guide to the Evaluation of Permanent Impairment, 6th Edition, Dr. Kornblatt assessed Pettioner's impairment at 2% of a leg. The Arbitrator, in noting that impairment does not equate to disability under the Act, gives this factor moderate weight.

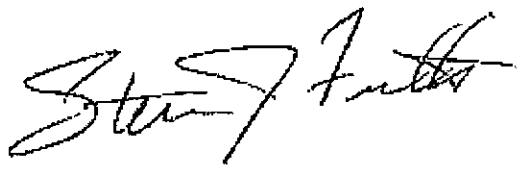
(ii) Petitioner was employed as an arborist at the time of the accident. The job activities involved lifting, bending and carrying such as cut tree branches and trunks. The Arbitrator notes that Petitioner was able to return to work in his prior capacity as a result of said injury. The Arbitrator notes that Petitioner returned to regular duty work with no restrictions in July 2012, 2 months after his knee arthroscopy. Even though Petitioner continues to complain of right knee pain, Dr. Nikoleit has not modified Petitioner's work status. The Arbitrator therefore gives great weight to this factor.

(iii) Petitioner was 31 years old at the time of his injury. His statistical life expectancy was 47 years and his statistical worklife expectancy was 28 years. The Arbitrator gives great weight to this factor.

(iv) Petitioner returned to his prior employment following his surgery. There was no evidence that his earning capacity has been adversely affected by his injury. The Arbitrator gives no weight to this factor.

(v) Petitioner sustained an injury to his right knee which required arthroscopic repair of a torn medial meniscus and a trochlear chondroplasty. Before his surgery Petitioner went through physical therapy without significant relief. Post-operative physical therapy provided some but not total relief. Following surgery Petitioner returned to work but continued to receive periodic medical care for his continuing complaints. He has a degenerative knee joint which requires injections of cortisone and Synvisc, a synovial fluid replacement, several times a year. Petitioner's treating physician, Dr. Nikoleit, has opined that Petitioner has a greater that 50% likelihood of need a total knee replacement. Respondent's § 12 expert, Dr. Kornblatt, did not dispute Dr. Nikoleit's opinion regarding a future knee replacement or its relation to the workplace accident. The Arbitrator gives great weight to this factor.

Therefore, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 30% loss of use of Petitioner's right leg pursuant to §8(b)2 and §8.1b(b) of the Act, equaling 64.5 weeks of permanent partial disability benefits at the maximum rate of $695.78 per week.



November 4, 2015

Steven J. Fruth, Arbitrator

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

WATSON, HEATHER Case# **12WC021584**

Employee/Petitioner

SILGAN CONTAINERS

Employer/Respondent

On 11/5/2015, 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 0.28% 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
NICHOLAS M SHIRO
510 N VERMILION
DANVILLE, IL 61832

0560 WIEDNER & McAULIFFE LTD
KHRIS DUNARD
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

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)

Heather Watson
Employee/Petitioner

Case # 12 WC 21584

v.

Consolidated cases: n/a

Silgan Containers
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 September 10, 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 (manifestation), April 19, 2012, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $41,600.00; the average weekly wage was $800.00.

On the date of accident, Petitioner was 34 years of age, single with 2 dependent child(ren).

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

Respondent shall be given a credit of $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $4,800.00 for other benefits, for a total credit of $4,800.00. At trial, the parties stipulated that TTD and maintenance benefits had been paid in full through February 15, 2015.

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 in the amount of $8,764.00 as identified in Petitioner's Exhibits 3, 4 and 8 for medical services provided to Petitioner as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall pay Petitioner additional maintenance benefits of $533.33 per week for 28 1/7 weeks commencing February 16, 2015, through August 31, 2015, as provided in Section 8(a) of the Act.

Petitioner's Petition for penalties and attorneys' fees is denied.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

October 28, 2015
Date

NOV 5 - 2015

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained a repetitive trauma injury arising out of and in the course of her employment for Respondent. The Application alleged a date of accident (manifestation) of April 19, 2012, and that Petitioner sustained an injury to the "Whole Body" as a result of "Repetitive bending, turning & twisting" (Arbitrator's Exhibit 6).

This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of maintenance benefits and medical bills. Petitioner also filed a Petition for Section 19(k) and 19(l) penalties as well as Section 16 Attorneys' Fees.

At trial, Petitioner claimed to be entitled to payment of temporary total disability benefits from March 22, 2013, through January 27, 2015 (96 4/7 weeks) and maintenance from January 28, 2015, through August 31, 2015 (30 6/7 weeks). Petitioner and Respondent stipulated that all temporary total disability and maintenance benefits had been paid through February 15, 2015, and that the disputed period of maintenance was from February 16, 2015, through August 31, 2015, a period of 28 1/7 weeks (Arbitrator's Exhibit 1).

In regard to medical bills, Petitioner tendered into evidence medical bills which totaled $8,764.00. Respondent did not dispute its liability for same and stipulated that the bills had either been paid or would be paid (Arbitrator's Exhibit 1).

This case was previously tried in a 19(b) proceeding on March 21, 2013, before Arbitrator Douglas McCarthy. Arbitrator McCarthy's Decision was filed with the Commission on April 12, 2013. Arbitrator McCarthy ruled in favor of the Petitioner and found that Petitioner sustained a compensable repetitive trauma injury to her low back and that her condition of ill-being was causally related to same. He awarded Petitioner temporary total disability benefits, medical bills and prospective medical treatment. The award for prospective medical treatment specifically ordered that Respondent approve and pay for an L5-S1 anterior lumbar interbody fusion with posterior instrumented fusion as recommended by Dr. Darvish and Dr. Rinella. Respondent filed a review of Arbitrator McCarthy's Decision with the Commission. With the singular exception of removing one sentence of Arbitrator McCarthy's Decision that did not alter his award, the Commission affirmed and adopted Arbitrator McCarthy's Decision in a Decision and Opinion on Review entered on April 22, 2014 (Petitioner's Exhibit 1). In spite of the preceding, Respondent disputed causal relationship when this 19(b) proceeding was tried (Arbitrator's Exhibit 1).

Dr. Anthony Rinella was Petitioner's primary treating physician and he performed back surgery on June 30, 2014. The surgical procedure consisted of a microdiscectomy at L5-S1 on the right side. Following surgery, Petitioner continued to be treated by Dr. Rinella who ordered physical therapy. When Dr. Rinella saw Petitioner on November 13, 2014, he ordered a functional capacity evaluation (FCE) of Petitioner (Petitioner's Exhibit 2; Deposition Exhibit 2).

The FCE was performed on January 20, 2015. According to the FCE report, Petitioner demonstrated "high levels of physical effort" during the testing. The physical therapist who performed the FCE noted that there was the presence of what he described as a "minor

inconsistency" in regard to the reliability and accuracy of Petitioner's complaints of pain and disability. However, he also noted that he was not implying intent on the part of Petitioner, but that Petitioner may have been able to do things, at times, beyond what she currently stated or believed (Petitioner's Exhibit 1; Deposition Exhibit 3).

The FCE examiner reviewed a statement of the physical demands of a Press Operator (the job Petitioner had at the time of manifestation) and concluded that Petitioner's physical abilities did not meet the job requirements. Specifically, the FCE examiner opined Petitioner could perform light to medium work with occasional lifting below waist height to 26 pounds; occasional sitting, bending, stooping, squatting, kneeling, carrying, stair climbing, ladder climbing and overhead reaching. The FCE examiner also opined that Petitioner was capable of walking on a constant basis (Petitioner's Exhibit 1; Deposition Exhibit 3).

Dr. Rinella subsequently saw Petitioner on January 28, 2015, and reviewed the report of the FCE. He opined that Petitioner was at MMI and imposed permanent work restrictions based on the FCE. Dr. Rinella opined that Petitioner was restricted from constant standing and walking (more than two-thirds of the day) and occasional sitting (up to one-third per day). He limited Petitioner's lifting to 20 pounds constantly and 50 pounds occasionally. He opined Petitioner could carry 20 pounds constantly and push/pull occasionally. In regards to Petitioner's agility, Dr. Rinella a restricted her from climbing ladders, as well as no repetitive stairs, crouching, crawling, twisting or bending (Petitioner's Exhibit 2; Deposition Exhibit 2).

At the direction of Respondent, Petitioner was examined by Dr. Donald deGrange, an orthopedic surgeon, on February 2, 2015. In connection with his examination of Petitioner, Dr. deGrange reviewed various diagnostic studies and medical reports including the report of the FCE. In regard to his examination of Petitioner, Dr. deGrange noted that it was a completely normal neurological examination. He opined that Petitioner was at MMI and could return to work without restrictions (Respondent's Exhibit 2).

Dr. deGrange was deposed on April 7, 2015, and his deposition testimony was received into evidence at trial. On direct examination, Dr. deGrange's testimony was consistent with his medical report and he reaffirmed his opinions that Petitioner was at MMI and could work without restrictions. In regard to the FCE, Dr. deGrange testified that he did not agree with its findings, primarily because of the subjective nature of the testing and the inconsistency noted by the examiner which Dr. deGrange described as "self-limiting behaviors." He opined that the examiner did not get a full and accurate view of Petitioner's physical capacities (Respondent's Exhibit 1; pp 18-20).

On cross-examination, Dr. deGrange stated that it would be "speculative" on his part to state that the FCE results were reliable. When questioned about whether he would rely on the FCE given Petitioner's minor inconsistency and her reliability regarding pain and disability, his response was "I do look at the report and I apportion an appropriate amount of weight to it. I wouldn't completely accept it or completely disregard it." Dr. deGrange then stated that the inconsistencies noted by the FCE examiner were not the reason for his opining that Petitioner could return to work without restrictions, but that it was the lack of objective findings on examination and his review of the diagnostic studies (Respondent's Exhibit 2; pp 26-28).

Dr. Rinella was deposed on August 19, 2015, and his deposition testimony was received into evidence at trial. In regard to the L5-S1 microdiscectomy surgery he performed on June 30, 2014, Dr. Rinella testified that he changed the surgical procedure from an interbody fusion to a microdiscectomy because he was not able to secure approval from the insurance carrier for performing the fusion surgery. Ultimately, Dr. Rinella performed the microdiscectomy and Petitioner made a good recovery subsequent to same (Petitioner's Exhibit 2; pp 13-16).

Dr. Rinella testified at length in regard to the FCE. He stated that if an FCE is well done (which it was in this case) then it is reliable in making a determination of work restrictions. He reaffirmed his opinion that Petitioner was at MMI and that the work restrictions he imposed were permanent. He specifically noted that Petitioner's physical effort findings were "reliable" (Petitioner's Exhibit 2; pp 17-21).

On cross-examination, Dr. Rinella was questioned about Petitioner's self-limiting behavior and he stated it was not present in this case. He was also interrogated about the minor inconsistency noted by the FCE examiner in regard to Petitioner's reliability and accuracy of her complaints of pain. Dr. Rinella responded that this did not cause him to have any level of concern. He also noted that the FCE was just one tool he used to determine what permanent restrictions were appropriate (Petitioner's Exhibit 2; pp 27-31).

At trial, Petitioner testified that she did a self-directed job search without the assistance of a vocational/employment expert. Petitioner stated that she did a significant amount of job searching online. Petitioner tendered into evidence a list of 13 jobs for which she submitted written applications between February 17, 2015, and August 20, 2015 (Petitioner's Exhibit 11).

Petitioner testified that she was hired by Teasdale Foods (the last employer on the list) and had just started working there on September 1, 2015. Petitioner works in inventory control and observes beans going by her on a conveyor belt and removing those that look bad. When she is working, Petitioner does have the option to sit or stand as needed. Petitioner stated that she still has some complaints of low back pain, especially with physical activity.

Conclusions of Law

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

The Arbitrator concludes that Petitioner's current condition of ill-being is causally related to the work-related repetitive trauma that manifested itself on April 19, 2012.

In support of this conclusion the Arbitrator notes the following:

In the prior 19(b) Decision, Arbitrator McCarthy found that there was a causal relationship between Petitioner's work activities and the condition of ill-being in her low back. This Decision was subsequently affirmed by the Commission.

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 services of $8,764.00 as identified in Petitioner's Exhibits 3, 4 and 8, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

In support of this conclusion the Arbitrator notes the following:

In the prior 19(b) Decision, as affirmed by the Commission, Respondent was ordered to pay for prospective medical treatment. At trial, Respondent stipulated that these medical bills had either been paid or would be paid.

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

The Arbitrator concludes Petitioner is entitled to additional maintenance benefits of 28 1/7 weeks commencing February 16, 2015, through August 31, 2015.

In support of this conclusion the Arbitrator notes the following:

Both Petitioner's primary treating physician, Dr. Rinella, and Respondent's Section 12 examiner, Dr. deGrange, opined that Petitioner was at MMI on January 28, 2015, and February 2, 2015, respectively.

Respondent terminated Petitioner's maintenance benefits effective February 15, 2015, based upon Dr. deGrange's opinion that Petitioner could return to work without restrictions.

Dr. Rinella testified that the FCE was a reliable study and the fact that the FCE examiner noted what he characterized as a "minor inconsistency" did not cause him concern.

The FCE examiner specifically noted that the minor inconsistency of Petitioner's complaints of pain and disability was not indicative of any intent on her part nor did invalidate the study. The examiner specifically noted that Petitioner exhibited high levels of physical effort.

Dr. Rinella testified that Petitioner did not exhibit self-limiting behavior and that the FCE was one tool he used to determine appropriate work restrictions.

Dr. deGrange's testimony as to his opinion in regard to the FCE was unclear. He stated that he disagreed with it; however, he also said he would give it an appropriate amount of weight and would not completely accept or disregard it. The Arbitrator is unable to determine what weight, if any, Dr. deGrange gave the FCE; however, it appears as though he totally ignored the FCE because he opined that Petitioner could return to work without restrictions.

Based on the preceding, the Arbitrator finds the opinion of Dr. Rinella to be more persuasive and credible than that of Dr. deGrange.

While the evidence regarding Petitioner's job search is limited to her testimony regarding same and the list of jobs for which she made an application, the Arbitrator finds Petitioner's testimony to be credible. This was supported by the fact that Petitioner was successful in her efforts to secure employment.

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

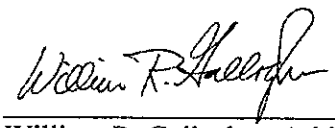
The Arbitrator concludes Petitioner is not entitled to Section 19(k) and Section 19(l) penalties or Section 16 Attorneys' Fees.

In support of this conclusion the Arbitrator notes the following:

As stated herein, the Arbitrator found Petitioner's treating physician, Dr. Rinella, to be more persuasive and credible than Respondent's Section 12 examiner, Dr. deGrange, and has ordered Respondent to pay Petitioner maintenance benefits.

Dr. deGrange examined Petitioner and opined that she could return to work without restrictions. Respondent based its termination of maintenance benefits on Dr. deGrange's opinion and the Arbitrator finds that it was neither vexatious nor unreasonable.

In regard to the medical bills awarded herein, there was no evidence as to when the bills were tendered to Respondent or that Respondent has, in fact, refused to make payment of same.



William R. Gallagher, Arbitrator

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SCHWARTZ, CHERYL Case# **12WC029827**
Employee/Petitioner

GELITA USA INC
Employer/Respondent

On 11/5/2015, 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 0.28% 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
MICHAEL S ROLENC
200 N LASALLE ST SUITE 2820
CHICAGO, IL 60601

4412 ACCIDENT FUND HOLDINGS INC
GRACE DiGERLANDO
200 W MADISON ST SUITE 3850
CHICAGO, IL 60606

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Cheryl Schwarz
Employee/Petitioner

v.

Gelita USA, Inc.
Employer/Respondent

Case # **12** WC **29827**

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 **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **October 22, 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 _____

FINDINGS

On **July 22, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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 **$48,093.93**; the average weekly wage was **$924.88**.

On the date of accident, Petitioner was **55** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$2,202.11** for TTD, **$N/A** for TPD, **$N/A** for maintenance, and **$N/A** for other benefits, for a total credit of **$2,202.11**.

Respondent is entitled to a credit of **$869.04** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $554.93/week for 25 weeks, because the injuries sustained caused 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.

David A. Kane
Signature of Arbitrator

November 5, 2015
Date

NOV 5 - 2015

CHERYL SCHWARZ V. GELITA USA, INC.

CASE NUMBER: 12 WC 29827

FINDINGS OF FACT:

On October 22, 2015, this matter was tried before Arbitrator Kane at the Illinois Workers' Compensation Commission in Chicago. The petitioner testified that she was employed as a process operator for Gelita and had been in their employ since approximately January of 2012. The petitioner testified that on July 22, 2012, after her work shift had ended, she slipped and fell in the shower at work striking her left shoulder, temple and jaw on the cement curb of the shower. Following the fall, she testified that she was "phasing in and out," as if she were going to pass out.

The petitioner testified she was taken to the St. Margaret Hospital by her foreman on July 22, 2012. She testified that she was not admitted to the hospital. Subpoenaed medical records dated July 22, 2012 evidence that the petitioner reported that she slipped and fell getting out of the shower. She complained of left jaw and temple pain as well as swelling in her left humerus. She denied neck pain, loss of consciousness, headache, nausea and vomiting, but reportedly did "not feel right." CT of the brain and facial bones did not reveal anything of significance. X-rays of the left wrist revealed mild soft tissue swelling around the wrist joint. X-rays of the left shoulder were negative for fracture or dislocation, but exhibited osteoarthritic changes of the AC joint. The petitioner was assessed with "fall due to wet surface," head contusion and arm contusion. (PX 1)

Subsequently, the petitioner testified that she was seen at Ingalls Occupational Health on July 25, 2012. She testified that she experienced pain in her left shoulder, left shin, and left temple. The petitioner testified that she continued to follow-up at Ingalls Occupational Health and, on August 1, 2012, she began physical therapy. She testified that she continued to follow up at Ingalls Occupational Health therafter.

On July 25, 2012, the petitioner was evaluated by Dr. Priya Shastri at Ingalls Occupational Health. Her primary pain was reportedly located in the left shoulder and upper arm as well as some pain over the face. She was noted to be alert and oriented x 3. Dr. Shastri diagnosed the petitioner with a contusion, "unspecified" pain and left wrist pain. It was recommended that she return to restricted work with no lifting or carrying in excess of 5 pounds. Tylenol was to be taken as needed. (PX 2)

On July 30, 2012, the petitioner returned to Ingalls Occupational Health with complaints of pain in the left shoulder, upper arm and left temple area. Interestingly, there are two medical notes from Ingalls Occupational Health dated July 30, 2012. One signed by a nurse, which references complaints of headaches that "came and went," but no vomiting, dizziness or loss of consciousness and the other, signed by a physician, that merely notes arm complaints, but no complaints of headaches, etc. Work restrictions were imposed and the petitioner was advised to begin physical therapy for her left shoulder. (PX 2) On August 1, 2012, the petitioner began attending physical therapy at Accelerated Rehabilitation Centers. (PX 8)

On August 7, 2012, the petitioner returned to Ingalls Occupational Health with the same complaints. She was again released to restricted work and continued therapy was recommended. (PX 2)

On August 21, 2012, the petitioner returned to Ingalls Occupational Health with a primary complaint of pain in the left shoulder; however, it was noted that the petitioner felt she was improving and that therapy helped with her pain. She was again prescribed work restrictions and advised to continue with therapy. (PX 2) On August 27, 2012, the petitioner ceased attending physical therapy for her shoulder after attending 6 sessions of therapy. (PX 8)

On August 29, 2012, the petitioner returned to Ingalls Occupational Health and a primary problem of left shoulder pain was noted. Reportedly, the petitioner

had improved after 5 sessions of physical therapy. She was diagnosed with a left shoulder contusion and work restrictions were imposed. (PX 2)

On September 13, 2012, the petitioner was evaluated by Dr. Timothy McManus. Reportedly, the evening of her accident, she began to experience nausea, dizziness, vomiting and reduced appetite. Allegedly, she continued to experience those symptoms for two weeks. Dr. McManus noted that he did not have any medical records to review. The petitioner complained of sleep disruptions, headaches, making errors at work, and reduced range of motion of her arm. Her prior medical history was "reportedly otherwise unremarkable." (PX 3)

Upon "mental status examination," Dr. McManus noted that the petitioner was alert and oriented to person, place, time and situation. Additionally, the petitioner's thought process appeared coherent and adequately associated. Affective range reportedly appeared constricted, emotional expression appeared blunted and the petitioner's mood appeared irritable and angry. Reportedly, there was no evidence of psychomotor retardation or agitation and the petitioner's frustration tolerance reportedly appeared low to fair. Pain control was noted to be variable for headache control and the petitioner denied the use or abuse of alcohol. She exhibited grossly intact auditory and visual acuity. Additionally, the petitioner's social interaction skills, language comprehension and expressive language appeared intact. Remote memory skills also reportedly appeared grossly intact "since she was recalling details of her work fall." (PX 3)

After evaluating the petitioner, Dr. McManus assessed her with cognitive disorder "NOS," adjustment disorder (unspecified), closed head injury with headaches and fall at work. Dr. McManus authorized the petitioner off of work for a period of 10 to 14 days, Lunesta was prescribed, and it was recommended that the petitioner be evaluated by an optometrist to rule out any visual impairment. (PX 3)

On September 13, 2012, the petitioner returned to Ingalls Occupational Health with continued complaints of pain in the left shoulder. She also complained of occasional headaches and nausea. Following her evaluation, the petitioner was diagnosed with a left shoulder contusion and post-concussion syndrome. It was noted that the "case was discussed with Dr. McManus who saw the patient" and recommended 10 days off of work for "brain rest." The petitioner was authorized off of work accordingly. (PX 2)

On September 17, 2012, the petitioner telephoned Dr. McManus' office and reported "no progress in any area of concern." She was encouraged to utilize a different sleep medication and it was noted that she would try Trazadone. (PX 3)

On September 24, 2012, the petitioner telephoned Dr. McManus' office and reported that she "finally received solid and uninterrupted nights of sleep." She also reported that "with improved sleep, her headaches had improved significantly." Because of the petitioner's "adamant objections to return to work on Saturday the 29th," it was noted that she would be released to return to work on October 3rd. (PX 3)

On September 24, 2012, the petitioner returned to Ingalls Occupational Health with complaints of intermittent headache and loss of sleep. Reportedly, her shoulder pain had resolved. It was noted that her work status would be per Dr. McManus and she was discharged from care. (PX 2)

On October 1, 2012, the petitioner returned to Dr. McManus and reported that she remained improved and that her headaches were "under improved control." She was released to return to work on October 3, 2012. (PX 3)

The petitioner testified that she was evaluated by Dr. Abassi on October 8, 2012. Per subpoenaed medical records, the petitioner was evaluated by Dr. Shaikh-Abassi on that date and reported her prior history following her injury of July 22, 2012. The petitioner reported that "last week she drank too much alcohol after many years and was drunk." Reportedly, she then passed out and was taken

to the emergency room on September 30, 2012. Lab results evidenced alcohol intoxication and CT of the head was normal. The petitioner presented at this evaluation because she "did not want to go back to drinking." Dr. Abassi assessed the petitioner with "insomnia, unspecified" and acute alcoholic intoxication. The petitioner was referred to an AA meeting and to Dr. Reddy for evaluation. She was to follow up in 4 weeks. (PX 4)

The petitioner testified that she was evaluated by Dr. McManus on October 19, 2012, and she remembered telling him about her alcohol usage. She testified that she had been dry for ten years at that time and felt that her recent prescription of Trazadone had caused her to drink. She testified that she was told that she had slapped her neighbor in a bar and that the police were called. She testified that she did not fall as a result of that accident and had gone to the hospital because they had a hard time awakening her.

On October 19, 2012, the petitioner returned to Dr. McManus and reported that she had consulted her primary care physician about her sleep medication because she had consumed alcohol at a wedding and she had not consumed alcohol in over 10 years. The petitioner reported that she had a prior problem with alcohol abuse and "she attributed her recent alcohol use solely to her use of Trazadone." When asked why she denied her alcohol use previously, the petitioner related that she "didn't think it was relevant." The petitioner reported that her primary care physician advised her to stop taking Trazadone and Lunesta was prescribed; however, the petitioner now complained of sleep problems again. Reportedly, the petitioner wished to consult with another physician at the Rehabilitation Institute and no further sessions were scheduled. (PX 3)

On March 28, 2013, the petitioner returned to Dr. Shaikh-Abassi for issues unrelated to her work injury of July 22, 2012. It was noted that she complained of fatigue and felt that her work shift (i.e. three 12 hour shifts) may be the cause of the same. She was assessed with chronic fatigue, chronic hepatitis C,

constipation and contact with and suspected exposure to other potentially hazardous substances. (PX 4)

The petitioner followed up with Dr. Shaikh-Abassi on March 29th, April 25th, and May 1st of 2013. On May 1, 2013, Dr. Shaikh-Abassi noted that he felt that the petitioner's fatigue was due to her long night shifts. The remainder of these reports are unrelated to the petitioner's work injury. The petitioner also returned to Dr. Shaikh-Abassi on May 23, 2013 for unrelated issues. (PX 4)

On June 27, 2013, the petitioner returned to Dr. Shaikh-Abassi and reported that she had "memory issues" since she hit her head in July of 2012 and that she "just doesn't feel the same – feels run down." Reportedly, the petitioner found it difficult to function on the 3rd shift and it was noted that she always worked three 12 hours night shifts in a row. It was discussed that the petitioner should talk to her boss about the same and possibly switching shifts. Reportedly, the petitioner felt more forgetful than usual and was always "double and triple checking herself at work." The petitioner was assessed with memory loss and referred to a neurologist. Dr. Shaikh-Abassi noted that he felt that her "three back to back 12 hour night shifts are not appropriate for her and she should talk to her company." (PX 4)

On July 9th, July 16th, September 3rd, October 16th, October 23rd, and December 5th of 2013, the petitioner was evaluated at Dr. Shaikh-Abassi's office for issues unrelated to her work accident. (PX 4)

On July 18, 2013, the petitioner was evaluated by Dr. Christopher Simon of Hinsdale Neurology. Reportedly, she presented for consideration of "multiple post traumatic neurological problems, following closed head injury last year." It was noted that the petitioner had a history of chronic hepatitis C and a remote history of alcohol abuse. She had been treated with interferon in the past. (PX 5; pg. 15) Reportedly, she worked as a process control engineer "with great responsibilities." Per this report, while staying in a hotel for work in Indiana the preceding year, the

petitioner stepped out of the shower and slipped and fell, landing on her right head. The petitioner reported that she began drinking again for a short time in September of 2012 after she was placed on Trazadone. Reportedly, at that time, the petitioner got into an altercation at a bar and was jailed during which time she fell and hit her head without obvious sequelae. Since that time, the petitioner had allegedly not started drinking again. (PX 5)

The petitioner complained of "developing poor memory" with an inability to retain or process. Reportedly, she worked three consecutive 12 hour shifts during the week and "by the second day she feels very forgetful." Allegedly, she had been much more labile and "feeling down." She complained of not having energy, but reportedly slept 8 to 9 hours per night. The petitioner denied difficulty with calculations, navigating familiar areas, driving or any of her basic ADLs. She complained of chronic daily pain over her forehead associated with nausea and sensitivity to light and sound. She denied neck pain, positional headache, blurry or double vision, visual field cut, or focal sensory or motor symptoms. The petitioner also denied dizziness, vertigo and change in gait. (PX 5)

After evaluating the petitioner, Dr. Simon noted that she presented with a "constellation of post-traumatic neuro-cognitive and vegetative symptoms..." and her clinical picture was "consistent with post concussive syndrome mainly as a result of her initial more significant head trauma and possibly exacerbated by her second head trauma in September of 2012." Dr. Simon noted that the petitioner's examination was significant for mild frontal-dysecutive dysfunction by Montreal Cognitive Assessment, where she had difficulty with "Trail making," memory retrieval and verbal fluency. The aforementioned was reportedly not unusual for post concussive syndrome and would explain the petitioner's difficulty with concentration, memory, sedation and multi-tasking. Her other "neuro-vegetative symptoms of fatigue, hypersomnolence, depressed mood and mood liability" were "likely part of the syndrome." Finally, Dr. Simon noted that "post concussive

migraine headaches would explain the petitioner's frequent headaches without prior history of migraines." A brain MRI was recommended and Venlafaxine was prescribed. Dr. Simon noted that although most patients recover from post concussive syndrome over several weeks to months, 10% to 15% can have symptoms over a year. (PX 5)

On August 1, 2013, the petitioner underwent a MRI of her brain, which exhibited single focus of T2 prolongation within the left corona radiate, which was "non-specific and most likely represents gliosis." (PX 5)

On August 6, 2013, the petitioner returned to Dr. Simon and it was noted that her MRI was normal. Venlafaxine was prescribed and the petitioner reported that over the past month she felt altogether better with fewer headaches, improved mood and less dizziness. She also reported sleeping better. It was noted that she continued with low-grade tension-type headaches and some dizziness. The petitioner's Venlafaxine was increased and she was advised to engage in more cognitively stimulating activities. (PX 5)

On February 12, 2014, the petitioner returned to Dr. Simon and reported that she felt like she was "losing her memory over the past several months." She denied depressed mood, anxiety, panic, sleep difficulty, disabling headaches, focal sensory or motor symptoms, neck pain, etc. After meeting with the petitioner, Dr. Simon noted that her injury was over a year ago, so it was "unusual that she should have a downturn in her cognitive functioning now," which raised the question of whether she might have an underlying psychological disorder, sleep disorder or other medical problem. Neuropsychological testing was recommended. (PX 5)

The petitioner testified that she was evaluated by Dr. Hill on March 12, 2014, due to her complaints of poor memory, poor functioning, and just not feeling well. At that time, the petitioner testified that she was referred to TMS Services, Dr. Roberts. On March 12, 2014, the petitioner underwent a Neuropsychological

Evaluation with Dr. Erin Hill. Various tests were administered. The petitioner reported difficulty with functioning, memory and problem solving along with diminished attention and concentration, which she attributed to a head injury she sustained at work (i.e. trip in shower) in 2012. She complained of ongoing symptoms of headaches (i.e. one to two times per month), poor balance, dizziness, occasional blurry vision, sadness, hopelessness, poor motivation, loss of pleasure in activities, periods of "nervousness" and sleep difficulties. The petitioner denied a history of depression, anxiety, manic symptoms, panic or substance abuse. Reportedly, following her fall "at some point" she was prescribed an antidepressant medication, but reported experiencing problematic side effects. (PX 6)

After reviewing the petitioner's medical records and summarizing the results of her neurocognitive assessment, Dr. Hill noted that the petitioner demonstrated good effort on response bias testing and overall baseline intellect was estimated to fall in at least the average range. Neurocognitive strengths included high average working memory, focused visual attention, visual reasoning and visual processing speed in addition to "solidly average" verbal reasoning, divided attention, planning abilities, problem solving, set shifting skills, semantic verbal fluency abilities, and verbal learning and memory for stories. In contrast, Dr. Hill noted that the petitioner demonstrated organizational difficulties when copying a complex figure, coupled with low average to moderately impaired verbal and visual learning and memory and right hand dexterity. Evaluation of mood reportedly revealed mild symptoms of depression. (PX 6)

"In general," Dr. Hill noted that the petitioner "demonstrated cognitive difficulties in the way of organization, visual learning and memory, and variable verbal learning and memory functions in the context of at least average baseline abilities. These difficulties are suggestive of overall reduced cognitive efficiency and are consistent with her reported difficulties." Dr. Hill noted that, "according to

her report, these changes represent a decline in baseline functions that occurred following an accident in which she struck her head." Based on the injury parameters (i.e. "brief alteration in consciousness, recall of the event, no positive imaging findings"), Dr. Hill noted that her injury would be characterized as a mild traumatic brain injury. According to Dr. Hill, most individuals who sustain a mild traumatic brain injury recover fully within 3 months; however, a subset of individuals continue to experience reported memory and attention changes. "Often additional factors such as mood, pain, and fatigue play a role in continued difficulties." For the petitioner, Dr. Hill noted that "fatigue, headaches and mild mood symptoms explain reported and observed cognitive difficulties." Ruling out additional medical factors such as underlying sleep disorder was recommended. (PX 6)

Dr. Hill recommended that the petitioner continue to follow-up with Dr. Simon and a sleep study was recommended along with individual psychotherapy. The petitioner was referred to Dr. Terri Schultz for psychotherapy. According to Dr. Hill, medication consultation for depression should be considered following re-assessment of mood symptoms after a designated period of therapy. Strategies to compensate for cognitive weaknesses were provided. Finally, follow-up neuropsychological evaluation was recommended should the petitioner experience a change in cognitive functioning. (PX 6)

On May 2, 2014, the petitioner returned to Dr. Shaikh-Abassi and complained of depression and constipation. Reportedly, the petitioner had "been depressed for a while -works from 6pm to 6am and this is hard for her." It was noted that "work has been tough." The petitioner was assessed with depressive disorder and chronic hepatitis C. Lab work was ordered and Dr. Shaikh-Abassi noted that he felt that her depression was "more related to her shift schedule." It was recommended that the petitioner see a therapist. (PX 4)

On September 30, 2014, the petitioner was seen by Ms. Jennifer Roberts of TMS Psychological Services. Reportedly, she complained of relationship stress, poor focus and memory trouble for a "few years." The aforementioned was noted to be precipitated by family and work stress. Her progression was noted to be stable and severity was described as moderate. After meeting with the petitioner, Ms. Roberts assessed her with adjustment disorder – mixed anxiety/depressed mood. According to Ms. Roberts, the petitioner struggled with "high levels of stress and relationship trouble that seems to be related to a challenging work environment (including 12 hour third shift alternating day). These troubles may or may not be related to a head trauma" the petitioner "endured about a year ago." Weekly individual therapy was recommended to improve stress management and decrease relationship stress. (PX 7)

The petitioner returned to Ms. Roberts on October 17th, November 11th, December 4th, and December 18th of 2014 and on January 15th and February 26th of 2015. She continued to complain of relationship, family and work stress. (PX 7)

On February 7, 2015, Dr. Russell Glantz, a neurologist, prepared a records review in which he restricted his opinions to the petitioner's neurological issues, including headaches and ongoing cognitive functioning. Dr. Glantz noted that based upon the records he reviewed, the petitioner bumped her head at the time of the slip and fall incident on July 22, 2012 and complained of jaw and temple pain in the emergency room. The petitioner did not lose consciousness and there was no diagnosis of any brain injury in the emergency room. A CT of the brain was taken and was reportedly normal. Dr. Glantz noted that the petitioner first complained of headaches on September 13, 2012 and a diagnosis of post concussive syndrome was provided at that time. Reportedly, this was 7 to 8 weeks post incident and, therefore, "because there was so long a delay in reporting symptoms, such symptoms of headache or cognitive dysfunction or dizziness, are

not connected to the incident of July 22, 2012." According to Dr. Glantz, if an individual suffers a concussion or brain injury, symptoms will be apparent almost immediately or within a few days of the incident. (RX 1)

In Dr. Glantz's opinion, the petitioner suffered, at most, a minor head injury. Dr. Glantz noted that the petitioner did not complain of neurocognitive difficulties to the Ingalls Clinic "in a time frame connectable to the incident." Again, Dr. Glantz noted that if neurocognitive difficulties are experienced, someone will complain of them either immediately or within a few days. Additionally, Dr. Glantz noted that the petitioner had a "significant compounding history." Reportedly, she was a prior alcoholic, but began drinking again in September of 2012. As a consequence of the aforementioned, the petitioner was "in some form of altercation and was kicked in the head," which means that "she had a head injury at that time." The aforementioned necessitated an emergency visit not only for the head injury, but also for the acute alcoholic intoxication. (RX 1)

Dr. Glantz noted that at one point, the petitioner began to complain of more memory difficulties after having apparently improved with respect to her symptoms, which "would be unusual for any symptomatology that was as a result of the prior head injury where one would not expect further worsening of symptoms." Around that time, it was noted that the petitioner was undergoing treatment for hepatitis C and "it is well known that the types of medications used to treat hepatitis C, including the interferon drugs may have problems ranging from subtle cognitive impairment to worsening headache, vomiting and even focal neurological symptoms." The aforementioned was reportedly not considered by the petitioner's treating physician, Dr. Simon, and it was noted that the petitioner failed to inform Dr. Hill about her prior substance abuse and to tell Dr. McManus of her prior alcohol abuse. Dr. Glantz noted that the importance of the aforementioned was that substance abuse frequently causes cognitive dysfunction

and needed to be taken into account when assessing an individual's psychological state. (RX 1)

Based upon Dr. Glantz's review of the petitioner's records, he opined that the petitioner did not require additional medical treatment for any head injury sustained on July 22, 2012. Even if the petitioner suffered from a very mild head injury, Dr. Glantz noted that she would have recovered by this time and reached MMI. Again, Dr. Glantz noted that there was no indication that any of the petitioner's symptomatology was connectable to her injury. Referring to neurological complaints, Dr. Glantz again noted that there was no diagnosis of such an injury in a time frame connectable to the incident and any treatment beginning in September of 2012 for subjective symptoms was unrelated to the July 22, 2012 incident. Dr. Glantz further noted that treatment by Dr. Simon, including testing, beginning one year after the incident, was not connected to the incident. Finally, Dr. Glantz noted that based upon his review of the treating records and his clinical experience, the petitioner did not sustain any permanent disability as a result of any possible neurological injury sustained on July 22, 2012. (RX 1)

At the time of trial the petitioner testified that she continued to work full time, 12 hour shifts at Gelita. The petitioner testified that her current complaints were poor memory, terrible mood, headaches, and problems sleeping/staying asleep.

On cross-examination, the petitioner testified that she recalled falling down the stairs in January of 2011 and undergoing two CT scans of her head at that time. On cross-examination, she testified that she was evaluated at the Emergency Room, on September 30, 2012, after becoming drunk and getting in an altercation with a neighbor. The petitioner testified that a CT scan of her head was taken at that time as well. She testified that her head pain did not increase following her altercation on September 30, 2012.

On cross-examination, the petitioner testified that she had been released to full duty work on October 3, 2012, and that she had worked full duty since that time. She denied sustaining any injuries to her head prior to July of 2012, other than the January 2011 incident. Other than the injury of September 30, 2012, the petitioner denied sustaining any other injuries to her head subsequent to her injury of July 22, 2012.

On cross-examination, the petitioner testified that the medication she took for Hepatitis C did not affect her cognition or memory. She testified that she did not take interferon drugs and had not taken such drugs that would affect her memory.

CONCLUSIONS OF LAW:

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (F) IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS THE FOLLOWING:

The burden lies with the claimant to establish the elements of his right to compensation. Wal-Mart Stores, Inc. v. Industrial Comm'n, 326 Ill.App.3d 438, 443, 761 N.E.2d 768, 773, 260 Ill.Dec.585, 590 (4th Dist. 2001) (citing *Nabisco Brands, Inc. v. Industrial Comm'n,* 266 Ill.App.3d 1103, 1106, 204 Ill.Dec. 354, 641 N.E.2d 578, 581 (1994)). This includes the burden of proving the existence of a causal relationship between the injury and the condition of ill-being. Beattie v. Industrial Comm'n, 276 Ill.App.3d 446, 449, 657 N.E.2d1196, 1199, 212Ill.Dec.851, 854 (1st Dist. 1995). The mere existence of testimony does not require its acceptance. Bernard v. Industrial Commission, 25 Ill.2d 254, 184 N.E.2d 864 (1962).

The Arbitrator finds no causal connection between the petitioner's post concussive syndrome and her injury of July 22, 2012. Following the petitioner's injury on July 22, 2012, her main complaint was left arm pain. Although the petitioner testified that she experienced headaches immediately following her accident, the medical records are silent relative to the same until September 13, 2012. Prior to September 13, 2012, none of the petitioner's treating physicians made any note of complaints of headache or neurological symptoms. In fact, the petitioner was noted to be alert and oriented x 3. On September 13, 2012, medical records evidence that the petitioner complained of occasional headaches and nausea. The medical records are silent relative to any complaints of memory issues until June 27, 2013, almost one year following the petitioner's accident. Then, on March 12, 2014, the first notation of complaints of poor balance, dizziness and occasional blurred vision are made by Dr. Hill. According to Dr.

Glantz, if an individual suffers from a concussion or brain injury, the symptoms will be apparent almost immediately or within a few days of the incident. Per subpoenaed medical records, the petitioner's symptoms of headache, nausaea, memory loss, irritability, trouble sleeping, etc., did not develop immediately or within a few days of the incident. In fact, some of the petitioner's symptoms did not develop until more than a year after her work related accident and, as such, are clearly unrelated to her injury of July 22, 2012..

The petitioner's complaints of nausea, headaches and sleep disruption truly first arose on September 13, 2012. Shortly thereafter, Dr. McManus prescribed Trazadone and by September 24, 2012, the petitioner reported "improved sleep" and it was noted that her "headaches had improved significantly." However, on September 30, 2012, the petitioner was intoxicated and involved in a non-worked related physical altercation in which she passed out. Per her own testimony, the petitioner was taken to the emergency room at that time because it was very difficult to wake her. Although on cross examination the petitioner denied striking her head on September 30, 2012, Dr. Simon's report of July 18, 2013 notes that the petitioner did, in fact, strike her head at that time and Dr. Glantz's records review also references that the petitioner struck her head on September 30, 2012. Interestingly, a MRI of the petitioner's brain was taken at the hospital on September 30, 2012. The Arbitrator notes that it was not until after the September 30, 2012 incident, that the petitioner's memory complaints arose.

Following her non-work related incident on September 30, 2012, the petitioner began treating with Dr. Shaik-Abassi because she "did not want to go back to drinking." She again complained of issues with sleep and, on March 28, 2013, Dr. Shaik-Abassi related her fatigue to her long night shifts. Relative to her "head complaints," the petitioner did not seek medical treatment between October 19, 2012 and June 26, 2013. On June 27, 2013, the petitioner returned to Dr. Shaik-Abassi and complained of memory issues since July of 2012. Again, this

was the first notation of memory complaints contained within the petitioner's medical records. The petitioner again complained of her dissatisfaction with working the third shift and working three 12 hour shifts in a row. At that point, the petitioner was referred to a neurologist for the first time.

The petitioner was evaluated by Dr. Simon Hill on July 18, 2013, and complained of "developing poor memory," lack of energy, chronic daily headaches with nausea and sensitivity to light and sound, and "feeling down." The petitioner returned to Dr. Simon on August 6, 2013 and reported feeling "altogether better." She did not return to Dr. Simon again until February 12, 2014 at which point she reported that she was "losing her memory over the past several months." According to Dr. Simon, the petitioner's injury was over a year ago, so it was "unusual that she would have a downturn in her cognitive functioning now," which raised the question of an underlying psychological disorder, sleep disorder or other medical problem. As such neuropsychological testing was recommended. Clearly, by that time, Dr. Abassi felt that the petitioner's complaints were related to her work shift and even Dr. Simon was beginning to question any causal relation between the petitioner's complaints and her reported work injury.

Per Dr. Simon's recommendation, the petitioner underwent neuropsychological testing with Dr. Hill on March 12, 2014. Subsequent to said testing, the petitioner did not return to Dr. Hill or Dr. Simon. However, she did return to Dr. Shaikh-Abassi on May 2, 2014 and he noted that he felt that her depression was "more related to her shift schedule" and he recommended that the petitioner see a therapist. Between September 30, 2014 and February 26, 2015, the petitioner attended individual therapy with Ms. Roberts during which time her main complaints were noted to be relationship, family and work stress. The petitioner did not present any evidence of medical treatment post February 26, 2015.

After weighing all of the evidence in this case, the Arbitrator concludes that the petitioner established that she sustained facial and left arm contusions that arose out of and in the course of her employment with the respondent on July 22, 2012. In forming this opinion, the Arbitrator relies upon the credible opinions of Dr. Russell Glantz and notes the significant gaps in the petitioner's medical treatment (i.e. gaps with no treatment between October 19, 2012 and July 27, 2013 and again from August 6, 2013 and February 12, 2014). The Arbitrator notes that the Commission has previously denied benefits based upon a lack of causal connection when there is a significant delay in receiving treatment or a significant gap in treatment. Gonzalez v. J.F. Daley International, *94 WC 23862, 99 IIC 3121;* Bauer v. E M Wiegman *98 WC 39838, 02 IIC 0839;* Mercado v. Trak Auto, *99 WC 61550, 02 IIC 0412;* Day v. Danville Housing Authority *10 WC 22490, 11 I.W.C.C. 0537.*

The Arbitrator takes special note of the fact that the petitioner's main complaints subsequent to her evaluation with Dr. Hill on March 12, 2014 appeared to revolve around her fatigue and stress due to her shift schedule as well as her relationship and family stressors. The Arbitrator finds the opinions of Dr. Glantz to be credible and compelling and agrees that there is no indication that any of the petitioner's neurologic symptomatology was connectable to her injury of July 22, 2012. Referring to neurological complaints, Dr. Glantz opined and the Arbitrator agrees that there was no diagnosis of such an injury in a time frame connectable to the incident and any treatment beginning for subjective symptoms in September of 2012 and thereafter was unrelated to the July 22, 2012 incident.

Furthermore, the Arbitrator notes that although the petitioner denied treatment with interferon medication for her Hepatitis C, Dr. Simon's report of July 18, 2013 evidences that the petitioner received such treatment. Additionally, the petitioner admitted to having a history of alcoholism. According to Dr. Glantz, such information is important as such medications can cause subtle cognitive

impairment to worsening headache, vomiting and even focal neurological symptoms. Furthermore, Dr. Glantz noted that substance abuse frequently causes cognitive dysfunction. Again, based upon the evidence submitted at trial, the Arbitrator finds that the petitioner failed to prove a causal connection between her post concussion syndrome and her injury of July 22, 2012.

Again, the Arbitrator relies on the records review of Dr. Glantz, in finding that the petitioner sustained contusions as a result of her injury of July 22, 2012. In reaching this conclusion the Arbitrator also takes special notice of the fact that the petitioner had resumed full duty work and continued to work full duty as of October 3, 2012, the petitioner did not report symptoms related to concussion within a time frame connectible to her injury, the petitioner's memory complaints did not arise until approximately one year after her injury, the significant gaps in the petitioner's medical treatment, and the petitioner's biggest complaint when seeing her primary care physician appeared to be the fact that she worked three 12 hour shifts a week. After viewing the evidence in its entirety, the Arbitrator adopts the opinions of Dr. Glantz and finds no causal connection between the petitioner's post concussion syndrome or her current condition of ill being and her injury of July 22, 2012.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (J) WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO THE PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES, AND (L) IS THE RESPONDENT ENTITLED TO A CREDIT, THE ARBITRATOR FINDS THE FOLLOWING:

The petitioner claims that she is entitled to out of pocket medical expenses in the amount of $217.26 for treatment incurred with Dr. Erin Hill. As the Arbitrator finds that there is no causal connection between the petitioner's condition of ill being subsequent to September of 2012 and her injury of July 22, 2012, the Arbitrator finds that the respondent is not liable for the petitioner's out of pocket medical expenses. Should the Arbitrator find that the respondent is liable for the payment of such out of pocket expense, the Arbitrator notes the stipulated to 8(j) credit in the amount of $869.04 relative to such bill.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (L) WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS THE FOLLOWING:

After weighing the evidence in this case, the Arbitrator concludes that the petitioner established that she sustained facial and left shoulder / arm contusions as a result of her injury of July 22, 2012. In forming this opinion, the Arbitrator relies upon the credible opinions of Dr. Russell Glantz. Based upon the Arbitrator's experience and expertise relating to this issue and based upon the evidence submitted at trial, the Arbitrator finds that the petitioner sustained permanent partial disability to the extent of 5% loss of use under section 8(d)2 of the Act.

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

COLLINS, ROBERT P Case# **12WC034038**
Employee/Petitioner

UNITED AIRLINES
Employer/Respondent

On 11/6/2015, 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 0.28% 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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MARTHA GELY-KRUTO
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
19(b)

Robert P. Collins
Employee/Petitioner
v.
United Airlines
Employer/Respondent

Case # **12** WC **34038**

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 26, 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, **June 14, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**83,361.60**; the average weekly wage was $**1,615.59**.

On the date of accident, Petitioner was **57** years of age, ***single*** with **no** dependent children.

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

Respondent shall be given a credit of $**64,011.08** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**64,011.08**.

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

ORDER

Respondent shall authorize and pay for bilateral shoulder surgery, as recommended by Dr. Nikoleit.

Respondent shall pay Petitioner temporary total disability benefits of $**1077.66** /week for **66 2/7**^{ths} weeks, commencing **July 25, 2012** through **February 10, 2013**, commencing **August 15, 2013** through **March 10, 2014**, and commencing **March 18, 2015** through **May 11, 2015**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **July 25, 2012** through **May 11, 2015**, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $ **64,011.08** for temporary total disability benefits that have been paid.

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

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

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

Walter Black

Signature of Arbitrator

November 6, 2015
Date

NOV - 6 2015

FACTS

Petitioner testified that he has worked for United Airlines for thirty one years, that on the date of accident he was a facilities technician, that he is now a maintenance technician lead, and that he injured both shoulders dismantling shelves with a sledge hammer on the June 14, 2012 accident date.

Petitioner continued working until he saw his physician, Dr. Rawal at Elmhurst Orthopaedics on June 19, 2012. Dr. Rawal ordered MRIs of both shoulders and thereafter recommended bilateral shoulder surgery.

Respondent's initial examining physician, Dr. Nicholson, opined on September 19, 2012 that petitioner's current shoulder symptoms were caused by the injury (PX7, p2).

Petitioner underwent right shoulder arthroscopic surgery on October 30, 2012 by Dr. Rawal. The operative report details a rotator cuff repair, an irreparable unstable labral tear that debrided, and a subacromial decompression (PX1, pp11-13).

Petitioner underwent left shoulder arthroscopic surgery on December 13, 2012 by Dr. Rawal. The operative report details a gleno-humeral debridement with grade 3 chondromalacia of the humeral head, a rotator cuff debridement, and a subacromial decompression (PX1, pp18-20).

Dr. Rawal recommended work hardening and work conditioning followed by a functional capacity evaluation on February 07, 2013. Petitioner testified he wanted to return to full duty for financial reasons. Dr. Rawal provided a work note for an unrestricted return to work on February 11, 2013(PX1, p23).

Petitioner's medical bills and temporary total disability benefits were paid.

Petitioner testified that upon returning to work he had continuing symptoms including loss of strength and increased pain. Petitioner returned to Dr. Rawal and on August 15, 2013 and underwent repeat arthroscopic right shoulder surgery. The operative report details repeat rotator cuff repair, glenoid chondroplasty, and labral debridement (PX2, pp8-10).

Dr. Nicholson re-examined petitioner on March 4, 2014. Dr. Nicholson opined that Petitioner was at maximum medical improvement for the left shoulder. Dr. Nicholson opined that the objective findings support the subjective complaints, that the mechanism of injury and current symptoms correlate, and that there are no pre-existing conditions. Dr. Nicholson felt that Petitioner may require a functional capacity evaluation to determine the type of activity he could safely do and not put himself into position for failure (PX8; RX1).

Petitioner's medical bills and temporary total disability benefits were paid.

Dr. Rawal released Petitioner to work full duty work on March 11, 2014 (PX2, p19).

Petitioner returned to work full duty on March 11, 2014. Petitioner testified that his symptoms persisted. Petitioner testified that he returned to Elmhurst Orthopaedics, but Dr. Rawal had left that medical group. Petitioner testified that he began treating with Dr. Nikoleit, at Elmhurst Orthopaedics. Dr. Nikoleit ordered imaging studies. A December 23, 2014 left shoulder MRI showed effusion, impingement, tendinitis/tendinosis, tears, arthritis and degeneration (PX12, p1). A December 23, 2014 right shoulder MRI showed arthritis, tendinitis/tendinosis, tears, and effusion (PX12, p2).

Petitioner testified that he was examined by Dr. Nikoleit on March 18, 2015, at which time he was recommended for bilateral shoulder surgery and taken off all work.

Dr. Nikoleit has authored an August 5, 2015 report. Dr. Nikoleit states that the right rotator cuff never healed properly, that Petitioner is experiencing pain, and that there is a recurrence of the tear. Dr. Nikoleit opines that it is "directly related to his injury". Dr. Nikoleit recommends a right rotator cuff repair and distal clavicle excision. Dr. Nikoleit further states that the left shoulder progression of degenerative changes since the first operation requires a hemiarthroplasty and distal clavicle resection. Dr. Nikoleit opines that "these are both related to his work as a maintenance employee and are directly related to the problems that he had while under the care of Dr. Rawal" (PX9, p2).

Respondent's subsequent examining physician, Dr. Phillips, saw Petitioner and March 10, 2015. Dr. Phillips agrees that bilateral shoulder surgery may be appropriate. Dr. Phillips opines that Petitioner's current condition is due to arthritis, which predates the accident (RX2, pp9-11). Dr. Phillips has authored a subsequent report on April 07, 2015 to the effect that arthritis predates the injury (RX3, p1).

Petitioner testified that his he has returned to for work duty as of May 12, 2015 and that he continues to have the same symptoms. Petitioner testified that there are a lot of things at work that he can no longer do.

Respondent disputes the most recent proposed surgeries and disputes temporary total disability benefits after March 10, 2015 in reliance upon Dr. Phillips' opinions.

DISCUSSION

Causation is the core issue.

Respondent relies upon Dr. Phillips' opinions. The Arbitrator finds that Dr. Phillips' opinions are not persuasive. Petitioner was asymptomatic before the June 14, 2012 accident date. Petitioner testified credibly regarding the accidental injury, the chronology of treatment, and his symptomology. The medical records are corroborative of the petitioner's credible testimony. Petitioner's two treating physicians as well as Respondent's initial examining physician found no pre-existing conditions that would preclude a causal connection. Petitioner's two treating physicians' records, as well as Respondent's initial examining physician reports, are consistent with and corroborative of a causal connection.

Based upon the foregoing, the Arbitrator finds that Petitioner's current condition of ill being is causally related to the accident, that the requested surgeries should be authorized, and that the claimed temporary total disability benefits should be paid.

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RIETGRAF, JEFFREY Case# **12WC042601**

Employee/Petitioner

ILLINOIS CEMENT COMPANY

Employer/Respondent

On 11/6/2015, 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 0.28% 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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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

Jeff Rietgraf
Employee/Petitioner

v.

Illinois Cement
Employer/Respondent

Case # **12** WC **42601**

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 **Christine M. Ory**, Arbitrator of the Commission, in the city of **Ottawa**, on **September 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. X Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. X What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **May 26, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**47,567.00**; the average weekly wage was $**914.75**.

On the date of accident, Petitioner was **42** 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.

To date, Respondent has paid $**7,469.48** in TTD and/or for maintenance benefits, and is entitled to a credit for any and all amounts paid.

Respondent shall be given a credit of $**7,469.48** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**7,469.48**.

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

ORDER

Respondent shall pay Petitioner the sum of $**548.85**/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 person as a whole.**

Respondent shall pay Petitioner compensation that has accrued from **08/27/2012** through **08/11/2013**, 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.

Christine Moy

Signature of Arbitrator

11/05/2015

Date

ICArbDec p. 2

NOV - 6 2015

EFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jeff Rietgraf,	)	
Petitioner,	)	
vs.	)	**No. 12 WC 42601**
Illinois Cement	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

STATEMENT OF FACTS

On May 26, 2012, the date of the accident, petitioner was working as a pre-heat tower cleaner. This required him to use a pressurized air gun, which exerted approximately 10,000 pounds per square inch, to knock cement build up off the interior of the tower. A chunk of the cement struck petitioner's hand causing him to lose control of the air gun. The shut off failed and the gun spun around and struck the back of petitioner's lower right leg. This caused a gash in petitioner's right calf that measured between six to seven inches.

Petitioner was taken via ambulance to Illinois Valley Hospital. Petitioner underwent surgery which consisted of incision and drainage and decompression of the right lower leg for the high-pressure injury/laceration of the right lower leg by Dr. Gaylin Lack (PX.2). Petitioner was hospitalized for two days. He was discharged to out-patient I.V. and instructed to follow up with Dr. Mitchell of Illinois Valley Orthopedics (PX.2).

At the time of his discharge from the hospital on May 28, 2012, the numbness in the dorsum of petitioner's had subsided to near normal and the swelling in the leg was almost completely gone. His pain had significantly improved.

Petitioner first saw Dr. Mitchell on May 29, 2012 and had no complaints of pain, only vague numbness of the dorsal aspect of the foot (PX.1, pp.22-23). He returned on June 6, 2012 for suture removal and had continued complaints of vague numbness and hypersensitivity to light touch at the dorsum of the lateral aspect of the right foot (PX.1, pp.19-20). On June 26, 2012, the petitioner returned to Dr. Mitchell again with complaints of numbness, tingling and burning of the right lower extremity; Dr. Mitchell recommended an EMG (PX.1, pp. 16-17).

The EMG was performed by Dr. Szymke on July 5, 2012. It showed a sensory nerve injury of the superficial peroneal nerve (PX.3).

At the referral of Dr. Mitchell, petitioner was seen by Dr. Julian Lin of Illinois Neurological Institute on August 20, 2012. Dr. Lin noted a large laceration measuring 15 cm. Dr. Lin noted the positive EMG for a sensory nerve injury of the superficial peroneal nerve. Dr. Lin did not believe petitioner would require surgical intervention and thought the paresthesia would improve with time. Dr. Lin prescribed Neurotin and released the petitioner to return to limited work the following week (PX.3).

He returned to Dr. Mitchell on August 21, 2012. Dr. Mitchell's exam showed good range of motion of the right foot and ankle. He had mild swelling of the ankle, but the laceration was well healed. He had full dorsiflexion and planter flexion of the ankle with good inversion and eversion. Dr. Mitchell recommended petitioner have physical therapy for strengthening,

continue the Neurotin and released the petitioner to return to office/desk work only (PX.1, pp.11-12).

Petitioner followed up with Dr. Mitchell on September 18, 2012. Dr. Mitchell noted petitioner was making excellent progress in physical therapy (PX.1, pp.7-9). On October 9, 2012, Dr. Mitchell released petitioner from care; to follow up with neurosurgeon (PX.1, pp3-4).

Petitioner returned to Dr. Lim on January 16, 2013. He complained of burning sensation on the top of his [right] foot mainly when petitioner is hit at the laceration site. Dr. Lin discussed possible exploratory surgery and possible excision of painful neuroma with or without grafting. At the time of this visit, petitioner wanted to avoid surgery. Dr. Lin released petitioner form his care.

Petitioner did return to Dr. Lim on November 11, 2013 with complaints of painful paresthesia in the right lower calf and dorsum of the right foot. Dr. Lim did not believe petitioner did not require exploration and repair of the superficial peroneal nerve. Dr. Lim determined petitioner was at maximum medical improvement. Dr. Lim would not rule out the possible need for a dorsal column stimulator if the paresthesia and pain persists (PX.3).

Petitioner testified he returned to light duty work on August 26, 2012. He received physical therapy at City Center Physical Therapy August through September, 2012 (PX.4). He returned to regular work in October, 2012. His job included operating jack hammers, shoveling, cleaning roofs and generally cleaning up messes.

Petitioner testified he has a difficult time wearing work boots. As the day goes on, the right leg and foot becomes sore and he has difficulty walking. The pain goes half way down the leg. The scar tingles. He gets electric shocks when the scar is bumped, which happens about three to four times a day. The pain goes as high as 8 to 10. He has tried various work boots and socks. At night he puts his foot up as it swells.

He has problems when any sort of pressure is applied to the laceration, which includes when he showers or swims as the water pressure causes pain. Since the accident he has not slept eight hours in a night; waking up three to four times when the covers or his fiancée bumps it. Winter is more difficult as the more clothing he wears the more it causes pressure on the laceration. He likes to wear shorts if at all possible as the clothing rubbing against the wound causes pain. He also likes to wear sandals, flip flops or no shoes at all as the tightness from regular shoes and boots causes pain. Petitioner used to enjoy biking, skiing and swimming. He participated in triathlons, but can no longer do any of these activities as any pressure from the clothing or the water causes pain.

Petitioner testified he has the most difficulty walking on uneven surfaces such as roofs or walking up ladders. He steps lightly on the right leg. He also puts his leg up when he can and at the end of the day.

The pain and numbness has never gone away. The most sensitive is the hole in his leg and the top of his foot.

Respondent obtained an AMA rating by Dr. James Cohen. Dr. Cohen determined the impairment rating at between 1 and 3% utilizing table 13-7 titled dysthetic pain and assigned a rating of 3% person as a whole impairment

CONCLUSIONS OF LAW

WITH RESPECT TO THE ISSUE OF WHETHER PETITIONER'S CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY THE ARBITRATOR FINDS THE FOLLOWING:

The Arbitrator finds the petitioner's leg complaints, which were an injury to the distal part of the superficial peroneal nerve with resultant paresthesis on the dorsum of the right foot and sensitivity to direct touch at the site of the laceration, were caused by the work injury. This is not only supported by the treating physicians, it is supported by Dr. James C. Cohen, who examined petitioner at the request of respondent pursuant to §12 of the Act.

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

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:

With regard to subsection (i) of §8.1b (b) the Arbitrator notes that permanent partial disability impairment report and/or opinion by Dr. James Cohen was submitted into evidence. Dr. Cohen assigned a 3% whole. The Arbitrator gives some weight to this factor.

With regard to (ii) of §8.1b (b) the occupation of the injured employee, the Arbitrator notes petitioner was employed as a heavy labor who was capable of returning to work without modifications, although petitioner had trouble finding a work boot that did not cause pain. Therefore, the Arbitrator gives some weight to this factor.

With regard to (iii) of §8.1b (b) the age of the employee at the time of the injury was 45 years of age, the Arbitrator notes the petitioner has a twenty year work life ahead of him. Therefore, the Arbitrator gives greater weight to this factor.

With regard to (iv) of §8.1b (b) the employee's future earning capacity, the Arbitrator notes that petitioner was able to return to his full-earning capacity, albeit with pain. Although working on ladders and inclines such as roofs give petitioner problems. The Arbitrator therefore gives some weight to this fact.

With regard to (v) of §8.1b (b) evidence of disability corroborated by the treating medical records, the Arbitrator notes the treating physician reports petitioner continues to have pain at the site of the laceration on the calf, especially when bumped even slightly. Also, petitioner has numbness in the top of his foot. Both the pain and numbness have not subsided. Petitioner has problems sleeping as even the slightest touch from anything or anyone awakens him. The Arbitrator therefore gives more weight to this factor.

Based on these factors, and the record taken as a whole, the Arbitrator finds Petitioner sustained permanent partial disability to the extent of 10% person as a whole pursuant to §8 (d) 2.

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

KAHN, JANNI Case# **13WC008268**
Employee/Petitioner

OSF MEDICAL GROUP
Employer/Respondent

On 11/5/2015, 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 0.28% 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:

4707 LAW OFFICE OF CHRIS DOSCOTCH
DAMON YOUNG
2708 N KNOXVILLE AVE
PEORIA, IL 61604

0507 RUSIN & MACIOROWSKI LTD
THOMAS P CROWLEY
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

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
19(b)

Janni Kahn
Employee/Petitioner
v.

Case # **13** WC **8268**

OSF Medical Group
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, 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, **December 27, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**47,158.80**; the average weekly wage was $**906.90**.

On the date of accident, Petitioner was **60** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of $**20,828.42** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**20,828.42**.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $**604.60**/week for **140** weeks, commencing **January 10, 2013** through **September 9, 2015**, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $**24,766.90**, as provided in Sections 8(a) and 8.2 of the Act.

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

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

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

Arbitrator Anthony C. Erbacci

November 2, 2015
Date

NOV 5 - 2015

FACTS:

On December 27, 2012, the Petitioner was employed by the Respondent as a nurse. The Petitioner testified that she was in a "float pool" and was assigned to work in various offices in the Respondent's facility. The Petitioner testified that on December 27, 2012, while working for the Respondent, she was in an office building in which carpet was being removed and replaced. The Petitioner testified that on that date she came into contact with dust from carpet removal. She stated when she had to walk from her desk to the copy machine she had to walk right by the removed carpet. She stated she had to walk past this area at least 30 times that day. The Petitioner testified that the dust irritated her throat.

The Petitioner testified that the next day she was working in the same office and came into contact with fumes from the glue the workers were using to lay down the new carpet. She testified that again she had to walk from her desk to the copy machine at least 30 times that day and was exposed to these fumes which were so strong that they made her eyes water and burn. The Petitioner testified that she also began coughing. The Petitioner testified that she picked up the bucket of glue the workman was using and read the label on the glue. She testified that the label indicated that the glue was a petroleum hydrocarbon product.

The Petitioner testified that December 28, 2012 was the last day she worked in that particular office but she continued to work for the Respondent in other offices through January 10, 2013. The Petitioner testified that throughout that time she continued to have a severe cough and she made an appointment with her doctor.

On January 10, 2012, the Petitioner saw Dr. Mulcahey at OSF Center for Health. The Petitioner gave a history of having a cough and bronco spasms after she was exposed to glue fumes and carpet dust when the office she was working in was being remodeled. Dr. Mulcahey noted that the Petitioner had extreme coughs with talking and activity and that she was coughing almost constantly and was having difficulty finishing her sentences due to coughing. Dr. Mulcahey referred the Petitioner to Dr. McVay, a pulmonary specialist.

On January 23, 2013, Petitioner followed up with Dr. McVay and continued to report symptoms of shortness of breath, coughing, and wheezing, with no temperature elevation. Dr. Mulcahey noted that the Petitioner had been treating with a round of antibiotics and steroids with little or no improvement in her overall breathing. Dr. McVay's assessment was acute broncho spasm with cough, a history of moderate persistent asthma, history of allergenic rhinitis and reactive airway disease.

On January 28, 2013, the Petitioner underwent a chest CT scan which was reported to demonstrate no abnormalities which would explain the Petitioner's symptoms.

The Petitioner followed up with Dr. McVay on February 19, 2013 still complaining of chronic cough since December from an exposure at work. Dr. McVay was continuing the Petitioner on a high dose of Prednisone with minimal relief in her coughing symptoms. The continued assessment was acute broncho spasm, acute chronic cough with history of moderate asthma and reactive airway

disease secondary to exposure.

On April 3, 2013, the Petitioner was seen at the University of Iowa Hospitals and Clinics. Petitioner was evaluated by Dr. Hartley. Petitioner gave Dr. Hartley a history of chronic cough which occurred following an occupation exposure to dust and solvents used during a carpet removal project at work in 2012. Dr. Hartley noted that the Petitioner had pre-existing adult onset asthma for approximately one year which had been well controlled using Singulair, 10 mg. at bedtime. Dr. Hartley noted that the Petitioner worked as a nurse in a "float pool" staffing physicians' offices and that on Thursday, December 27, 2012, she was assigned to work in a Psychiatry office where workmen were ripping out old carpeting and the staff was complaining of burning sensations in the eyes. Dr. Hartley opined that the Petitioner was exposed to dust and irritant chemicals at work causing an exacerbation of her asthma and cough.

On April 16, 2013, the Petitioner followed up with Dr. McVay complaining of continued cough. The Petitioner gave Dr. Mulcahey a history that she had recently been seen in Iowa City where it was felt the exposure had precipitated her current coughing episodes. Dr. Mulcahey stated the continued cough was a concern and that it may be a reflex vs. reflux induced cough.

The Petitioner continued to follow up with Dr. Mulcahey and on June 25, 2013 she stated to Dr. Mulcahey that her cough never went away and was worse with speaking and eating. The Petitioner reported that she was very depressed and never left the home as people stared at her when she coughed.

On July 2, 2013, the Petitioner followed up with Dr. Hatipoglu at OSF Illinois Lung and Critical Care. The Petitioner gave a history of chronic cough which started in December, 2012 after being exposed to glue vapor. Dr. Hatipoglu noted that the cough had been extensively worked up including a CT scan of the chest, monitoring, bronchiscopy, pulmonary function testing and therapeutic trials of medications. Based on this history, Dr. Hatipoglu felt the Petitioner had chronic cough hypersensitivity syndrome or larynx sensory dysfunction. Dr. Hatipoglu noted the Petitioner had GERD for many years, but did not have the cough until recently. Because of the onset of the coughing symptoms after the glue vapor exposure and the constant nature of the cough, Dr. Hatipoglu opined that GERD was not the etiology.

Dr. McVay recommended that the Petitioner see Dr. Hendricker at OSF Voice and Swallowing and Disorder Center for consultation. Petitioner saw Dr. Hendricker on August 26, 2013. The Petitioner gave Dr. Hendricker a history of onset of cough on December 27, 2012 with some removal of some carpet from her work place, associated with adhesives with exposure to hydrocarbons. The Petitioner reported previous episodes of cough in 2008 following an upper respiratory infection which lasted for four weeks and resolved on its own. Outside of that time, there has been no reoccurring cough except for the exposure to the carpet removal. Dr. Hendricker performed a laryngoscopy and stroboscopy. Dr. Hendricker also did a reflux test, reviewed a reflux findings score and the Petitioner's medications. Dr. Hendricker's impression was chronic cough, irritable larynx syndrome, reflux, and well controlled asthma.

The Petitioner next followed up with Dr. Mulcahey on April 4, 2014 complaining of a continuous cough. Dr. Mulcahey diagnosed her with irritable larynx syndrome and depression. The Petitioner reported that she continued to work with the speech therapist regarding the chronic cough and had

made some improvement. The Petitioner stated she was getting tired due to the medications and Dr. Mulcahey opined she could not drive due to the medications. The Petitioner again followed up with Dr. Mulcahey on June 21, 2014 and again on July 14, 2014 with continuing complaints of chronic cough due to irritable larynx syndrome. Dr. Mulcahey wanted the Petitioner to wean herself off the use of Prednisone and the assessment was moderate to severe persistent asthma, chronic cough and GERD.

On September 10, 2014, the Petitioner followed back up with Dr. Hendricker complaining of constant cough. Dr. Hendricker recommended larynx control therapy strategies and he felt the Petitioner would benefit from therapy from Nicole McKinly. Petitioner followed up with Nicole McKinly from September 10, 2013 through May 6, 2014 for speech therapy.

On January 12, 2015 the Petitioner followed up with Dr. Mulcahey complaining of continued chronic cough. The Petitioner reported that she did have good days and bad days and that she was compliant with all medications. The Petitioner was to continue her medications.

Dr. Mulcahey's evidence deposition was taken on January 5, 2015. Dr. Mulcahey testified she is a Board Certified Internal Medicine physician and she worked at OSF. Dr. Mulcahey testified that the Petitioner gave her a history of being involved in a work accident on December 27, 2012. Dr. Mulcahey testified that she had seen Petitioner on November 2, 2012 for a routine visit with a physical and that the Petitioner was noted to be doing very well without any problems. Dr. Mulcahey testified that the Petitioner followed up with her on January 10, 2013 complaining she was exposed to glue fumes and carpet dust on December 27, 2012. Dr. Mulcahey testified that she continued to treat the Petitioner on a regular basis after the accident and that, by August 4, 2014, the Petitioner had been diagnosed with irritable larynx syndrome and was working with a speech therapist and the cough was chronic.

Dr. Mulcahey also testified that the Petitioner was suffering from depression and stated to a reasonable degree of medical certainty the depression was related to the cough. Dr. Mulcahey also testified the chronic cough or irritable larynx syndrome was related to the accident in question. Dr. Mulcahey opined that the irritable larynx syndrome was a permanent condition and she would hope the cough would eventually lessen. Dr. Mulcahey testified she relied upon several medical journals to diagnose the Petitioner with irritable larynx syndrome. Dr. Mulcahey testified that she reviewed Dr. Mosian's IME report and that she disagreed that the Petitioner's chronic cough was due to unchecked reflux. Dr. Mulcahey testified that the Petitioner had acid reflux for approximately 20 years and she never had a chronic cough. Dr. Mulcahey opined that since the Petitioner has had the irritable larynx syndrome, she has been unable to work and that she was still unable to work at time of deposition. Dr. Mulcahey testified Petitioner did treat with her prior to the incident in question and she did have some coughing issues in February, 2012, but that was a different issue since she had bronchitis and a respiratory infection which took months to clear. Dr. Mulcahey also testified that the Petitioner had coughing episodes in 2008 which were again related to a respiratory infection, not irritable larynx syndrome.

The evidence deposition of Dr. Hendricker was taken on May 29, 2015. Dr. Hendricker testified that he was a medical doctor who worked at OSF as a Board Certified Otolaryngologist. Dr. Hendricker testified that the Petitioner first saw him on August 21, 2013 on a referral from Dr. McVay. The issue was intractable coughing and the Petitioner gave a history of a persistent cough that

started on December 27, 2012 and was associated with removal of carpet at her workplace where she came into contact with adhesives. Dr. Hendricker testified that he did an examination at that visit with a laryngoscopy and a stroboscopy. Dr. Hendricker found laryngeal edema and some mild irritation. Dr. Henricker's diagnosis was chronic cough which was severe and related to irritable larynx syndrome. Dr. Hendricker did know the Petitioner had a component of reflux and asthma history, but noted that both were well controlled. Dr. Hendricker described irritable larynx syndrome as "a term that basically describes hypersensitivity laryngeal symptoms. They can be a variety of things; cough is one that would be included in that. It is first mentioned in the literature in 1999 and is kind of a catch bucket term for a lot of again hypersensitivity laryngeal symptoms." Dr. Hendricker testified to a reasonable degree of medical certainty he believed the irritable larynx syndrome was related to the exposure that the Petitioner experienced while they were laying and removing carpet on December 27, 2012. Dr. Hendricker testified that he had treated irritable larynx syndrome in the past and that this diagnosis is very common. Dr. Hendricker testified that hydrocarbons are a trigger associated with irritable larynx syndrome. Dr. Hendricker testified that irritable larynx syndrome was first outlined in published peer review journals back in 1999. Dr. Hendricker testified that according to the journals, triggers can be volatile chemicals and dust.

At the request of the Respondent, the Petitioner was evaluated by Dr. Moisan on June 3, 2013. Dr. Moisan's report of that date was admitted into the record as Respondent's Exhibit 8. Dr. Moisan's supplemental report dated August 5, 2013 was admitted into the record as Respondent's Exhibit 9. Dr. Mosian was given a history that the Petitioner had been a long standing Registered Nurse in the Peoria area and was working in a flex pool type arrangement working in various offices and clinics. The Petitioner stated she was working in an office where carpet was being ripped up in an adjacent room and she developed a cough. Dr. Mosian noted that it was apparently quite dusty and this was going on from approximately 8:00 a.m. until noon. The Petitioner gave a further history of being exposed to glue vapors that were present and again beginning to cough. The Petitioner stated since that time she had been unable to go back to work because of an incessant cough. Dr. Mosian opined that the episode of coughing on her initial exposure to the carpet being torn out was almost certainly due to allergenic triggers of dust mites with the removal of the carpeting. The exposure to the fumes/vapor was most likely exerted as a simple irritant effect. Dr. Mosian felt the initial cough response would not be unusual, but extremely uncommon for this to persist to this degree. Dr. Mosian felt it was possible the initial cough was due to the exposure to putative allergenic (dust mites) and may have transiently worsened the reflux further intensifying the cough, however, at some point long before now, the original allergenic trigger and sequella should have abated. At the time of the June 3, 2013 report, Dr. Moisan felt the Petitioner was not able to resume tasks which included talking on the phone for more than brief periods of time with patients or staff. He also felt she was not contagious or a risk for staff members. He felt she would be at MMI in two to four weeks.

The Petitioner testified that she currently continues to cough constantly throughout the course of each day and that she wants to continue to treat with Dr. Mulchahey. The Arbitrator notes that the Petitioner coughed incessantly throughout the morning prior to the hearing and throughout the course of the hearing.

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:

Petitioner testified at trial she was exposed to dust and a hydrocarbon glue substance while working for Respondent on December 27, 2012. The medical records are consistent with this history. Dr. Mulcahey, Petitioner's treating physician, testified to a reasonable degree of medical certainty that Petitioner is diagnosed with irritable larynx syndrome. Dr. Mulcahey testified the exposure to dust and/or chemicals can cause or aggravate irritable larynx syndrome.

Dr. Hendricker testified he is a Board Certified Otolaryngologist. As part of this specialty, he regularly treats irritable larynx syndrome. Dr. Hendricker also testified the diagnosis of irritable larynx syndrome has been reviewed in peer review journals since 1999. Dr. Hendricker testified the triggers for irritable larynx syndrome is exposure to chemicals and dust. Both Dr. Hendricker and Dr. Mulcahey testified to a reasonable degree of medical certainty Petitioner's exposure at work caused or aggravated her irritable larynx syndrome and necessitated the need for medical treatment.

Dr. Mosian, in Respondent's IME report of June 3, 2013, had a very similar opinion as to the cause and problem the Petitioner was experiencing. Dr. Mosian felt her exposure to possible dust mites caused an allergic reaction which caused a potential airway disease. In Dr. Mosian's second report, he stated that irritable larynx syndrome was not a legitimate diagnosis and it was more likely caused by reflux. The medical records and Dr. Mulcahey and Dr. Hendricker's testimony illustrate Petitioner has had reflux for 20 years and it was well controlled. Also, Arbitrator notes Petitioner had reflux for over 20 years and did not develop the cough until she was exposed to dust and chemicals at work. Also, Dr. Mosian disputes the irritable larynx syndrome as a diagnosis, but Dr. Hendricker testified this diagnosis is in peer reviewed medical journals.

Based upon this information, Arbitrator finds Dr. Mulcahey and Dr. Hendricker's opinions on causation more persuasive. Thus, Petitioner proved accident and causation for the December 27, 2012 work accident.

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

The findings and conclusions of the Arbitrator relating to accident and causation are adopted and incorporated herein.

Petitioner introduced evidence of the following medical expenses incurred as a result of Petitioner's December 27, 2012 work accident:

OSF Medical Group-Dr Mulcahey	$ 585.00
OSF IL Lung Inst-Dr. Brian McVay	$ 4,312.00
OSFMG 5/2/13	$ 530.00
Central Ill Pathology	$ 670.00
University of Iowa Health Care	$ 1,999.00
OSF St. Francis	$16,157.90
CIRA	$ 513.00
TOTAL:	$24,766.90

The Petitioner also introduced evidence of personal expenses apparently related to obtaining medical treatment from facilities outside the State of Illinois. The Arbitrator declines to award those expenses as no evidence was presented regarding the reasonableness or necessity of those charges.

The Petitioner testified that she wants to continue to treat with Dr. Mulchahey however, there was no evidence presented regarding any specific procedure or diagnostic testing that has been prescribed for the Petitioner. The Arbitrator notes, in fact, that the Petitioner appears to have reached a plateau in her condition and may actually be at maximum medical improvement. Therefore the Arbitrator does not award any specific prospective medical treatment for the Petitioner.

Based on Arbitrator's findings related to accident and causation, Arbitrator finds the medical treatment rendered to Petitioner in regards to irritable larynx syndrome was reasonable, necessary, and causally related to the work accident of December 27, 2012. The Arbitrator therefore awards medical expenses in the amount of $25,230.37, subject to the limitations of the Medical Fee Schedule provided for in the Act.

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

The findings and conclusions of the Arbitrator relating to accident and causation are adopted and incorporated herein.

Based on Dr. Mulcahey's testimony Petitioner has been unable to work from January 10, 2013 to September 9, 2015, Petitioner has proven by a preponderance of the evidence she was temporarily and totally disabled from January 10, 2013 through September 9, 2015, a period of 140 weeks. The Arbitrator finds that the Petitioner is entitled to temporary total disability benefits of $604.60/week for 140 weeks, commencing January 10, 2013 through September 9, 2015, as provided in Section 8(b) of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LOWERY, ALISON Case# **13WC010888**

Employee/Petitioner

KANSAS COMMUNITY UNIT SCHOOL DISTRICT 3

Employer/Respondent

On 11/5/2015, 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 0.28% 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:

1662 CRAIG & CRAIG LLC
JOHN L BARGER
1807 BROADWAY AVE
MATTOON, IL 61938

1337 KNELL LAW LLC
MATT BREWER
504 FAYETTE ST
PEORIA, IL 61603

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

Alison Lowery
Employee/Petitioner

v.

Kansas Community Unit School District 3
Employer/Respondent

Case # 13 WC 10888

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 Urbana, on September 10, 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 _____

FINDINGS

On April 1, 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 $39,946.48; the average weekly wage was $1,079.63.

On the date of accident, Petitioner was 33 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, Petitioner's claim for payment of medical bills is denied.

Respondent shall pay Petitioner permanent partial disability benefits of $647.78 per week for 50 weeks because the injuries sustained caused the 10% loss of use of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

William R. Gallagher, Arbitrator

November 1, 2015
Date

NOV 5 - 2015

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 1, 2011. According to the Application, Petitioner sustained an injury to the left shoulder when an autistic student attacked her (Petitioner's Exhibit 1; Arbitrator's Exhibit 2 - March 25, 2014).

This case was previously tried in a 19(b) proceeding on March 25, 2014. At that time, Petitioner sought an order for payment of medical bills and prospective medical treatment. Respondent did not dispute its liability for Petitioner's left shoulder injury; however, Respondent disputed liability for Petitioner's subsequent left upper extremity conditions, specifically, complex regional pain syndrome.

The Arbitrator's Decision was filed with the Commission on April 22, 2014. In that Decision, the Arbitrator ruled in favor of the Petitioner and found that Petitioner's complex regional pain syndrome was related to the accident of April 1, 2011. The Arbitrator also ordered that Respondent authorize and pay for prospective medical treatment (Petitioner's Exhibit 2).

Respondent filed a review of the Arbitrator's Decision with the Commission. On January 30, 2015, the Commission entered its Decision and Opinion on Review. In that Decision, the Commission modified the Arbitrator's Decision and ruled that Petitioner's subsequent left upper extremity conditions, including the complex regional pain syndrome, were not related to the accident of April 1, 2011. The Commission found that, in regard to Petitioner's left shoulder injury, that she was at MMI as of November 4, 2011, and entitled to an award of permanent partial disability for same. The Commission remanded the case to the Arbitrator for a determination of the nature and extent of permanent partial disability (Petitioner's Exhibit 3).

Petitioner's primary treating physician for her left shoulder was Dr. Gary Ulrich, an orthopedic surgeon. Dr. Ulrich performed arthroscopic surgery on Petitioner's left shoulder on June 22, 2011. The procedure consisted of a superolabral anterior posterior repair (Petitioner's Exhibit 1; Petitioner's Exhibit 2 - March 25, 2014).

Subsequent to the left shoulder surgery, Petitioner remained under Dr. Ulrich's care and he ordered physical therapy. Petitioner received physical therapy from June 24, 2011, through October 14, 2011 (Petitioner's Exhibit 1; Petitioner's Exhibit 4 - March 24, 2014).

Dr. Ulrich last saw Petitioner on November 4, 2011, and noted that Petitioner had done very well and had completed her physical therapy. On clinical examination, Petitioner had a full range of motion of the left shoulder and a strength of 4/5. At that time, Dr. Ulrich opined that Petitioner was at MMI (Petitioner's Exhibit 1; Petitioner's Exhibit 1 - March 24, 2014).

At trial, Petitioner testified that she no longer worked for Respondent, but subsequently obtained a job with Marshall School District as a Special Education Teacher. While her job title is the same as it was when she worked for Respondent, Petitioner stated that she has no physical contact with students. Further, the students she presently works with at Marshall are Junior High and High School students.

Petitioner stated that she still has symptoms of pain/weakness in the left shoulder especially upon active use. Petitioner agreed that most of the range of motion of the left shoulder has been restored; however, Petitioner still limits the amount of lifting that she does. She agreed that Dr. Ulrich and opined that she was at MMI and released her to return to work without restrictions.

Petitioner's counsel tendered into evidence the medical record and bill of Dr. Arthur Rettig, regarding his evaluation of Petitioner of October 13, 2014. At that time, Petitioner saw Dr. Rettig primarily for the complex regional pain syndrome. Dr. Rettig recommended referral to a pain specialist (Petitioner's Exhibits 4 and 6).

Petitioner's counsel also tendered into evidence the medical record and bill of Dr. Kenneth Spicklemire regarding his evaluation of Petitioner of April 3, 2015. At that time, Petitioner saw Dr. Spicklemire for left shoulder pain and numbness. Dr. Spicklemire suggested future treatment including medications and acupuncture (Petitioner's Exhibit 5 and 7).

Conclusions of Law

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

The Arbitrator concludes that Respondent is not responsible for payment of the medical bills incurred by Petitioner in connection with treatment provided by Dr. Rettig and Dr. Spicklemire on October 13, 2014, and April 3, 2015, respectively.

In support of this conclusion the Arbitrator notes the following:

Dr. Rettig saw Petitioner on October 13, 2014, primarily for the complex regional pain syndrome. As noted herein, the Commission ruled that this condition was not causally related to the accident of April 1, 2011.

Dr. Spicklemire saw Petitioner on April 13, 2015, and evaluated her left shoulder condition. Dr. Ulrich, Petitioner's primary treating physician for the left shoulder condition had previously opined that Petitioner was at MMI on November 4, 2011, and the Commission concurred.

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

The Arbitrator concludes that Petitioner has sustained permanent partial disability to the extent of 10% loss of use of the person as a whole.

In support of this conclusion the Arbitrator notes the following:

Petitioner sustained a left shoulder injury which required arthroscopic surgery. Petitioner still had shoulder symptoms consistent with the injury she sustained.

William R. Gallagher, Arbitrator

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GILILAND, SAMUEL B Case# **13WC011418**

Employee/Petitioner

SOLO CUP

Employer/Respondent

On 11/5/2015, 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 0.28% 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:

0834 KANOSKI BRESNEY
CHARLES N EDMISTON
129 S CONGRESS
RUSHVILLE, IL 62681

1109 GAROFALO SCHREIBER & STROM
ANDREW RANE
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

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
NATURE AND EXTENT ONLY

Samuel B. Gilliland
Employee/Petitioner

v.

Solo Cup
Employer/Respondent

Case # 13 WC 11418

Consolidated cases: _____

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Urbana, on September 10, 2015. By stipulation, the parties agree:

On the date of accident, February 17, 2012, 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 $26,899.60; the average weekly wage was $517.30.

At the time of injury, Petitioner was 28 years of age, single, with 0 dependent child(ren).

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

Respondent shall be given a credit of $5,764.29 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $5,764.29. The parties stipulated that all TTD benefits were paid in full.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $310.38 per week for 51.25 weeks because the injury sustained caused the 25% loss of use 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.

William R. Gallagher, Arbitrator

October 29, 2015
Date

NOV 5 - 2015

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on February 17, 2012. According to the Application, Petitioner was putting out a machine fire and sustained an injury to his left hand (Arbitrator's Exhibit 2). At trial, Petitioner and Respondent stipulated that temporary total disability benefits and medical had been paid in full and that the only disputed issue was the nature and extent of disability.

Petitioner worked for Respondent operating and maintaining various machines in Respondent's facility. On February 17, 2012, one of the machines caught on fire and Petitioner attempted to put it out with a fire extinguisher. A piece of plastic was caught in the machine and, when Petitioner attempted to remove it, a part of the machine was thrown out of it striking Petitioner's left hand.

Petitioner's Exhibit 1 is the record of Carle Foundation Hospital where Petitioner was treated. There are two numbered sections in the record, the first of which is stated as pages 1 to 41. The second numbered section of the record is stated as pages 1 to 183. The Arbitrator will indicate the appropriate record before the page numbers.

Following the accident Petitioner received medical treatment at the ER of Carle Foundation Hospital. It was noted that Petitioner had a laceration on the dorsum of his left hand that extended to the middle portion of the little finger. X-rays were taken which revealed a comminuted fracture at the base of the left little finger with several comminuted fragments. Petitioner was referred to Dr. James Sobeski, an orthopedic surgeon (Petitioner's Exhibit 1; Record 1, pp 12-18).

Dr. Sobeski subsequently evaluated Petitioner on February 20, 2012. At that time, Petitioner had a loss of sensation on the radial side of the little finger and no active extension of the MP joint. Petitioner rated his pain as 9/10. Dr. Sobeski recommended that Petitioner undergo a surgical repair of the left small finger extensor tendon (Petitioner's Exhibit 1; Record 2, pp 89-90).

Dr. Sobeski performed surgery on February 24, 2012, and the procedure consisted of repair of the extensor tendon and debridement of non-viable tissue. The operative report also noted that the collateral ligament was torn off the proximal phalanx insertion, but there was no place to put it to perform a repair. The digital nerve was totally lacerated and was also not repairable. Dr. Sobeski did not attempt to perform a nerve graft procedure (Petitioner's Exhibit 1; Record 2, pp 5-6).

Following surgery, Petitioner continued to be treated by Dr. Sobeski who ordered occupational therapy. Petitioner received occupational therapy from March 7, 2012, through June 11, 2012 (Petitioner's Exhibit 1; Record 2, pp 104-183).

Petitioner saw Dr. Sobeski on June 12, 2012. At that time, the radial border of the little finger was still numb. Dr. Sobeski described the motion of the finger as "great" but noted that Petitioner lacked about 10° of extension at the PIP joint. He opined that Petitioner was fully healed but

would have permanent partial disability. He also opined that Petitioner could develop arthritis in the MP joint. He released Petitioner to return to work to his regular job (Petitioner's Exhibit 1; Record 2, pp 94-95).

At the direction of Respondent, Petitioner was examined by Dr. Prasant Atluri, a hand surgeon, on April 28, 2015. In connection with his examination of Petitioner, Dr. Atluri reviewed medical records provided to him by Respondent. Dr. Atluri 's impressions were left small finger trauma with open proximal phalanx fracture and left small finger complex wound with radial digital nerve injury. Dr. Atluri opined that Petitioner had AMA impairment ratings of 54% of the small finger which converted to a five percent (5%) hand and a five percent (5%) upper extremity rating (Respondent's Exhibit 1).

At trial, Petitioner complained of pain, numbness and loss of sensation in the left little finger and left hand. Petitioner also stated that any jarring or vibration increases his pain so he avoids those activities. Petitioner's pain symptoms and swelling generally increase with weather changes. The Arbitrator observed Petitioner attempting to make a fist and, while he could do so with his other fingers, Petitioner was unable to completely flex his little finger to the palm of his left hand.

Petitioner stated that he was released to return to work to his regular job; however, he did not return to work for Respondent. At the time of trial, Petitioner was unemployed.

Conclusion of Law

The Arbitrator concludes that Petitioner has sustained permanent partial disability to the extent of 25% loss of use of the left hand.

In support of this conclusion the Arbitrator notes the following:

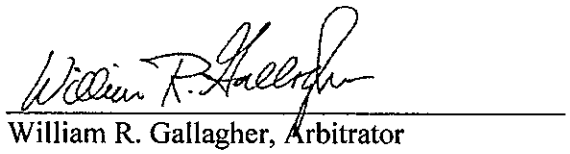
Dr. Atluri he opined that Petitioner had an AMA impairment rating of 54% of the small finger which converted to a five percent (5%) hand and a five percent (5%) upper extremity rating. The Arbitrator gives this factor moderate weight.

Petitioner was employed by Respondent operating and maintaining various machines. The circumstances of this accident clearly indicated that this job required the active use of Petitioner's upper extremities. Petitioner did not return to work for Respondent and the Arbitrator does not know what other types of work Petitioner has performed in the past. The Arbitrator gives this factor minimal weight.

Petitioner was 28 years of age at the time of this accident. He will have to live with the effects of this injury for the remainder of his working and natural life. In that regard, Dr. Sobeski noted that Petitioner may develop arthritis in the MP joint. The Arbitrator gives this factor moderate weight.

There was no evidence that this injury will have any effect on Petitioner's future earning capacity. The Arbitrator gives this factor no weight.

The medical treatment records clearly indicated that Petitioner sustained a serious injury to the left little finger which included nerve and ligament injuries which could not be surgically repaired. Petitioner still has symptoms in his left little finger and hand consistent with the injury he sustained. The Arbitrator gives this factor significant weight.



William R. Gallagher, Arbitrator

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

THE ESTATE OF NORTHWAY, LAURENCE Case# **13WC024394**

Employee/Petitioner

NESTLE CHOCOLATE AND CONFECTION

Employer/Respondent

On 11/6/2015, 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 0.28% 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:

4276 COYNE REINKE LAW
JIM COYNE
120 W MADISON ST SUITE 900
CHICAGO, IL 60602

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

THE ESTATE OF LAURENCE NORTHWAY
Employee/Petitioner

v.

NESTLE CHOCOLATE and CONFECTION
Employer/Respondent

Case # **13** WC **24394**

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 **MARIA S. BOCANEGRA**, Arbitrator of the Commission, in the city of **Chicago, IL** , on **September 3, 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 _____

FINDINGS

On **July 3, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$63,440.00**; the average weekly wage was **$1,220.00**.

On the date of accident, Petitioner was **67** 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.

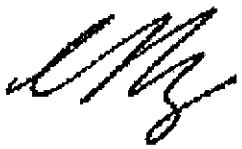
ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **$712.55/week** for **13.36 weeks**, because the injuries sustained caused 8% loss of the right foot, as provided in Section 8(e)(11) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$712.55/week** for **13.36 weeks**, because the injuries sustained caused 8% loss of the left foot, as provided in Section 8(e)(11) of the Act.

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

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



Signature of Arbitrator

11-5-2015
Date

NOV - 6 2015

FINDINGS OF FACT

On 9/3/15, the Estate of Laurence Northway ("Petitioner") and Nestle Chocolate and Confection ("Respondent") proceeded to arbitration regarding disputed issues between the parties. The parties agree that on 7/3/12, Laurence Northway, now deceased for unrelated reasons and for which Petitioner was substituted as a proper party, was an employee of Respondent and that on that date, he sustained an accident arising out of and in the course of that employment. Ax1, Rx1. The parties further agreed notice of the accident within the time limits stated in the Act. Ax1. The parties agreed that Laurence Northway's average weekly wage was $1,220.00, that he was married to Barbara Northway with no dependents and was 67 years old at the time of the accident. Ax1. The sole issues in dispute were causal connection and the nature and extent of Laurence Northway's injuries.

On 7/3/12, Laurence Northway was working on a boiler performing a hydrostatic pressure check on the Respondent's premises when a hose broke loose causing 200 degree water to pour into his right foot and splashed his left ankle. Px1. He was treated by the company nurse before being seen at US Healthworks. Exam showed tenderness to palpation over the lateral aspect and dorsum of the right foot and tenderness to palpation over the right lower leg circumferentially superior to the right ankle. Doctors described and drew an image indicating that over the lateral aspect of the right leg above the lateral malleolus was an 8 cm x 8 cm unroofed blister with an area of erythema. The area was noted to be weeping. Also described and depicted was a 2.5 cm x 3 cm intact blister inferior and medial to the right lateral malleolus. Additionally, a 7 cm x 5.5 cm area of erythema and sloughed skin was identified on the posterior aspect of the right foot over the Achilles tendon, also weeping. Finally, a 4 cm x 2 cm blister superior to the right medial malleolus was identified. Impression and diagnosis was bilateral lower extremity burns (partial thickness) and bilateral lower extremity pain (mild). *Id.* Silver sulfadiazine and bandages were prescribed. *Id.*

On 7/5/14, doctors performed wound check of the right foot/ankle and left lower leg. On the right, erythema and sensation to light touch were noted. On the left, 7 cm x 5.5 cm partial thickness burns on the lateral foot extending to the medial foot around to the posterior ankle were noted, along with erythema, foul smell and brown/green discharge. Blisters measuring 16 cm x 15.5 cm and 2.5 cm x 3 cm were identified. Laurence Northway was advised to not wear steel toed shoes and to elevate the legs. On 7/13/12 and 7/31/12, debridement was performed removing areas of dead and/or loose skin in areas of the foot. In follow up throughout August 2012, Laurence Northway was advised to keep dressing changed and cleaned, keep feet elevated, avoid steel toe boots and to continue with creams and medications. On 8/31/12, Laurence Northway was released from care without restriction. Diagnoses were right lower extremity partial thickness burns and right lower extremity pain, resolved.

Petitioner passed away from unrelated causes in October, 2014 and his wife, Barbara Northway, testified at the hearing on behalf of Petitioner. Rx1. Barbara Northway was the only witness and her testimony went unrebutted.

Barbara Northway testified that she was married to Laurence Northway for 38 years prior to his passing in 2014. When she learned of his accident, she testified she observed blistered and very swollen feet and both legs she observed burns on both feet up to mid calf. She recalled the right was a little worse than left. She also observed the back of his legs and she noticed they were burned in both heels and up about half way to mid calf.

Barbara Northway recalled Laurence treated for about two months. During this time, she testified she noticed peeling of the skin and the skin turning color, from pink, to dark red, to brown then to white. She also recalled Laurence changed his bandages and applied creams.

Barbara testified that when he finished treatment, he continued with dressings and cream until early 2013. At that time, she noticed his legs looked multi-colored: pink, brown, white and taught/tight looking skin. She noticed his toes were curled inward, still swollen and were a discolored brownish pink and white. She stated that Laurence was a white male Caucasian and the white she observed was as if his pigment was all gone. She also noticed the burned areas were hairless compared to before. Barbara also testified that Laurence walked differently after the accident and that he once fell. As of 2014, Mrs. Northway testified that the decedent's condition had not improved either and essentially looked the same

Regarding disability, she testified Laurence Northway no longer helped coach sports and had done so for 10 years prior to the summer of 2013. She stated he had trouble standing on the right foot and that he began wearing knee high socks all year.

She also noticed that Laurence Northway had difficulty shoveling snow off steps and sidewalks and someone was hired for that. He could also no longer bend down to pull weeds. Barbara Northway described her husband as going from a middle-aged man to an old man overnight due to his injuries. She testified that prior to the work accident; she did not observe Laurence Northway with any injuries or problems to the feet, ankles or shins.

On cross examination, Barbara Northway agreed that following her husband's treatment, he returned to work full time in his usual job as stationary engineer until his death. Rx1. She agreed that he stopped working to treat his unrelated cancer. Regarding her husband's injuries, she agreed that she did not take pictures at any point in time after the accident and that she did not know about ligament or tendon damage and did not know whether he suffered any broken bones.

CONCLUSIONS OF LAW

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

The Arbitrator concludes Laurence Northway's, for which Petitioner is a proper party, current condition of ill-being is causally related to the undisputed work accident. the evidence established that prior to the work accident, Laurence Northway had no prior injuries, burns or problems to his legs, ankles or feet. Following the work accident, US Healthworks documented Petitioner's extensive injuries to the legs, ankles and feet. Barbara Northway testified that following the work accident, Petitioner sustained no new injuries to his legs, ankles or feet. Thus, under a chain of events theory, the Arbitrator concludes Petitioner's current condition of ill-being is causally related to the 7/3/12 work accident.

ISSUE (L) What is the nature and extent of the injury?

The medical evidence and the unrebutted testimony at trial established the Laurence Northway finished treatment for his work injuries in August 2012 and therefore determination of the nature and extent of his injury, if any, is ripe for consideration. The Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that Laurence Northway suffered injuries causing permanent and partial disability.

The parties do not dispute that Laurence Northway, employee at the time of his injury of Respondent, died from unrelated causes in October 2014, leaving his widow, Barbara Northway, who testified at arbitration. Ax1, Rx1. Thus, since Laurence Northway reached maximum medical improvement for his work injuries before his unrelated death, the Arbitrator finds that at least some permanent partial disability has accrued and is therefore due and owing to Laurence Northway. Any such accrued benefit does not abate at death. *Bell v. Ill. Workers' Comp. Comm'n*, 2015 IL App (4th) 140028WC.

Barbara Northway testified extensively on her observations and recollection as to the appearance of Laurence Northway's burns. The Arbitrator is asked to consider an award of disfigurement under Section 8(c) based upon Barbara Northway's testimony as well as the medical evidence. Having found compensability under Section 8(e), the Arbitrator declines to award disfigurement under Section 8(c). Section 8(c) provides that where compensation is payable under Section 8(e), no compensation is payable under Section 8(c). Further, Section 8(e)(19) provides that "in the case of *specific loss* and subsequent death of such injured employee from other causes than such injury leaving a widow . . . then the amount due for such injury is payable to the widow..." (Emphasis Added). Thus, the Act does consider benefits 8(c) an accrued benefit payable in the case of a subsequent unrelated death.

The Arbitrator concludes that the evidence establishes Laurence Northway suffered permanent and partial disability. In so finding, the Arbitrator relies on the credible testimony of Barbara Northway and on the treatment records as evidence of same. In this case, petitioner presented sufficient testimony and evidence to find, by a preponderance of the evidence, that petitioner suffered from permanent injuries. Petitioner's accident caused him to suffer. Not only did the medical records confirm significant injuries, but Barbara Northway testified that petitioner still exhibited immobility, a limp, and pain despite more than two years from the date of the injury. Moreover, the severity of petitioner's injury and treatment alone creates an inference that a person might never fully recover.

Barbara Northway testified she was married to petitioner for 40 years and observed him active with coaching, gardening and snow removal before the accident. she testified his ability to perform these tasks was limited if not impaired after the accident. The Arbitrator believes she was most familiar with his physical capabilities before and after the accident. She also testified he had no prior problems or injuries to the legs, ankles for feet. After the accident, she noticed he had problems standing and walking.

For injuries occurring on or after 9/1/11, in determining permanent partial disability, Section 8.1(b) provides that permanent partial disability shall be established using the following criteria: (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.

Regarding (i) or the reported level of impairment, no impairment rating was submitted into evidence. Failure to submit an impairment rating does not preclude an award of permanency. The Arbitrator assigns no weight to this factor.

Regarding (ii), Laurence Northway's occupation was as an operator engineer before and after his work accident until the time of his unrelated death. Barbara Northway testified her husband worked full time and

without restriction upon his release back to work following medical treatment. she said he left work permanently to attend to his unrelated illness. The Arbitrator finds that the accident and resultant injuries did not permanently affect his ability to work. The Arbitrator assigns significant weight to this factor.

Regarding (iii), Laurence Northway's age at the time of the injury was 67 years. The Arbitrator gives weight to this factor as potentially increasing Petitioner's level of permanent partial disability because of the nature and condition of his injuries imposed upon the natural aging process and degeneration of a person of this advanced age.

Regarding (iv) or future earning capacity, the evidence showed Laurence Northway earned his full wages and suffered no impairment of earnings as a result of his injuries. The Arbitrator assigns no weight to this factor.

Regarding (v) or evidence of disability corroborated by the treating medical records, the Arbitrator weighs this factor in favor of Laurence Northway and Petitioner. Barbara Northway testified at length as to Laurence Northway's disability following his accident in and around the home. Medical records show that he suffered burns in the lower legs, ankles and feet. Mr. Northway underwent debridement to remove dead and hanging skin, was required to elevate his feet and legs for some time and avoided wearing steel toe boots before returning to full duty work. However, evidence also established that Laurence Northway was able to return to work, able to wear steel toed boots and was otherwise free of restriction. The Arbitrator assigns the greatest weight to this factor.

Considering all of the factors pursuant to Section 8.1(b) in conjunction with Section 8(e)(11), the Arbitrator concludes that the work accident of 7/3/12 caused injury to Petitioner's right foot resulting in permanent partial disability of **8%** loss of use of the right foot at a rate of **$712.55** per week for **13.36 weeks**.

Further, considering all of the factors pursuant to Section 8.1(b) in conjunction with Section 8(e)(11), the Arbitrator concludes that the work accident of 7/3/12 caused injury to Petitioner's left foot resulting in permanent partial disability of **8%** loss of use of the left foot at a rate of **$712.55** per week for **13.36 weeks**.

The Honorable Maria Bocanegra

11-5-2015

Date

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

MOORE, WILEY
Employee/Petitioner

Case# **13WC039970**

GLEESON ASPHALT INC
Employer/Respondent

On 9/29/2015, 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 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4488 THE PERICA LAW FIRM PC
BOB L PERICA
229 E FERGUSON AVE
WOOD RIVER, IL 62095

5074 QUINTAROS PRIETO WOOD & BOYER
MICHAEL J SCULLY
233 S WACKER DR 70TH FL
CHICAGO, IL 60606

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)

Wiley Moore
Employee/Petitioner

v.

Gleeson Asphalt, Inc.
Employer/Respondent

Case # **13** WC **39970**

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 **Lindsay**, Arbitrator of the Commission, in the city of **Collinsville**, on **July 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 **Are PX 6, PX 6A, and RX 6 admissible?**

FINDINGS

On the date of accident, **November 20, 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 **$30.38 per hour**; the average weekly wage was **$1,215.20**.

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

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

Respondent shall be given a credit of **$54,619.92** for TTD, **$n/a** for TPD, **$n/a** for maintenance, and **$n/a** for other benefits, for a total credit of **$54,619.92**.

Respondent is entitled to a credit of **$n/a** 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 prove that his current condition of ill-being is causally connected to his injury. Petitioner's claim for prospective medical care, medical bills, temporary total disability benefits, and penalties and attorney's fees 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

September 27, 2015
Date

ICArbDec19(b)

SEP 29 2015

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

According to the medical records Petitioner underwent an MRI of the cervical spine on December 3, 2009 which showed an osteophyte complex on the right at C5-6 with neuroforaminal encroachment and probable exiting nerve root impingement. Uncoverteberal degenerative changes were noted, as well as, disc osteophyte complex on the right encroaching on the right neuroforamen and contacting the right exiting nerve root. There was mild disc bulging at C4-5 level impinging on the thecal sac. Mild ventral effacement of the thecal sac and flattening of the cervical cord was also observed at this level. (RX 4).

Petitioner underwent a second cervical MRI on November 1, 2011 of the cervical spine. The impression was increasing degenerative disc disease and increased disc osteophyte complex at C4-5 and degenerative changes at C5-6 and the remainder of the cervical spine (RX 4). C4-5 had a large central disc osteophyte complex that had increased in size. There was mild flattening along the ventral midline cord and mild bilateral foraminal narrowing (RX 4). Also at C5-6 there was a broad-based disc and endplate spurs with effacement of the ventral CSF with moderate right greater than left foraminal narrowing (RX 4; RX 2, p. 9/15)

Approximately two years later,on November 21, 2013 Petitioner was examined by Dr. Carr for complaints of constant aching, burning, and discomfort in the right trapezial muscle and a constant burning and shooting discomfort on the side of his right shoulder. He also complained of frequent numbness, burning and tingling in the back of his hand. Petitioner described a work injury on November 20, 2013 when he was working, walking backwards, and stepped in an uncovered waste water drainage hole. One leg fell into the hole while the other one remained above ground. Petitioner struck his flank and right knee along with his right elbow and jammed his shoulder superiorly and his neck into lateral flexion and extension. Petitioner reported to the doctor that he would be filing a report with his employer but his superintendent and foreman were immediately notified of the injury. Dr. Carr conducted a physical examination concluding that it was more probable than not that Petitioner was injured as a result of the traumatic forces experienced during the accident. Petitioner underwent palliative care including manipulations wit heat, interferential stimulation, myofascial releases, and stretching. Petitioner was told to avoid heavy lifting and use ice. (RX 2, pp. 2-3)

On November 22, 2013 Petitioner presented to Dr. Kai-Chun Yang and gave the same history of injury. His complaints included injury to his right side, neck, arm, shoulder, elbow, and left back. A history of degenerative disc disease was noted. The plan was to obtain images of the right elbow, shoulder and lumbar spine. "(RX 2, p. 3)

On November 25, 2013 Petitioner signed his Application for Adjustment of Claim herein alleging that he injured his right shoulder, right elbow, and right knee on November 20, 2013 while putting plastic down and he fell in an uncovered storm drain. (PX 2)

Petitioner continued to treat with Dr. Carr on November 23, 2013, November 25, 2013, and November 27, 2013 through December 13, 2013 during which time he received manipulations, stimulation, heat and stretching. (RX 2, p. 3) On November 25, 2013 Dr. Yang had Petitioner undergo cervical spine x-rays due to a fall. The history sheet reflected Petitioner having fallen into a man hole five days earlier with right shoulder and elbow pain and mild cervical and lumbar pain. They revealed early osteoarthritic changes. He also ordered right shoulder and elbow x-rays due to pain and trauma which also showed osteoarthritic changes of the right shoulder and elbow with no acute process. Mild lumbar spine x-rays also showed mild osteoarthritic changes but no acute process. (RX 4)

Dr. Yang re-examined Petitioner on December 13, 2013 noting a recent increase in pain. Petitioner continued to have limited range of motion of his shoulder due to pain and tenderness of the right elbow with limited range of motion. He was given prescriptions for hydrocodone, Flexeril, and Gabapentin and scheduled for a cervical epidural steroid injection with Dr. Randle. He was provided with a right arm trigger point injection and given a script for physical therapy after the injection. Petitioner was to remain off work through January 15, 2014. (RX 2, p. 4)

Petitioner continued to receive treatment from Dr. Carr and it was noted that he had undergone cervical steroid injections at C5-6 and C6-7. (RX 2, p. 4)

On January 7, 2014, at the request of Dr. Yang, Petitioner underwent a lumbar spine MRI. He completed an MRI Patient Data Sheet and did not respond to questions regarding whether his medical condition stemmed from an auto accident or workers' compensation injury. The History Sheet stated Petitioner had sustained an injury on 11/20/13 when he fell backwards into a manhole. He was complaining of low back pain with bilateral leg numbness and denied any prior surgery or MRI of his lumbar spine. The MRI revealed a circumferential bulge with a left far lateral annular tear at L4-5, mild lumbar spondylosis with facet arthropathy and mild right foraminal narrowing at L4-5 but no focal disc herniations or spinal canal stenosis. (RX 4)

On February 20, 2014 Petitioner presented to Dr. Kelly Cushing seeking care and help for anxiety. Petitioner presented with a history of chronic back pain due to an injury in 2008 for which he was undergoing steroid injections. Dr. Cushing noted that Petitioner had recently been seen in the ER at Washington University for a rash diagnosed as idiopathic urticarial. He had been discharged on Loratadine and Vicodin but didn't fill the script for Vicodin as he was already using it as prescribed by his neurologist, Dr. Randle, who he was seeing in Alton for his chronic back pain (cervical, right shoulder and lower back) who had been following him since 2008 for injury-related lower back pain. Petitioner was complaining of severe stress in his life due to his father's terminal illness and severe anxiety for which he had been under care by his primary care physician in Alton (whose name he could not recall). Petitioner was noted to be very vague with his history. Petitioner did not wish to leave a urine sample or undergo a blood draw due to anxiousness about his father. He received a series of phone calls and insisted he had to leave and would reschedule later. (RX 2, pp. 4-5; RX 7)

Petitioner continued treating with Dr. Carr. (RX 2, p. 5)

On March 27, 2014 Petitioner presented to Dr. Scott Purvines for neck, shoulder and right arm pain. Dr. Purvines' plan of care is not known.[1] (RX 2, p. 5)

Petitioner underwent an examination with Dr. Robert Backer on May 13, 2014 at the request of Respondent. (RX 8) Petitioner gave a history of being in an accident on November 20, 2013 (RX 8). Dr. Backer noted that Petitioner was not a good historian in providing the account. Dr. Backer diagnosed Petitioner with pain with range of motion in the right shoulder. He did relate to that to the work injury and stated that reasonable treatment was necessary. (RX 8). Dr. Backer recommended evaluation by an orthopedic surgeon and an MRI of the cervical spine. Dr. Backer also indicated that two previous MRIs had been done and needed to be compared to determine whether or not Petitioner would be in need of any additional treatment (RX 8). Dr. Backer indicated that Petitioner had no objective signs for any low back or right leg pain. Dr. Backer felt Petitioner's neck pain was related to his work injury. Dr. Backer noted ongoing complaints of low back pain and right leg pain but no objective signs on exam or by MRI to suggest any lumbar injury. He didn't think Petitioner needed any further low back care or treatment and that he was at maximum medical improvement for any low back complaints. He didn't render a causation opinion regarding Petitioner's low back; however, he documented Petitioner's history of low back pain and lower extremity complaints since the work accident. (RX 8).

Petitioner continued treating with Dr. Carr on May 20 and 22, 2014. (RX 2, p. 6)

Petitioner was seen at the emergency room at Barnes-Jewish Hospital on May 25, 2014 regarding complaints of neck, shoulder and arm pain of one year's duration. Petitioner complained of paresthesia, decreased sensation, and weakness in the right and intermittent paresthesia and decreased sensation to the bilateral feet following an accident in November of 2013. Petitioner reported being under the care of doctors since November but waking up that morning and being unable to move his neck past the midline on the right. Petitioner couldn't explain how much pain he was in and was noted to be agitated and uncooperative with the exam and not answering all the questions posed to him. He reported himself as a "case of insurance company run around....And what they do is pump you full of pain killers and try to put your surgery off." Petitioner said that "when it would get bad his body would go intro stress" and showed a picture of a rash on his thigh (on cell phone) He stated that the pain was located in the same area as his chronic pain but now more severe. X-rays were negative for fracture of the cervical spine or right shoulder. Petitioner didn't want to do blood work up again because he had been there a whole day one other time. Petitioner had taken two percocets while at x-ray as well as flexeril. He was discharged in stable condition with medications. (RX 2, p. 6; RX 7)

Petitioner was treated by Dr. Carr on May 28, 2014. (RX 2, p. 6)

Petitioner then had an MRI of the cervical spine on June 2, 2014 that showed degenerative disc disease and disc osteophyte complex at C4-5 and C5-6 resulting in mild central canal stenosis. There was also moderate right foraminal stenosis at C4-5 (PX 4; RX 2, p. 6).

Petitioner had treatment with Dr. Carr on June 6, 2014 and on June 25, 2014. (RX 2, p. 7)

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[1] Missing from the record. See page 5 of Dr. Lehman's report.

On July 8, 2014 Petitioner returned to Dr. Purvines's office. His discomfort was primarily in his neck and shoulder blades. He also had numbness and tingling in his elbow down to his hand. Activity worsened the complaints. Petitioner had undergone radiofrequency ablation of the cervical joints with no improvement. He had normal strength in his bilateral upper extremities with some slight decrease in sensation in the ulnar distribution of the right hand. He also had decreased range of motion in the right shoulder blade. They reviewed Petitioner's cervical MRI which showed "acute appearing" disc herniations in Petitioner's neck and very likely musculature injury of the right shoulder. Dr. Purvines recommended a shoulder evaluation before considering cervical spine burger and he recommended a two level anterior cervical discectomy and fusion as well as an EMG to look for an ulnar neuropathy at the elbow. (RX 2, p. 7)

The medical records from Barnes Jewish Hospital on July 9, 2014 confirm Petitioner presented there with complaints of severe right shoulder, neck pain and back pain and that the onset was sudden (RX 7). He arrived by ambulance having been involved in a motor vehicle accident. Petitioner had been traveling 15 or 30 mph and was a restrained drive. He denied loss of consciousness and was walking around at the scene of the accident and requested a backboard. He had a complete work-up and treatment including x-rays and CT diagnostics. Nothing acute was noted. Petitioner was diagnosed with strains and contusions and was prescribed Diazepam.(RX 7; RX 2, p. 7).

On July 24, 2014 Petitioner was examined by Dr. Thomas[2]. Dr. Thomas recommended an MR arthrogram of Petitioner's right shoulder and he imposed restricted duty. (RX 2, p. 8)

A right shoulder MRI was performed on August 6, 2014 and showed mild to moderate supraspinatus and infraspinatus tendinopathy without evidence of a full thickness rotator cuff tear along with degenerative changes. (RX 2, p. 8)

Petitioner continued to treat with Dr. Carr from August 18, 2014 through September 5, 2014 for cervical spine pain, low back pain, numbness and tingling. (RX 2, p. 8)

Petitioner returned to Dr. Purvines on September 11, 2014 in follow-up for his persistent neck and upper extremity discomfort. He denied any new symptoms, just ongoing persistence of his previous symptoms. It was noted that his symptoms were limiting him substantially and keeping him from getting back to work. Strength and sensation in his upper extremities was normal. Petitioner had ongoing decreased range of motion of his neck. (RX 2, p. 8)

Petitioner again treated with Dr. Carr from 9/24/24 through 11/4/14 with the patient noted to be "suffering a few setbacks due to an exacerbation in his symptoms." (RX 2, p. 8)

Medical records from December 1, 2014 from Barnes Jewish Hospital show that Petitioner presented with unbearable pain in his neck and right shoulder. He gave a history of being involved in an accident about a year earlier followed by involvement in a home invasion two weeks earlier with an aggravation of his pain. He also gave a history of working in his yard that day/the day before and now having worsening pain. Petitioner also stated he was waiting to get a disc replaced in his neck (previously scheduled for September but then needing to be rescheduled) and twisted wrong with worsening pain

[2] Dr. Lehman's summary notes that "His injury was reiterated to Dr. Thomas."

radiating down his right shoulder and arm. He also reported constant right hand numbness. (RX 7). Petitioner was discharged with no medications. (RX 7).

No medical records subsequent to December 1, 2014 were included in the record.

On January 28, 2015 Dr. Lehman issued a medical records review at the request of Respondent. He did not examine Petitioner. After a lengthy review of Petitioner's medical records [3] Dr. Lehman concluded as follows: (1) Petitioner's care and treatment to date had been reasonable; (2) The treatment, while reasonable, is not causally connected to Petitioner's accident at work; (3) The chiropractic treatment had been excessive and unrelated to the accident; (4) Petitioner's right shoulder complaints/condition was not related to the work accident and Petitioner required no further care for the shoulder; (5) Petitioner's current cervical spine condition was not related to the work accident but Petitioner did need further treatment; and (6) Petitioner's current lumbar condition was unrelated to the work accident. (RX 2)

The deposition of Dr. Scott Purvines was taken on May 14, 2015. (PX 4) Dr. Purvines is a board certified neurosurgeon who began treating Petitioner in March of 2014. At that time he took a history from Petitioner in which Petitioner related being engaged in his normal work activities when he fell into a hole and subsequently developed neck, shoulder and right upper extremity pain along with numbness extending down to the palms of his hand and his fingers (especially the ring finger). Petitioner had difficulty with range of motion on the right shoulder and neck discomfort extending down between his shoulder blades. All of the foregoing complaints were worse with use of his arm. Dr. Purvines believed that Petitioner had previously undergone both physical therapy and pain management before presenting to him. (PX 4, pp. 3-7)

Dr. Purvines conducted a physical examination which revealed neck tenderness extending down between the shoulder blades, painful range of motion (especially with flexion, right lateral rotation, and flexion) and numbness in his right hand. Petitioner did not bring his cervical MRI with him but in light of Petitioner's painful right shoulder range of motion the doctor felt a referral/evaluation by a shoulder specialist was appropriate. Dr. Purvines could not recall who Petitioner went to for the shoulder evaluation. However, he returned to see him thereafter and they ultimately reviewed the cervical MRI which was done on June 2, 2014. . Dr. Purvines testified that Petitioner had disc abnormalities at C4-5 and C5-6. He felt Petitioner's MRI findings at C4-5 were consistent with his complaints except for the right shoulder symptoms. Dr. Purvines also believed that Petitioner's complaints in his hand were consistent with a possible ulnar neuropathy. Dr. Purvines was under the belief that Petitioner had undergone a radio frequency ablation previously. When asked if the MRI showed disc herniations at C4-5 and C5-6, the doctor responded "Yes." (PX 4, pp. 7- 10)

Dr. Purvines testified that they discussed surgery for Petitioner's neck but he still recommended a shoulder evaluation before proceeding with surgery. (PX 4, p. 10)

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[3] The summary for which provided most of the medical back ground for this case as Petitioner's PX 3 containing many treatment records was not admitted

Petitioner returned to see Dr. Purvines on September 11, 2014 and they agreed to proceed with a C4-5 and C5-6 anterior cervical discectomy and fusion. (PX 4, pp. 10-11)

Dr. Purvines again examined Petitioner on December 16, 2014. At that visit Petitioner reported having undergone some sort of "traumatic episode" which the doctor could not exactly recall; however, since that event, Petitioner had been experiencing an increase in his familiar discomfort (ie.,. the same distributions as previously). Petitioner had even gone to the emergency room and Petitioner advised he was given some medication and discharged. (P 4, p. 13)

Dr. Purvines testified that Petitioner's symptoms are being generated by disc abnormalities at C4-5 and C5-6. He also believes there may be an issue with Petitioner's right shoulder and, possibly, his right elbow (ulnar neuropathy) which may or may not be related to the other issues. (PX 4, pp. 13-14) When asked if he had an opinion within a reasonable degree of medical certainty as to whether or not this accident history that he gave him of November 20, 2013 was the cause of the problems he presented with, the doctor replied, "I can say that it's consistent." (PX 4, p. 14) He explained that Petitioner's symptoms have remained consistent during their period of treatment. He has not released Petitioner to return to the work he had been doing. (PX 4, p. 14) He added that he hasn't seen any records that would make him believe Petitioner's symptoms aren't related but he doesn't do very much background investigation of his patients. Everything Petitioner told him seemed consistent with the story of his injury. (PX 4, p. 15)

On cross-examination Dr. Purvines testified that if he and Petitioner discussed any of Petitioner's history prior to November of 2013, he didn't record it. He didn't recall doing so. (PX 4, pp. 16-17) He agreed that Petitioner denied any permanent relief from the injections or the physical therapy. He did not recall if he reviewed any of those records. (PX 4, p. 17) Petitioner did not report any history of neck pain before November 20, 2013 but the doctor testified that he probably didn't ask him about it. They also did not discuss any further injuries. (PX 4, pp. 17-18)

Dr. Purvines acknowledged that he only saw the June 2, 2014 MRI and if there were others that had been done he didn't record it. He also acknowledged that throughout the time he has been treating Petitioner he could not recall whether or not he gave Petitioner work restrictions. (PX 4, pp. 22-23) His reports did not state anything. (PX 4, p. 23) He believed his Summary Report of September 11, 2014 might have indicated he couldn't work. (PX 4, p. 23) Dr. Purvines acknowledged that he has not seen any records from Alton Memorial Hospital other than a January 7, 2014 lumbar MRI and a November 25, 2013 cervical MRI. He could not recall that Petitioner ever mentioned a car accident occurring on May 16, 2008. He had not seen a CT scan of Petitioner's cervical spine dated May 16, 2008, any records from St. Anthony's Health Center from November of 2009, or any information pertaining to a tree falling on him in November of 2009. Dr. Purvines was also unaware of a December 3, 2009 cervical spine MRI. Petitioner had never told him that he had been diagnosed with a mild bulging disc at C4-5. He did not compare any MRIs pertinent to Petitioner's neck. He was also unaware that Petitioner

had fallen down some stairs on November 1, 2011. When asked if it would alter his opinion if he had the previous MRIs from 2009 and 2011 Dr. Purvines testified, "That's a difficult question to answer since I haven't seen them. In my opinion the new MRIs demonstrate an acute abnormality, however, that likely isn't years old." (PX 4, pp. 28-29)

On redirect examination Dr. Purvines explained that there were certain MRI characteristics suggestive of recent soft tissue injury. It was his understanding that Petitioner was performing heavy labor work at the time of his accident and wasn't having any problems at all until after that accident. (PX 4, pp. 29-30) He has never released or recommended that Petitioner return to work. (PX 4, p. 30)

The deposition of Dr. Lehman was taken on June 24, 2015. Dr. Lehman testified to decades of experience as an orthopedic surgeon (RX 1). Dr. Lehman testified that he reviewed all the medical records in this case in January of 2015. He noted significant clinical findings for previous shoulder and cervical spine pain associated with a prior motor vehicle accident, prior injury involving a fallen tree striking Petitioner's back and cervical MRIs that demonstrated degenerative changes at C5-6 (RX 1). Dr. Lehman testified that with respect to Petitioner's neck issues and review of the MRI's, that Petitioner had foraminal stenosis and entrapment of the exiting nerve (RX 1). Dr. Lehman noted Petitioner had fallen into a hole and had been evaluated for the fall on March 27, 2014.

Dr. Lehman testified that Petitioner had long term facet arthropathy which began in 2009 and increased between 2009 and 2011 (RX 1). This was long-term condition that did not change after Petitioner's alleged accident in 2013 (RX 1). Dr. Lehman concluded the Petitioner's 2013 accident had no causal relationship to his condition because he did not suffer any acute changes in his condition (RX 1). Petitioner did not even experience any further degenerative changes since the previous evaluations predating the accident (RX 1).

Dr. Lehman testified that his conclusions with respect to the cervical spine were based on review of the MRI scans and that there was no causal relationship between the medical records and there had been similar levels in pathology of progression in the scans that were previously taken in 2009 and 2011 (RX 1). Dr. Lehman testified Petitioner's treatment was not medically causally related to Petitioner's accident and did not require any work restrictions to the cervical spine and lumbar spine or right shoulder in relation to this accident (RX 1). The doctor felt that Petitioner's current limitations were not related to his accident. (RX 1).

Petitioner's case proceeded to arbitration on July 30, 2015. Petitioner was the only witness testifying at the hearing. The disputed issues were accident, causal connection, medical bills, temporary total disability benefits, prospective medical care, and penalties and attorney's fees. During the hearing several evidentiary issues were raised which were also taken with the case.

Petitioner testified that on November 20, 2013 he was working for Respondent. He had worked there three months prior performing concrete work and highway work

Petitioner testified that on the day of the alleged injury, he was shoveling concrete and building curbs for handicapped sidewalks. Petitioner testified that there was another employee for Respondent

working with him; however, he couldn't recall his name. On November 20th, it was about to rain, so they were going to cover the area with plastic to protect the concrete. Petitioner testified that as he grabbed the plastic to stretch it out, his leg went into an uncovered sewer grate. Petitioner testified that his right leg, back, right shoulder and neck went backwards and landed on his right side on the ground. Petitioner continued working until he was done for the day. Petitioner testified that at the time of accident, his right leg, lower part of his back, right shoulder, and neck all went backwards. As he explained it, his left leg was on top of the road surface; his right leg was inside the hole. He mainly landed on his right elbow and "flipped backwards" because he was walking backwards. Petitioner testified that his foreman asked him if he was okay and he responded that he didn't know yet. His foreman then had him go since it was raining. Petitioner also testified that "a first person" told him to go get it checked out.

Petitioner testified he went to see Dr. Carr on November 20, 2013.

Petitioner testified he saw Dr. Gregory Randle who did a series of injections and nerve blocks. Dr. Randle is associated with Vigilant Pain Managements. Petitioner testified he continued to treat with Vigilant Pain Management. Petitioner presented no medical records or evidence from Vigilant Pain Management to support any treatment.

Petitioner testified that Dr. Randle recommended and scheduled him for surgery in September. His attorney then asked him if Dr. Purvines scheduled the surgery and Petitioner responded "Yes."

Petitioner acknowledged being seen by Dr. Backer at the request of Respondent's insurance carrier.

Petitioner testified he then went to see Dr. Purvines at St. Luke's Hospital Brain & Spine Institute in September 2014.

Petitioner testified on July 9, 2014 he was involved in a motor vehicle accident. Petitioner testified to right shoulder, neck and back injuries when seen at the ER.

Petitioner testified that he was involved in a car accident on August 25, 2014. He was hit by another vehicle that ran him off side of the road and came in contact with a pole.

Petitioner testified that he was involved in a home invasion in mid-November 2014. He claimed that there were two men in his home and they exchanged words and yelled. Petitioner testified that he hit his left shoulder.

Petitioner also testified he had an injury on December 1, 2014 while he was working in his yard at home. He had an injury to his neck, right shoulder and arm while twisting his body, picking up windows, screens and pine tree limbs. Petitioner further testified that his neck was messed up from his car accident.

Petitioner also acknowledged having a prior injury while working on the hospital extension in Alton. However, he had no lost time from work; rather, he worked light duty.

Petitioner acknowledged treating with Dr. Carr prior to November 21, 2013 and that the treatment went back to when he got hurt on the Alton hospital job and was on light duty.

Petitioner testified to being arrested on October 17, 2013 by Missouri State Highway Patrol. Petitioner testified he was arrested for possession of controlled substances. Petitioner refused to answer whether or not he was arrested for being in possession of methamphetamines. Petitioner also refused to answer whether or not he was arrested for possession of Alprazolam. Petitioner further refused to testify and answer whether or not he was arrested for possession of Diazepam. Petitioner pled the Fifth Amendment at trial.

Petitioner testified that he hasn't undergone surgery as every time it is scheduled, it gets cancelled. Petitioner continues to experience bad pain in his neck, right shoulder and down through his right arm. Petitioner believes he may have a muscle problem in his shoulder and an ulnar nerve problem in his elbow. He described his neck pain as intense. His elbow feels like it is on fire. The arm pain going from his bicep to his elbow feels thick and hot. Petitioner's fourth and fifth fingers on the right hand are always numb as is the pad. He has good days and bad days.

Petitioner brought his medications with him to the hearing and testified that they have been prescribed by Dr. Randle. Petitioner has lost weight as Dr. Purvines suggested it in order to have a quicker recovery.

The Arbitrator concludes:

With regard to Issue (C), Did an accident occur that arose out of the course of Petitioner's employment by Respondent?:

Petitioner sustained an accident on November 20, 2013 that arose out of and in the course of his employment. Petitioner's testimony on the issue of accident was unrebutted and corroborated by the histories provided to the various medical providers. Petitioner testified that a co-worker (a shop worker for Respondent) was with him at the time of the accident and interacted with him thereafter. Petitioner also testified to speaking with his foreman. Respondent offered no rebuttal witnesses. Petitioner was both in the course of his employment and his injury arose out of his employment.

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

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

Petitioner failed to prove that his current condition of ill-being in his neck, right shoulder, and right arm is causally related to his November 20, 2013 accident. Petitioner failed to meet his burden of persuasion on causation or that his need for surgery is causally related to the work accident. In support thereof the Arbitrator notes the following.

1. Petitioner's credibility. Petitioner was not an altogether credible witness. From the beginning of his testimony there were inconsistencies. For example, he testified that the same day as the accident he presented to Dr. Carr. Keeping in mind that Dr. Carr's records were not a part of the record, the only reference to them is found in Dr. Lehman's IME report and Dr. Backer's IME report. According to it, Petitioner presented on November 21, 2013, the day after his accident. Petitioner also only claimed left shoulder injuries as a result of the home invasion episode at his house in

2014; however, the medical records indicate differently. Petitioner also provided some very confusing testimony regarding who recommended and scheduled his back surgery. At first he testified it was Dr. Randle. His attorney then brought up Dr. Purvines. None of it was flushed out. This was very troubling to the Arbitrator in light of Petitioner's representations to Dr. Cushing in February of 2014 wherein the doctor clearly noted that Petitioner had a history of chronic back pain due to an injury in 2008 for which he was undergoing steroid injections. Petitioner did not mention the accident with Respondent herein whatsoever. Petitioner further told Dr. Cushing that he was seeing Dr. Randle since 2008 for his chronic back pain (cervical, right shoulder, and low back). Dr. Randle's records aren't a part of the record. Petitioner provided no testimony in an effort to sort all of this out or explain it.

Petitioner also was not truthful with Dr. Purvines. The doctor recommended surgery on September 11, 2014, to Petitioner's neck. (PX 4) Petitioner testified that he was involved in a motor vehicle accident on July 9, 2014. He was taken by ambulance from the scene and placed in a neck brace and back brace. In the emergency room, he complained of injuries to his right shoulder, back, and neck. Petitioner also had a motor vehicle accident on August 25, 2014. He testified that he was sideswiped by another driver running off the road. Petitioner did not give any history of either car accident to Dr. Purvines as it is not documented in the September 11, 2014 medical report or in any other records from Dr. Purvines. (PX 4) Petitioner further testified he was at the emergency room for neck pain on December 1, 2014. Petitioner testified his neck was messed up after his car accident. Petitioner also testified that he injured his right shoulder, neck and arm while working in his yard on December 1, 2014. The medical records read that on December 1, 2014, he was working in his yard and injured his neck, right shoulder and arm after twisting. Petitioner testified he was picking up pine tree limbs, storm windows and screens. Petitioner stated he was picking up more than one but less than 50. Again, Dr. Purvines did not have any of this information to accurately assess in his evaluation and treatment of Petitioner.

2. Missing records. Petitioner testified to treatment with a number of physicians and treatment facilities (ex. Vigilant Pain Management); yet, no records were admitted into evidence. The Arbitrator has had to try and put together a chronology of treatment based upon summaries from Respondent's examining physicians. The records themselves were never independently admitted. Petitioner admitted to treating with Dr. Carr before the accident and, yet, no medical records from Dr. Carr were admitted into evidence. While Petitioner testified to no lost time before his November 20, 2013 accident that doesn't mean he was asymptomatic. He acknowledged to several doctors that his complaints in 2014 went back to a 2008 accident and was chronic in nature.

3. Dr. Purvines' Testimony and Opinions. The Arbitrator did not find them persuasive. Dr. Purvines did not have a clear understanding and knowledge of Petitioner's prior medical problems in his neck. He did not review the earlier MRIs. In sum, he was rendering opinions without knowing all of the necessary information pertinent to Petitioner's case. Dr. Purvines testified that he had not reviewed all the medical records and did not review the prior MRI scans. He was not operating on all

knowledge associated with Petitioner's treatment. Dr. Purvines was not aware of any of the motor vehicle accidents involved. This is significant as his recommendation for surgery occurred on September 11, 2014 which was only two weeks after the second car accident on August 25, 2014.

The Arbitrator is aware that Dr. Backer issued an IME report at Respondent's request on May 13, 2014 and found causal connection for Petitioner's neck, right shoulder, and low back. However, even though Dr. Backer indicated Petitioner's neck pain was related to the work injury, Dr. Backer believed the petitioner should have had an MRI of the cervical spine to complete the work-up of his neck. Dr. Backer was aware of the two prior cervical MRIs and made it clear that those would need to be compared to the new MRI. Additionally, Dr. Backer's causation opinion was based on Petitioner's condition in May of 2014. The issue at the present time concerns Petitioner's current condition and whether an award of cervical surgery is in order. Dr. Backer did not address those issues.

With regard to Issue (J),Were the medical services provided to Petitioner reasonable and necessary and should Respondent pay all appropriate charges for all reasonable and necessary medical services:

Petitioner failed to meet his burden of proof on causation. Furthermore, to the extent medical bills may have been attached and included as part of PX 1, no supporting medical records were produced by the various treaters. Petitioner's request for an award of medical bills is denied.

With regard to Issue (L), What temporary benefits are in dispute, TTD?:

Petitioner failed to establish that he is entitled to TTD benefits from March 9, 2015, through July 30, 2015, as he failed to prove causation. Additionally, the Arbitrator notes that there are no off-work slips included in the record.

It is undisputed that Respondent paid $54,332.11 in TTD benefits and is entitled to a credit for all TTD paid to Petitioner.

With regard to Issue (M), Should any penalties or fees be imposed on Respondent?:

Consistent with her causation determination above, the Arbitrator denies penalties and fees to Petitioner. Even if Petitioner had prevailed on causation, the Arbitrator would have denied penalties and attorney's fees. Petitioner failed to establish that the denial of medical benefits, TTD, was unreasonable or vexatious. Respondent reasonably relied on the opinions of Dr. Lehman, as well as the substantial medical records submitted into evidence by Respondent. The Arbitrator also found Petitioner lacked credibility. Therefore, the denial of benefits does not rise to the level for penalties or fees and is denied.

With regard to Issue (N), Is Respondent due any credit (overpayment of TTD)?:

Respondent paid TTD benefits from November 20, 2013, through July 30, 2015 in the amount of $54,332.11; however, at the time of arbitration it denied liability for the benefits. Consistent with her causation determination, the Arbitrator awards Respondent a credit for all TTD benefits paid.

With regard to Issue (O), Whether the Police Report is admissible?:

R.X. 6 is not admitted as it constitutes hearsay.

The police report introduced at trial constitutes hearsay testimony, and therefore, should not be admitted. Even, assuming arguendo, it was admitted it concerns events pre-dating the alleged accident herein and has little probative value.

With regard to Issue (O), Whether Petitioner's Exhibits 6 and 6A- the Deposition Transcripts of Dr. Lehman in a prior civil case and his subsequent Curriculum Vitae are inadmissible?:

PX 6 and PX 6A are not admissible.

The Illinois rules of evidence apply to proceedings before the Illinois Workers' Compensation Commission ("IWCC"), "except to the extent they conflict with the act." 50 Ill. Admin. Code §7030 70(a) (2002). *See also, National Wrecking Co. v. Industrial Commission*, 816 N.E.2d 722 (2004). The controlling and relevant legal authorities resolving similar evidentiary issues in civil torts will also, therefore, be controlling and relevant in the workers' compensation context. The present question invokes issues that have been thoroughly treated by several well-established precedential and statutory authorities.

Depositions from prior cases may only be introduced at trial in later cases under specific circumstances. *Hubbert v. Dell Corporation*, 359 Ill.App.3d 976 (2005). Whether a deposition transcript can be admitted depends on whether [a] the party against whose interest the deposition testimony is being used had notice of the deposition and [b] [the party against whose interest the deposition testimony is being used had] an opportunity to cross-examine the deponent" (emphasis added). In *Hubbert*, Plaintiff introduced a deposition transcript from a different case over Respondent's objection. *Id.* The court held that "because there was no evidence that the defendant was a party to the [previous case] or that defendant's attorneys had notice or an opportunity to cross-examine [the deponent]...[the deposition was inadmissible]."

The facts of the present case fit squarely within *Hubbert's* framework. Respondent – the "party against whose interest the deposition testimony is being used -- had no notice of Dr. Lehman's previous depositions. Respondent, moreover, had "no opportunity to cross-examine" Dr. Lehman in Dr. Lehman's previous depositions. Petitioner may not, therefore, introduce the previous deposition transcript at trial.

Even if, *arguendo,* the depositions would not be precluded under *Hubbert*, the depositions would be heavily limited under the precedential and statutory rules governing the admissibility of discovery depositions generally. "Only rarely may any portion of a discovery deposition be used at trial." *Berry v. American Standard, Inc.*, 382 Ill.App.3d 895, 900 (2008).

Petitioner has tried to introduce Dr. Lehman's deposition testimony as an admission against Respondent's interest. Successful admission under this exception requires a finding that Dr. Lehman acts as an *agent* of Respondent. *Greaney v. Industrial Commission*. The court has held that a doctor retained by a respondent to conduct an Independent Medical Examination, and expert witnesses in general, "[are] not *per se* agent[s] of the party who hired him or her..." "[T]herefore, the expert's prior statements and opinions are not admissible as admissions against that party's interest."

PX 6 A is also rejected. It constitutes hearsay. Dr. Lehman was deposed and Petitioner's attorney did cross-examine him regarding the professional matter. The proper time to have presented the settlement agreement was during the doctor's deposition.

The Arbitrator finds that Respondent's objections to Petitioner's Exhibits 6 and 6A are sustained and the exhibits will not be admitted into evidence.

****

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

JOHNSEN, CLIFFORD Case# **14WC035800**

Employee/Petitioner

CITY OF CHICAGO

Employer/Respondent

On 11/6/2015, 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 0.28% 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:

4564 ARGIONIS & ASSOC LLC
PHIL GOYETTE
180 N LASALLE ST SUITE 2105
CHICAGO, IL 60601

0010 CITY OF CHICAGO LAW DEPT
NANCY J SHEPARD
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Clifford Johnsen
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **14** WC **35800**

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 **Christine Ory**, Arbitrator of the Commission, in the city of **Chicago**, on **September 14, 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, **October 2, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**70,753.80**; the average weekly wage was $**1.360.65**.

On the date of accident, Petitioner was **55** 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 $**43,672.79** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**43,672.79**.

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

ORDER

Respondent shall pay the reasonable and necessary costs related to the surgery to petitioner's right knee as prescribed by Dr. Karnezis in accordance with §8.2 of the Act.

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

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

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

Christine McCoy

11/05/2015

Signature of Arbitrator — Date

NOV - 6 2015

ICArbDec19(b)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Clifford Johnsen,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 14 WC 35800**
	)	
City of Chicago,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on October 2, 2014, 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 on that date the Petitioner sustained accidental injuries that arose out of and in the course of the Petitioner's employment with the Respondent 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. They further agree that in the year preceding the injuries, the Petitioner earned $70,753.80, and that his average weekly wage was $1,360.65.

At issue in this hearing is as follows: (1) Is the Petitioner's current condition of ill-being of the right knee causally connected to the undisputed work accident; and (2) Is the Petitioner entitled to any prospective medical care to his right knee.

STATEMENT OF FACTS

Petitioner testified he was employed by respondent as a motor truck driver. Petitioner testified his job included driving a sanitation truck and also working as an equipment manager. On October 2, 2014, petitioner was working as an equipment manager at respondent's Lemont Street lot. He was moving spare refuse trucks to get them out of the way.

Petitioner testified that as he getting out of one of the trucks, he slipped on a piece of loose asphalt. He tried to stop his fall by grabbing a bar on the truck with his left hand, but fell to the ground under the truck, landing on his back and hitting his head. Petitioner testified that he got up and started vomiting due to the bump on his head. Petitioner testified he twisted his right knee in the fall. He testified that he had pain in his left arm, lower back and right knee.

Petitioner testified that he notified his supervisor of the accident and was taken to Mercy Works for treatment. Petitioner testified he reported to the doctors at Mercy Works on October 2, 2014 that he had pain in his left arm, lower back and right knee; he also had a bump on his head. The history recited in Mercy Works indicate petitioner stepped out of a truck, slipped and fell, but while falling he attempted to break his fall by hanging on to the truck with his left hand

and felt a "pop" in his left shoulder and then fell on his back. These records also indicate petitioner had struck his head but without loss of consciousness, anticoagulants (sic), nausea or vomiting. The records from Mercy Works of October 2, 2014 fail to indicate petitioner had any complaints relative to his right knee (RX.1).

Petitioner testified that when he awoke the next day his right knee was swollen and painful. He iced the knee. Petitioner asked around to find an orthopedic surgeon and found Dr. Tom Karnezis of the Illinois Orthopaedic and Hand Center. Petitioner first saw Dr. Karnezis on October 13, 2014.

The history by petitioner to Dr. Karnezis was that he injured his left shoulder, right knee and lumbar back coming out of a truck. He told Dr. Karnezis that he stepped on a rock while holding onto the side rail of the truck and his right leg twisted. He spun and fell down to the ground. He yanked his left shoulder and suffered an impact and/or twisting injury to the right lumbar back as well as to the right knee (PX.1).

Dr. Karnezis diagnosed left shoulder sprain with possible rotator cuff tear; right knee sprain of the medial collateral ligament and possible meniscal tear; and lumbar back sprain to the right side (PX.1). Dr. Karnezis ordered an MRI of the left shoulder, right knee and lower back. Petitioner was kept off work and ordered to return to Dr. Karnezis in a week (PX.1).

He returned to Dr. Karnezis on October 20, 2014. X-rays were obtained, off work note was provided and NSAID and Norco were prescribed (PX.1).

Petitioner next saw Dr. Karnezis on October 27, 2014. Petitioner had pain in his left shoulder and positive impingement sign, with difficulty raising his arm. He had a right knee sprain with tenderness to the medial collateral ligament to the posterior part of the knee and lumbar back pain. Petitioner was kept off work and prescribed NSAID. The MRIs of his shoulder, back and knee were not yet obtained (PX.1).

Petitioner returned to Dr. Karnezis on November 12, 2014. The pain in his left shoulder continued with evidence of impingement syndrome and inability to lift his left shoulder without significant amount of pain. He had a right knee sprain with tenderness to the medial collateral ligament and was unable to walk comfortably or fully extend his knee. He had stiffness to the lumbar back with difficulty ambulating and spasms and pain. Petitioner was scheduled to have ultrasound to the shoulder and MRIs of the left shoulder, right knee and back. Dr. Karnezis anticipated petitioner would be at MMI in the next two to three weeks (PX.1).

Petitioner next saw Dr. Karnezis on November 24, 2014. His condition remained the same. MRI had not yet been obtained (PX.1).

Petitioner obtained the MRI of his right knee on December 15, 2014. The MRI report stated petitioner had a moderate chondromalacia at the patellofemoral articulation with slight medial subluxation of the patella with small joint effusion. The report also stated there was mild intrasubstance degeneration with both medial and lateral menisci, but no evidence of meniscal or ligament tear (PX.2).

Petitioner returned to Dr. Karnezis on December 22, 2014. Dr. Karnezis reported the MRI of the left shoulder revealed a rotator cuff tear and X-rays showed anterior posterior and

superior labral tear which was consistent with the mechanism of the injury. Surgery to the shoulder was scheduled. Also on December 22, 2014, Dr. Karnezis reported petitioner had right knee derangement with medial and lateral meniscal fraying and tearing with significant pain medial laterally with effusion. Dr. Karnezis reported there was no evidence on X-ray of arthropathy but the petitioner may have a small chondral injury to the patella (PX.1).

Petitioner returned to Dr. Karnezis on January 5, 2015. Petitioner continued to have the same complaints relative to his left shoulder and surgery was again proposed. Dr. Karnezis noted a disc bulge and posterior annular tear at L4-5. As for the right knee, Dr. Karnezis indicated petitioner has patellofemoral chondromalacia and chondral injury with joint effusion and tearing to the medial lateral menisci. Petitioner had difficulty going up and down stairs. Dr. Karnezis estimated petitioner would be off for six to months recovering from shoulder surgery and for treatment of petitioner's right knee. (PX.1)

On January 16, 2015 Dr. Karnezis' findings and recommendations for petitioner's left shoulder injury and back remained the same. However, as for petitioner's right knee, Dr. Karnezis now reports petitioner has a large tear to the medial as well as to the lateral menisci to that side and recommends arthroscopic surgery to the right knee (PX.1).

On February 9, 2015, Dr. Karnezis stated that petitioner had a large rotator cuff tear and labral tear with an inability to elevate the arm without crepitus and pain. Petitioner also had contralateral right knee pain with evidence of patellofemoral pain and inability to go up and down stairs and performing his daily activity. Dr. Karnezis was scheduling surgery for the left shoulder and also indicated petitioner would need right knee arthroscopy due to the pain. Petitioner was kept off work (PX.1).

Respondent had petitioner examined by Dr. Kathleen Weber on February 9, 2015. Dr. Weber noted tenderness in the medial joint line as well as at the distal IT band and lateral femoral condyle and inferior lateral facet. She reviewed the MRI of December 15, 2014, which she reported showing chondromalacia primarily of the patellofemoral compartment with edema in the trochlea and patella, as well as degenerative changes of the medial and lateral meniscus, but no tear (RX.2).

Dr. Weber believed the petitioner's right knee complaints were related to the work accident of October 2, 2014. Dr. Weber opined that petitioner had pre-existing degenerative changes that more likely than not were exacerbated by the work-related injury, but found no meniscal pathology. Dr. Weber diagnosis was right knee strain with underlying preexisting patellofemoral chondromalacia. Dr. Weber recommended an injection and a short course of physical therapy (RX.2).

Petitioner underwent left shoulder surgery by Dr. Karnezis on February 12, 2015. The post-operative diagnosis was osteochondral lesion with anterior loss body. On February 16, 2015 petitioner returned to Dr. Karnezis for pump removal (PX.1).

Petitioner followed up with Dr. Karnezis on March 4, 2015. Petitioner's left shoulder was regaining motion despite adhesive capsulitis. Dr. Karnezis noted petitioner had difficulty ambulating due to his right knee internal derangement. Dr. Karnezis noted evidence of meniscal tearing and small osteochondral lesion of the right knee (PX.1).

On March 23, 2015 petitioner received follow up care by Dr. Karnezis for his shoulder. Dr. Karnezis noted that he would continue care of the right knee with observation (PX.1).

Petitioner received follow up care for the left shoulder on April 22, 2015 by Dr. Karnezis. On April 22, 2015 Dr. Karnezis reviewed the MRI of December 15, 2014 which showed evidence of small degeneration of the meniscus and possibly tearing of the signals extending to the surface. Dr. Karnezis also reported a small lesion to the medial femoral condyle anteriorly and that the cartilage of the medial and lateral joint spaces appeared to be intact and aligned as does the cartilage of the patellofemoral joint on axial views (PX.1).

On May 18, 2015, Dr. Karnezis reported petitioner had a cortisone injection in his shoulder which helped. Dr. Karnezis also had done a cortisone injection into petitioner's right knee at the previous visit. The petitioner reported this injection was effective in reducing his pain and symptoms allowing him to walk much more briskly. On June 8, 2015 Petitioner reported the right leg symptoms reoccurred. Dr. Karnezis again recommended right knee arthroscopy. At that time, petitioner's shoulder was progressing nicely (PX.1).

On July 13, 2015 Dr. Karnezis initiated physical therapy for petitioner's right knee as recommended by Dr. Weber who had examined petitioner on February 9, 2015pursuant to §12. Dr. Karnezis also reported that specific images of the right knee MRI showed evidence of a medial meniscus tear (PX.1).

Petitioner testified that at the time of hearing he had not completed the physical therapy program for his right knee. However, he had completed six weeks of physical therapy and it had not alleviated his symptoms. Petitioner testified the physical therapy had made the swelling and pain in his right knee worse. Petitioner also testified that the cortisone injection he had received on April 22, 2015 had helped for only three to four days, and then the pain returned.

Petitioner denied having prior right knee, left shoulder or back injuries or problems. He denied any injuries or accident subsequent to the work accident of October 2, 2014.

CONCLUSIONS OF LAW

In support of the Arbitrator's decision with regard to whether Petitioner's present condition of ill-being is causally related to the injury, the Arbitrator makes the following conclusions of law:

Although the records from Mercy Works on October 2, 2014 fail to reflect a history of an injury to the right knee, Dr. Karnezis' records from October 13, 2014 recited a history of the injury to the right knee. Also, Dr. Weber, who examined petitioner, pursuant to §12, determined petitioner's right knee strain and exacerbation of the underlying preexisting patellofemoral chondromalacia was the result of the work accident.

Therefore, the Arbitrator finds that there is a causal connection between petitioner's right knee condition, which includes exacerbation of the underlying preexisting patellofemoral chondromalacia, as well as a tear of the medial meniscus, was the result of the work accident of October 2, 2014.

In support of the Arbitrator's decision with regard to whether surgery to the right knee is reasonable and necessary to cure petitioner of the injury, the Arbitrator makes the following conclusions of law:

Both Dr. Karnezis and Dr. Weber agree petitioner injured his right knee as a result of the work accident of October 2, 2014. Dr. Weber did not find petitioner had a torn medial meniscus, but rather an aggravation of the preexisting patellafemoral chondromalacia. However, Dr. Weber did note medial joint line tenderness. In his second report dated July 13, 2015, Dr. Karnezis stated that although Dr. Weber did not believe petitioner suffered a meniscal tear, Dr. Karnezis found a meniscus tear on specific images of the MRI.

At the time of hearing, petitioner had not completed the physical therapy as prescribed by Dr. Karnezis. He had, however, completed as much physical therapy as recommended by Dr. Weber, which had not provided significant relief, and, according to the petitioner, the physical therapy seemed to have made his right knee worse. He had also received the cortisone injection recommended by Dr. Weber. The injection failed to provide petitioner with any lasting relief.

A review of specific images of the right knee MRI, Dr. Karnezis, found a medial meniscus tear. This is consistent with Dr. Weber's finding of tenderness at the medial joint line. As petitioner's right knee injury has not been alleviated by time, steroid injection or physical therapy, surgery is warranted, including a possible meniscal repair.

Accordingly, the Arbitrator awards the costs of the arthroscopic surgery for petitioner's right knee, which would include repair of the meniscus, in accordance with §8.2 of the Act.

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

RUFIN, LOUIS Case# **15WC016516**
Employee/Petitioner

GET FRESH PRODUCE INC
Employer/Respondent

On 11/6/2015, 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 0.28% 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:

0700 GREGORIO & ASSOC
TODD P KLEIN
2 N LASALLE ST SUITE 1650
CHICAGO, IL 60602

0560 WIEDNER & McAULIFFE LTD
TIMOTHY S McNALLY
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Louis Rufin
Employee/Petitioner

v.

Get Fresh Produce, Inc.
Employer/Respondent

Case # 15 WC 16516

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on September 28, 2015 and October 28, 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, **4/3/15**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 $3,572.46; the average weekly wage was $892.86.

On the date of accident, Petitioner was 45 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 $1,479.74 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $1,479.74 .

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

ORDER

The Arbitrator finds that Petitioner failed to establish accidental injuries causally related to his employment. The Arbitrator adopts the opinions of Dr. Witkowski and Dr. Vora in finding that petitioner failed to establish an entitlement to benefits by a preponderance of the evidence.

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.

David A. Kane
Signature of Arbitrator

November 6, 2015
Date

ICArbDec19(b)

NOV - 6 2015

Petitioner is a delivery driver for respondent. He delivers produce to local restaurants. Petitioner testified that he unloads a truck with boxes of produce by pushing a two-wheel dolly down a ramp. Petitioner described the ramp as being at a 45-degree angle.

Petitioner testified that he experienced a work accident on April 3, 2015. That morning, he picked up his truck in Bartlett, Illinois to drive to Chicago to make a delivery to Weber Grill in the River North neighborhood. Petitioner arrived at Weber Grill to deliver produce, and testified that he made approximately three to four trips inside. As petitioner was unloading boxes of potatoes, which he approximated weighed between 200 and 220 pounds, he felt a crunching, pinching and stabbing sensation in his right foot. Petitioner testified that this occurred as he was walking halfway down the 45-degree ramp while holding the dolly.

Petitioner testified that he felt immediate pain, but was able to finish his workday. Per petitioner's testimony, he finished his route in extreme pain, but felt some improvement over the weekend while wearing gym shoes.

Petitioner first sought medical care at Cadence Occupational Health Clinic on April 6, 2015. (Petitioner's Exhibit 1). Upon reporting to that facility, the history was noted that petitioner had "felt a crunch, pinch in the area of the metatarsal phalangeal articulation," while "walking with products down a ramp on a two-wheeler." X-rays were negative for fracture or dislocation, and an examination revealed no soft tissue swelling.

Petitioner noted that "the pain worsens only when he is wearing his Red Wing work boots which he started wearing about 3 weeks ago. Was able to wear his gym shoes over the weekend and walked to the park without problems. However, when he put his work boots back on today for work, his pain increased." Following an evaluation, Dr. Baksinski instructed petitioner to take ibuprofen and released him to regular work. The diagnosis was right foot pain. (Petitioner's Exhibit 1).

Petitioner returned to Dr. Baksinski on April 8, 2015. (Petitioner's Exhibit 1). He complained of pain localized in the right foot, apparently between the second and third metatarsals. Petitioner described the pain as moderate and intermittent. Petitioner again noted that the pain was worsened by work boots, and described the sensation to feeling "like he's walking on a rock." Petitioner noted that he had purchased Dr. Scholl's inserts, without improvement. Petitioner noted that he initially felt well at home, but that his foot had been aggravated to the point of "excruciating pain" when he needed to walk 7 to 8 minutes from the employer's parking lot to work. (Petitioner's Exhibit 1).

A physical examination appears to have been normal, and Dr. Baksinski noted the possibility of a neuroma. Work restrictions were provided at this time, and included no use of pedals to drive and no ramp work. (Petitioner's Exhibit 1).

Petitioner returned to Dr. Baksinski on April 20, 2015. (Petitioner's Exhibit 1). Petitioner reported no improvement, and pain as a 7 on a scale of 10. Petitioner also reported numbness in his right foot, and "pain that

radiates up the right leg to the upper thigh." Dr. Baksinski noted that the radiology reports had been negative. He prescribed Naproxen and continuing work restrictions. Petitioner also received a referral to a podiatrist. (Petitioner's Exhibit 1).

Petitioner reported to Dr. Witkowski with the orthopedics division of Cadence Physician's Group on April 22, 2015. (Petitioner's Exhibit 2). Dr. Witkowski noted that petitioner had been referred by Dr. Baksinski. Petitioner reported that he had been working on restrictions, which included sitting at a high stool. Petitioner reported to Dr. Witkowski that, since the accident, "he has noticed pain located on the medial aspect of his foot, which radiates all the way up into the medial aspect of his leg and into the groin area." Petitioner rated the pain as an 8 on a scale of 10, and was not complaining of any back pain. Dr. Witkowski stated the following:

> I had a long discussion with him regarding his current condition. I cannot attribute any organic problem with his foot that is leading to the radiating pain of the medial aspect of the leg. He had no specific injury at work and I am finding it very hard to agree with this being a work comp incident. He may have developed metatarsalgia. I discussed with him that metatarsalgia would not cause radiating pain up the leg. Other potential etiology of his symptoms could be his lumbar spine or some type of radicular pain. However, I would like to get an MRI of the foot to rule out any organic problem with the foot...
>
> (Petitioner's Exhibit 2).

Petitioner opted not to return to Dr. Witkowski or Dr. Baksinski. Rather, he established care with Dr. Betman, a podiatrist. (Petitioner's Exhibit 3). After petitioner began care with Betman, respondent requested a Section 12 evaluation with Dr. Vora of the Illinois Bone and Joint Institute. Dr. Vora evaluated petitioner on May 29, 2015. Prior to trial, both Dr. Betman and Dr. Vora offered their testimony via evidence deposition.

TESTIMONY OF DR. BETMAN

Dr. Betman testified that he first evaluated petitioner on April 25, 2015. At that time, petitioner provided a history that he had been descending a ramp while on a truck when he felt something inside his foot. Petitioner denied any trauma. (Petitioner's Exhibit 4 at 11). Dr. Betman conducted an evaluation, which included X-rays and ultrasound. The X-rays were negative for fracture and Dr. Betman was of the opinion that the ultrasound was positive for a neuroma of the third interspace. Dr. Betman testified that a neuroma is a thickening or swelling of a nerve. (Petitioner's Exhibit 4 at 11-13).

Dr. Betman believed that the condition was related to the alleged work accident. As a basis for this opinion, Dr. Betman described that he believed that petitioner had suffered a "squeezing, a compression-type injury, that he sustained obviously some type of trauma while walking down the ramp." (Petitioner's Exhibit 4 at 14).

Dr. Betman prescribed Tramadol and recommended physical therapy. He also placed petitioner off of work at that time. (Petitioner's Exhibit 4 at 14-15). Petitioner returned to Dr. Betman on May 11, 2015 at which time he reported little improvement. As such, Dr. Betman recommended an injection and compounding cream in addition to therapy. (Petitioner's Exhibit 4 at 15-16). As to work restrictions, Dr. Betman believed that petitioner could work a mainly sedentary job. (Petitioner's Exhibit 4 at 17). At this time, Dr. Betman also recommended custom orthotics to treat petitioner's symptoms. (Petitioner's Exhibit 4 at 17-18).

Petitioner next reported to Dr. Betman on May 28, 2015. He continued to complain of significant pain at the third interspace in the foot, within an inability to walk more than one-half of one block before feeling symptoms. (Petitioner's Exhibit 4 at 19). As a result of those symptoms, it appears that Dr. Betman was of the opinion that petitioner could not work in any capacity. Dr. Betman continued to diagnose a neuroma, and recommended the petitioner seek hydrotherapy while he waited approval of the other services, i.e., the compounding cream, injection and therapy. (Petitioner's Exhibit 4 at 20-22). Dr. Betman also recommended Voltaren gel. (Petitioner's Exhibit 4 at 22).

Petitioner continued to report to Dr. Betman through June and July 2015. During that time, his complaints remained largely unchanged. Dr. Betman continued to recommend physical therapy, an injection, compounding cream and Voltaren gel. Dr. Betman also continued petitioner off of work. (Petitioner's Exhibit 4 at 23- 29).

Dr. Betman testified that he had reviewed the May 29, 2015 report of Dr. Vora. Dr. Betman testified that he disagreed with Dr. Vora's report. (Petitioner's Exhibit 4 at 29-30). The basis of Dr. Betman's opinion appears to have been that petitioner did not complain of pain prior to the reported work incident. Dr. Betman also believed that the ultrasound findings were consistent with petitioner's claimed injury. (Petitioner's Exhibit 4 at 30).

On cross-examination, Dr. Betman confirmed that petitioner denied any trauma occurred on the alleged date of accident. Specifically, petitioner denied hitting his foot, twisting his foot or stepping on an object. (Petitioner's Exhibit 4 at 32). Dr. Betman confirmed that the only history petitioner reported was that he was "going down the ramp of his truck and felt something." (Petitioner's Exhibit 4 at 34). Dr. Betman noted that he had not reviewed the records of Cadence Occupational Health or Cadence Orthopedics. (Petitioner's Exhibit 4 at 35-36). Dr. Betman also noted that a neuroma, which was his working diagnosis, would not cause pain to travel up into the ankle or the leg. (Petitioner's Exhibit 4 at 36-37). Dr. Betman later testified in response to questions regarding the mechanism of the accident and its causal connection to a neuroma, "well, again he felt something on the inside of his foot while he was – whatever caused it I don't know."

TESTIMONY OF DR. VORA

Dr. Vora, a board certified orthopedic surgeon, evaluated petitioner pursuant to Section 12 on May 29, 2015. (Respondent's Exhibit 1 at 4-8).

Dr. Vora took a history from petitioner, who reported that he experienced a sudden onset of right foot pain while walking down a ramp with a two-wheel dolly. (Respondent's Exhibit 1 at 8). Petitioner reported that he believed that the pain may be caused by his work boots, so attempted to loosen the same and continue work. (Respondent's Exhibit 1 at 8). Dr. Vora reviewed medical documentation and conducted a physical examination. Following the same, he diagnosed subjective right foot pain. (Respondent's Exhibit 1 at 8-10).

Dr. Vora specifically noted that petitioner's pain pattern was non-anatomical, noting that petitioner's complaints of pain radiating up towards the groin could not be explained by a neuroma. (Respondent's Exhibit 1 at 10-11). Dr. Vora was of the opinion that there was no objective evidence of a foot injury. (Respondent's Exhibit 1 at 11). Dr. Vora testified that he would disagree with the diagnosis of a neuroma for several reasons. First, Dr. Vora noted that "I have never had a single patient complain of pain from a neuroma that goes to the knee and into the groin. There is no literature that would ever document that or support that. It's anatomically impossible. It doesn't work that way." (Respondent's Exhibit 1 at 11-12). Moreover, Dr. Vora explained that neuromas do not occur as a result of an incident as described by petitioner. Dr. Vora explained that an interdigital Morton's neuroma "cannot occur from a misstep." (Respondent's Exhibit 1 at 12).

Dr. Vora testified that he did not believe that ultrasound was of diagnostic benefit in evaluating neuroma. Dr. Vora noted that for an ultrasound to have any value, it must correlate with the clinical findings.

(Respondent's Exhibit 1 at 13). Dr. Vora described the ultrasound as a subjective test, and that clinical examination did not support the notion that petitioner suffered from a neuroma. (Respondent's Exhibit 1 at 13-15). Dr. Vora reiterated that the records of Dr. Witkowski also did not support that diagnosis, nor did the alleged mechanism of accident.

Dr. Vora further explained his belief that the mechanism of accident could not have caused a neuroma. (Respondent's Exhibit 1 at 15). Dr. Vora explained:

> So a neuroma is a soft tissue condition. It's a nerve that's like a piece of spaghetti. If you had an incident for example that causes somebody to have a trauma or a misstep, to injure the nerve would be like – it's simply impossible to injure the nerve which is a soft piece of spaghetti before example you can get a fracture of the metatarsal which surrounds the tunnel. So people can have a misstep, have a hyper plantar flexion or dorsal flexion injury and get a metatarsal stress fracture or a metatarsal fracture or a Lis franc injury which is ligaments in the midfoot that go first, but those are static structures that are rigid. You don't just get a piece of spaghetti looking neuroma all of a sudden becoming inflamed from a misstep. There is no – you can review 1,000 orthopedic journal articles on the causation of neuroma and you wouldn't see that description as an etiology. It doesn't make sense.

(Respondent's Exhibit 1 at 13-14).

Dr. Vora explained that even if petitioner's mechanism of accident is accepted as true, a neuroma could not be caused. (Respondent's Exhibit 1 at 38). Dr. Vora noted that a bone injury must be present to cause a stretching of the nerve. (Respondent's Exhibit 1 at 38-39). Conversely, non-traumatic neuromas, in the opinion of Dr. Vora, were conditions that are slowly aggravated. He noted that "it starts slowly, and then after a few months it starts getting worse and worse." (Respondent's Exhibit 1 at 39).

Dr. Vora reiterated that he did not believe that there was any objective evidence of an injury, and that there appeared to be no need for further care or work restrictions. (Respondent's Exhibit 1 at 16).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

As to issue "C," did an accident occur that arose out of and in the course of petitioner's employment by respondent, the arbitrator finds as follows:

The Arbitrator finds that petitioner failed to establish an accident arising out of or occurring in the course of the employment. As petitioner was unloading boxes of potatoes, which he approximated weighed between 200 and 220 pounds, he felt a crunching, pinching and stabbing sensation in his right foot. Petitioner testified that this occurred as he was walking halfway down the 45-degree ramp while holding the dolly.

The records of Dr. Betman confirm that petitioner solely reported feeling pain upon taking a step. He noted that petitioner reported that there was no trauma, denied twisting, denied hitting his foot on anything, and denied stepping on anything. (Petitioner's Exhibit 4 at 31-32). This lack of trauma is consistent with reports to Dr. Baksinski. It is further worth noting that Dr. Witkowski stated "He had no specific injury at work and I am finding it very hard to agree with this being a work comp incident." Dr. Vora classified the history as a "misstep."

While petitioner was moving a dolly down a ramp, there is a lack of evidence in the record to support that the dolly or ramp played any role in the alleged work accident. There is no evidence in the record to support that the ramp was defective or hazardous. Moreover, pushing a dolly, with nothing more, does not constitute a work accident. In essence, petitioner's testimony and history to the medical providers is that he felt pain while taking a step. In this regard, it is also worth noting that none of the medical providers attributed the alleged injury to the incline of a ramp or the weight of a dolly. In fact, when questioned on this point, Dr. Betman waffled:

Q: ... If Mr. Rufin testified that he was using a two-wheeler and he was walking heavy product down a ramp how would that cause a neuroma?

[objections and response omitted]

A: Well, again he felt something on the inside of his foot while he was - - Whatever caused it I don't know.

(Petitioner's Exhibit 4 at 41).

The Arbitrator notes that the "'arising out of' component of a compensable workers' compensation injury is primarily concerned with causal connection. To satisfy this requirement it must be shown that the injury had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Sisbro v. Indus. Comm'n*, 207 Ill. 2d 193; 797 N.E.2d 665 (2003). Here, petitioner has failed to establish that his alleged injury resulted from anything other than taking a step and experiencing pain. "If an employee is exposed to a risk common to the general public to a greater degree than other persons, the accidental injury is also said to arise out of his employment. However, if the injury results from a hazard to which the employee would have been equally exposed apart from the employment, or a risk personal to the employee, it is not compensable." *Caterpillar Tractor Co. v. Indus. Comm'n*, 129 Ill. 2d 52; 541 N.E.2d 665 (1989). The Arbitrator finds that petitioner's testimony and history to the medical providers fails to support a hazard unique to his employment.

Therefore, the Arbitrator finds that petitioner failed to establish an accident arising out of his employment.

As to issue "F," is petitioner's current condition of ill-being causally related to the injury, the arbitrator finds as follows:

Even if petitioner had established an accident arising out of the employment, the arbitrator finds that petitioner failed to carry his burden of proof in establishing that his injuries are causally connected to the alleged accident. The arbitrator begins by noting that it is axiomatic that the petitioner carries the burden of proof to establish the issue of causal connection by a preponderance of the evidence. *Sisbro v. Indus. Comm'n*, 207 Ill. 2d 193; 797 N.E.2d 665 (2003). The arbitrator notes that the only two orthopedists who evaluated petitioner did not believe that petitioner had suffered a work injury. One of these physicians was Dr. Witkowski, a treating physician. Dr. Witkowski's opinions are bolstered by respondent's Section 12 examiner, Dr. Vora.

It is worth noting that Dr. Witkowski's records clearly state his belief that he did not believe petitioner had suffered a work accident. Dr. Witkowski noted that petitioner had "no specific injury at work and I am finding it very hard to agree with this being a work comp incident." (Petitioner's Exhibit 2) Petitioner ceased treatment with Dr. Witkowski after Dr. Witkowski offered this opinion.

The Arbitrator notes that Dr. Witkowski's assessment is consistent with the opinions of Dr. Vora that a "misstep" would be incapable of causing a neuroma. Dr. Vora noted that development of a neuroma from an incident as described by petitioner would be anatomically impossible, and that a traumatic neuroma would require a broken bone or other ligamentous injury.

Dr, Witkowski and Dr. Vora offered rather empatic opinions that the neuroma could not be related to work. While Dr. Betman opined to the contrary, the Arbitrator notes that he did not provide a detailed basis for his opinion. First, it must be noted that Dr. Betman did not review the records of Cadence or Dr. Witkowski. (Petitioner's Exhibit 4 at 36). While Dr. Betman testified that petitioner "sustained obviously some type of trauma while walking down the ramp," he failed to explain the nature of the trauma. (Petitioner's Exhibit 4 at 14). When questioned on this point, Dr. Betman appeared to be of the opinion that so long as petitioner experienced symptoms at work, then the case should be covered under workers' compensation. Dr. Betman stated "Well, again he felt something on the inside of his foot while he was - - Whatever caused it I don't know." (Petitioner's Exhibit 4 at 41). When evaluating all of the evidence, the Arbitrator finds that the opinions of Dr. Betman lack sufficient basis to overcome the opinions of Dr. Witkowski and Dr. Vora, the two orthopedic specialists involved in this matter.

Moreover, Dr. Witkowski and Dr. Vora were both consistent in their opinions that there would be no anatomical explanation for petitioner's

complaints of radiating pain up through his leg. The arbitrator notes that these radicular complaints were reported to Dr. Witkowski, Dr. Vora and Dr. Betman. Even Dr. Betman acknowledged that a neuroma would not typically cause symptoms into the ankle or leg. (Petitioner's Exhibit 4 at 37). There is substantial disagreement in the record as to whether petitioner even suffers from a neuroma, and whether his complaints are anatomically credible based on the opinions of Dr. Vora.

Based on the opinions of Dr. Witkowski and Dr. Vora, the Arbitrator finds that petitioner failed to carry his burden of proof in establishing the issue of causal connection.

As to issue "J," were the medical services that were provided to petitioner reasonable and necessary" the arbitrator finds as follows:

Based on petitioner's failure to carry his burden of proof on the issues of accident and causation, the arbitrator denies the claim for medical expenses in its entirety.

As to issue "K," is petitioner entitled to prospective medical care, the arbitrator finds as follows:

Due to petitioner's failure to carry his burden of proof on the issues of accident and causation, the arbitrator denies the request for prospective medical care.

As to issue "I," what temporary benefits are in dispute, the arbitrator finds as follows:

Due to petitioner's failure to carry his burden of proof on the issues of accident and causation, all claims for temporary total disability benefits are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Billy Carney,
Petitioner,

vs.

NO: 06WC 7696

State of Illinois Department of Corrections,
Respondent,

15IWCC0816

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 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 14, 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.

DATED: NOV 3 - 2015
o102815
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CARNEY, BILLY
Employee/Petitioner

Case# 06WC007696

ST OF IL DEPT OF CORRECTIONS
Employer/Respondent

15IWCC0816

On 11/14/2014, 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:

0009 ANESI OZMON RODIN NOVAK KOHEN
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CHICAGO, IL 60601

0639 ASSISTANT ATTORNEY GENERAL
CHARLENE COPELAND
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

NOV 14 2014

RONALD A. RARDIA, 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

Billy Carney
Employee/Petitioner

v.

State of Illinois Dept. of Corrections
Employer/Respondent

Case # **06** WC **7696**

Consolidated cases: _____

15IWCC0816

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 **New Lenox**, on **Oct. 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 _____

15IWCC0816

FINDINGS

On **May 4, 2005**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**43,806.00**; the average weekly wage was $**842.42**.

On the date of accident, Petitioner was **34** 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 $**51,188.69** for TTD, $**0** for TPD, $**0** for maintenance benefits, for a total credit of $**0**.

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

ORDER

Petitioner's claim for additional TTD is denied

Respondent shall pay Petitioner permanent partial disability benefits of **$ 505.45**/weeks for **100** weeks, because the injuries sustained caused the **20**% loss of the person as a whole, as provided in the 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

11/12/14
Date

NOV 14 2014

15IWCC0816

FINDINGS OF FACT

This case was previously tried before Arbitrator Hennessy in Joliet on May 2, 2008. On June 18, 2008, Arbitrator Hennessy issued a decision finding that Petitioner was entitled to 156-1/7 weeks of temporary total disability benefits at a rate of $561.62 per week, representing the period from May 4, 2005 through May 2, 2008, and awarding Section 19(k) penalties in the amount of $18,212.02 and Section 19(l) penalties in the amount of $3,660.00. (PX#1) The Arbitrator notes that Respondent stipulated to accident and causal connection in that proceeding. The Arbitrator takes judicial notice of the fact that the Arbitration Decision became final after neither party filed a review. Subsequently, Petitioner was convicted of a felony and went to prison on May 22, 2008. Respondent terminated TTD benefits as of July 23, 2008 for Petitioner's failure to attend an IME.

The issues in dispute at this hearing are: causation, TTD and the nature and extent of Petitioner's injuries.

Petitioner, Billy Carney, was a 34 year- old Youth Supervisor II employed by the Illinois Youth Center in Joliet. On May 3, 2005, he was attempting to break up a fight between youths when he fell to the ground. He ultimately underwent lumbar decompression, discectomy and a fusion at L5/S1 performed by Dr. DePhillips on January 31, 2006 as a result of his work injuries. Dr. DePhillips later removed the hardware on January 22, 2008. Petitioner's last visit with Dr. DePhillips occurred on February 25, 2008 when the doctor prescribed additional physical therapy; however, he did not give Petitioner any restrictions at that time.

Subsequently, Petitioner was convicted of a felony and went to prison on May 22, 2008. As of the date of this arbitration hearing, Petitioner was incarcerated and testified via evidence deposition on June 20, 2012. Petitioner testified that he was never aware of a Section 12 exam scheduled by Respondent for July 23, 2008. (PX#4, p.6, see PX#2) He testified that he was assigned to the upper bunk after arriving at Lawrence Correctional Center. After examination by a prison doctor, he was allowed a lower bunk. (Px. 4, p. 9) Petitioner testified that the prison assigned him to a janitorial position but after an evaluation by the prison doctor, he was given a medical permit placing him on the medically unassigned list indefinitely. Respondent's Exhibit 3 is a letter from counsel for Petitioner indicating that the prison was having him work carrying mop buckets which exceeded his restrictions. There is no indication how much the buckets weigh. Petitioner stated that his left foot hurts and at night it is necessary to hang it off the bed. Regarding his back, he testified that he cannot be in any one position for any amount of time but must keep moving around. He continued by adding that he also experiences numbness in the back of his leg. (Px. 4 pgs. 10-14)

The medical records from Lawrence Correctional Center reflect that Petitioner was lifting weights on June 21, 2011 and that on September 13, 2012, he had full range of motion. A physical therapy note dated January 21, 2013 states a vocalized desire to be strong, agile and fit by the time he leaves because snowboarding and skiing are very much a part of who he is. (Px. 6)

At the request of Petitioner's counsel, Dr. Jeffrey Coe performed a records review of Petitioner's medical records on August 2, 2012. Dr. Coe's deposition was taken November 26, 2012 following his IME report. (Px. 5) Dr. Coe characterized Petitioner's recovery following surgery as guarded. (Px.5, p. 45) Dr. Coe testified that it was his medical opinion that Petitioner's current complaints were related to his May 2005 accident while employed by the Illinois Youth Center. He also opined that Petitioner could benefit from further medical treatment. Dr. Coe echoed the suggestion of Petitioner's prior physician - Dr. Patel - regarding treatment such as medication, diagnostic and therapeutic injections and a trial of a spinal cord stimulator. (Px. 5, p. 44) Dr. Coe

15IWCC0816

confirmed that the Petitioner had continued complaints as indicated in the records of the prison doctor who Petitioner saw during his incarceration. Dr. Coe diagnosed Petitioner with a post laminectomy syndrome. (Px. 5, p. 41) Furthermore, Dr. Coe was not aware of any permanent restrictions that had been given to Petitioner by any of his doctors. (Px.5, p. 56)

Respondent's IME was Dr. David Robson, who authored a report on February 18, 2012. Dr. Robson is a board certified orthopedic surgeon who also performed a review of Petitioner's medical records. Dr. Robson's deposition was subsequently taken on August 8, 2013. Dr. Robson estimated that he had performed between 4,000 and 5,000 one or two-level spinal fusions. (Rx. 1, p. 8) He testified that he had reviewed Dr. Coe's deposition and he would not recommend any diagnostic injections because Petitioner's diagnosis is clear. Dr. Robson confirmed that Petitioner sustained a herniated disc at L5/S1, underwent a spinal fusion and the CT verified that the fusion was solid. Dr. Robson disagreed with Dr. Coe's assessment of needing a spinal stimulator. Dr. Robson disagreed with Dr. Coe's assessment that the Petitioner was permanently and totally disabled, and believed that the Petitioner could return to some kind of work. Dr. Robson testified that Petitioner had reached maximum medical improvement (MMI) after he was seen by Dr. Lorenz and found to have a solid spinal fusion on January 9, 2007. (Rx. 1, p. 19)

CONCLUSIONS OF LAW

1. With regard to the issue of causation, the Arbitrator finds that the Petitioner has met his burden of proof. Moreover, the Arbitrator is bound by the "law of the case" on this issue. Under the rule of the "law of the case", where an issue is once litigated and decided, the unreversed decision of a question of law or fact made during the course of litigation settles that question for all subsequent stages of the suit. Irizarry v. Industrial Commission, 337 Ill.App.3d 598, 606, (2nd Dist., 2003). Furthermore, the stipulation of a party on a Request for Hearing form is binding on the parties as to the claims made therein. Walker v. Industrial Commission, 345 Ill.App.3d 1084, (4th Dist., 2004). Respondent stipulated that Petitioner's condition of ill-being was causally related to his accident in the first proceeding. That case was tried before Arbitrator Hennessy on May 2, 2008. The Decision was issued by Arbitrator Hennessy on June 18, 2008 and not appealed or reviewed by either party. Therefore, the Arbitrator concludes that Petitioner's condition of ill-being as of the date of the Arbitrator Decision is causally related by stipulation of the parties, and under the law of the case.

2. Regarding the issue of TTD, the Arbitrator finds that the Petitioner has failed to meet his burden of proof regarding his entitlement to TTD beyond the period already awarded in the prior hearing. In support of this finding, the Arbitrator points to the lack of any evidence indicating the Petitioner is unable to work. The Arbitrator notes that there was evidence indicating the Petitioner could not sleep on a top bunk and could not perform certain prison activities, but those restrictions are not tantamount to indicating the Petitioner cannot perform work outside of the prison setting. In fact, Petitioner's incarceration made it impossible for a determination of whether he could legally go back to any type of work. The Arbitrator is not persuaded by Petitioner's assertions that the Respondent's attempt at setting up an IME in July, 2008 was merely a sham, because there was no medical evidence contemporaneous with period of TTD claimed, indicating that the Petitioner could not work. For all practical purposes, the Petitioner could not work as of July 2008, because he was serving prison time for committing a felony crime. Accordingly, the Arbitrator concludes that there is insufficient medical evidence to support Petitioner's claim that he was temporarily totally disabled beyond the period indicated in Petitioner's prior hearing. Therefore, Petitioner's claim for additional TTD is denied.

15IWCC0816

3. The Arbitrator finds that as a result of his undisputed, work-related accident, the Petitioner has sustained injuries resulting in a 20% loss of use of the person as a whole. In support of this finding, the Arbitrator notes that Respondent does not dispute the fact that Petitioner sustained a back injury at work which resulted in a one-level fusion. The testimony of both IME doctors state that Petitioner was never given any permanent restrictions. The Arbitrator finds persuasive the medical records from Petitioner's treating doctors where no restrictions were ever given; the prison records indicating that he appears to be active while serving time in prison; and the testimony of Dr. Robson, who opined that Petitioner was not totally disabled nor did he need any ongoing treatment.

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

Geronimo Ayala,

Petitioner,

vs.

NO: 08 WC 31472

15IWCC0812

Forrester Products And Illinois State Treasurer and Ex-Officio Custodian of the Illinois Injured Workers' Benefit Fund,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, causal connection permanent partial disability, Petitioner engaged in insanitary or injurious practices pursuant to §19(c) 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 6, 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 Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under §4(d) of the Act, in the event of the failure of Respondent-Employer to pay the benefits due and owing the Petitioner. Respondent-Employer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $32,900.00. 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: NOV 2 – 2015

MB/mam
o:9/3/15
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0812

AYALA, GERONIMO
Employee/Petitioner

Case# 08WC031472

FORRESTER PRODUCTS AND ILLINOIS STATE TREASURER AND EX-OFFICIO CUSTODIAN OF THE ILLINOIS INJURED WORKERS' BENEFIT FUND
Employer/Respondent

On 1/6/2015, 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.

0013 DUDLEY & LAKE LLC
PETER M SCHLAX
325 N MILWAUKEE AVE SUITE 202
LIBERTYVILLE, IL 60048

0000 FORRESTER PRODUCTS
1260 NEIL LN
NORTH CHICAGO, IL 60064

5199 ATTORNEY GENERAL
MELISSA HINTERHAUSER
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

15IWCC0812

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

Geronimo Ayala
Employee/Petitioner

v.

Case # **08** WC **31472**

Consolidated cases: _____

Forrester Products and Illinois State Treasurer and Ex-Officio-Custodian of the Illinois Injured Workers' Benefit Fund

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 **George Andros**, Arbitrator of the Commission, in the city of **Waukegan**, on **11/24/2014**. 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 **Proof of non-insurance**

FINDINGS

On **1/28/2007**, 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 $**13,520.00**; the average weekly wage was $**260**.

On the date of accident, Petitioner was **62** years of age, ***married*** with **0** dependent children.

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

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

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical services of $453, as provided in Sections 8(a) and 8.2 of the Act.

Permanent Partial Disability: Schedule injury (For injuries before 9/1/11)

Respondent shall pay Petitioner permanent partial disability benefits of $199.32/week for 162 weeks, because the injuries sustained caused the 100% loss of the right eye, as provided in Section 8(e) of the Act.

Injured Workers' Benefit Fund

The Illinois State Treasurer, ex-officio custodian of the Injured Workers' Benefit Fund, was named as a co-respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act. In the event the Respondent/Employer/Owner/Officer fails to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing the Petitioner pursuant to Section 5(b) and 4(d) of this Act. Respondent/Employer/Owner/Officer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent/Employer/Owner/Officer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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

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

#01 George J Andros

Signature of Arbitrator

January 3rd, 2015

Date

JAN 6 - 2015

FINDINGS OF FACT AND CONCLUSIONS OF LAW 08 WC 31472

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "A" (OPERATING UNDER THE ACT), "B" (EMPLOYEE/EMPLOYER RELATIONSHIP), "C" (ACCIDENT ARISING OUT OF AND IN THE COURSE OF EMPLOYMENT), "D" (DATE OF ACCIDENT) AND "E" (NOTICE TO RESPONDENT", THE ARBITRATOR FINDS THE FOLLOWING FACTS:

Petitioner testified he was employed as a worker in Respondent, Forrester Products', pallet business making and refurbishing wood pallets. On January 28, 2007, he was using a nail gun to nail a large box together at eye level when, after firing the nail gun into a board, a piece of wood explosively dislodged from the board he was nailing, breaking his safety glasses and striking him in the right side of his face and in the area around his right eye. He experienced an immediate onset of pain and he reported the incident to his supervisor, Jaime Ventura. Petitioner further testified that Ventura immediately informed the owner of the company who refused to acknowledge the injury or send the Petitioner for medical care.

Because Respondent's business involves demolition and construction of pallets, use of pneumatic nail guns and, in this instance, the construction of a large wood box, the Arbitrator determines that Respondent's business does fall within the automatic coverage provisions (Section 3) of the Illinois Workers' Compensation Act and that there was an employee/employer relationship. The Arbitrator further finds that Petitioner did suffer an injury that arose out of and in the course of his employment with Respondent in the manner described above on January 28, 2007 and that timely notice of the accident was indeed provided to Respondent. The Arbitrator also notes that certified notice of the November 24, 2014 hearing was sent by Petitioner to Respondent (Pet. Group Ex. 8).

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "F" (CAUSAL CONNECTION), THE ARBITRATOR FINDS THE FOLLOWING FACTS:

Petitioner testified that in the absence of his employer sending him for medical care, he self-treated the injury to his face and eye by applying warm salt water compresses. He testified that the pain gradually subsided over the next couple of weeks. However, as the pain began to subside, the Petitioner experienced a gradual onset of vision changes in his right eye. Petitioner testified that previous to the accident he had perfect vision in his right eye and had no occasion to seek medical care for his right eye.

Experiencing a progression of vision changes as described above, Petitioner sought medical care on April 28, 2007 at the Eye Care Center of Lake County. He reported being struck in the right side of his face with a piece of wood and experiencing an onset of double vision and an inability to read with his right eye. (Pet. Ex. 1).

He next had a retina consultation with Dr. Marc Levin on August 13, 2007 to whom he provided a history of having been hit with a piece of wood to the right side of his face approximately six months before. (Pet. Group Ex. 2). He was advised of the need to undergo surgery but was without funds or insurance coverage to pay for same. (Pet. Group Ex. 3). He next sought help at the Lake County Health Department on November 3, 2012, reporting a worsening of his vision since an injury that occurred at his place of employment. He was further referred for further ophthalmologic evaluation. (Pet. Group Ex. 4).

He was evaluated by Dr. Wexler on December 19, 2012, who assessed: "legal blindness-no light perception right eye" following a traumatic incident approximately four years before. Dr. Wexler further indicated that "no treatment possible to restore visual function in right eye." (Pet. Group Ex. 6).

Petitioner's testimony regarding the onset and progression of his vision problems is consistent with the history and assessments documented in the medical records. Dr. Wexler relates Petitioner's vision loss to the traumatic incident suffered four years previously. Therefore, the Arbitrator does find that Petitioner's current condition of ill being, namely legal blindness in his right eye, is causally connected to Petitioner's accident of January 28, 2007.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "G" (PETITIONER'S EARNINGS), "H" (PETITIONER'S AGE) AND "I" (PETITIONER'S MARITAL STATUS), THE ARBITRATOR FINDS THE FOLLOWING FACTS:

Petitioner testified that he was a part-time employee earning $260.00 per week and had been with the company since 1991 for an annual salary of $13,520.00 per week. The Arbitrator therefore finds Petitioner's average weekly wage, calculated pursuant to Section 10 of the Act, was $260.00 per week. Petitioner testified that he was 62 years of age and married with no dependent children on the date of the accident.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "J" (MEDICAL SERVICES AND PAYMENT FOR SAME), AND "N" (RESPONDENT CREDIT) THE ARBITRATOR FINDS THE FOLLOWING FACTS:

Petitioner's testimony regarding the onset and progression of his vision problems is consistent with the histories and assessments found in Petitioner's medical records. In evidence are bills from the Eye Care Center of Lake County in the amount of $80.00, (Pet. Ex. 1, p. 3) and $198.00 (Pet. Ex. 7, p. 1) and a paid receipt for services at Lakeshore Eye Physicians in the amount of $175.00 (Pet. Ex. 2, p. 7). Petitioner testified that none of these bills have been paid or reimbursed by Respondent.

The Arbitrator therefore awards medical expenses in the above amounts, all totaling $453.00 as provided in Sections 8(a) and 8.2 of the Act. The Arbitrator further finds that the Respondent, having paid none of these expenses, is not due any credit.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "L" (NATURE AND EXTENT OF THE INJURY) THE ARBITRATOR FINDS THE FOLLOWING FACTS:

Petitioner testified that he is unable to see anything out of his right eye. Dr. Wexler has indicated that Petitioner suffers from "legal blindness – no light perception in the right eye" and that there is "no treatment possible to restore visual function in the right eye". (Pet. Group Ex. 6). The Arbitrator therefore concludes that Petitioner has lost 100% of the use of his right eye entitling him to 162 weeks of compensation at the minimum permanent partial disability rate of $192.32 applicable on Petitioner's January 28, 2007 date of accident.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "M" (PENALTIES) AND "O" (PROOF OF NON-INSURANCE), THE ARBITRATOR FINDS THE FOLLOWING FACTS:

Although Respondent paid no benefits, a Petition for Penalties was not filed and therefore the Arbitrator does not impose an award of penalties or fees upon Respondent.

In evidence at Petitioner's Group Ex. 5 is a certification from the Insurance Compliance Division of the Illinois Workers' Compensation Commission verifying that after a search of the NCCI Proof of Coverage On-Line Database, there appears to be no policy information showing proof of workers' compensation insurance on January 28, 2007 for Respondent, Forrester Products. (Pet. Ex. 5, p. 2). The Illinois State Treasurer, Ex-Officio Custodian of the Illinois Workers Benefit Fund, having been named as a Co-Respondent in this matter and having been represented by the Illinois Attorney General at hearing, the Arbitrator further finds that this award is proper and hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DUNCAN, VANISA Case# **09WC032818**

Employee/Petitioner

NAVISTAR/INTERNATIONAL TRUCK & ENGINE

Employer/Respondent

On 10/13/2015, 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 0.06% 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:

0293 KATZ FRIEDMAN EAGLE ET AL
RICHARD K JOHNSON
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

2461 NYHAN BAMBRICK KINZIE & LOWRY
LINDA ROBERT
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Vanisa Duncan
Employee/Petitioner

v.

Navistar/International Truck & Engine
Employer/Respondent

Case # **09** WC **32818**

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 **LYNETTE THOMPSON-SMITH**, Arbitrator of the Commission, in the city of **Chicago**, on **August 20, 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 _____

FINDINGS

On **3/27/2008**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**29,632.01**; the average weekly wage was $**881.06**.

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

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

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

Respondent shall be given a credit of $**139,317.28** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**139,317.28**.

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

ORDER

Respondent shall pay Petitioner maintenance benefits of $587.37/week for 33 weeks, commencing 3/12/2013 through 10/28/2013, as provided in Section 8(a) of the Act.

Respondent shall pay reasonable and necessary medical services of $1,399.50, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $587.37/week for 245 weeks, commencing 6/17/2008 through 1/10/2009 and 1/24/2009 through 3/11/2013, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits, commencing 10/29/2015, of 470.13/week for the duration of the disability, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.

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

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

FINDINGS OF FACT

The disputed issues in this case are: 1) accident; 2) causal connection; 3) medical bills; 4) temporary total disability; 5) maintenance; 6) 8(d)1; and 7) the nature and extent of Petitioner's injuries. *See,* AX1.

Ms. Vanisa Duncan, (hereafter "Petitioner") began working for Navistar International Truck (hereafter "Respondent") at the Melrose facility on July 18, 1994. At the time of the hearing, Petitioner was still employed by Respondent, but was on medical leave, authorized by Respondent. At the time of the hearing, Respondent was not paying workers' compensation benefits but Petitioner was eligible for health care and retirement benefits.

Petitioner began working as an assembler for Respondent in 2008. While working for Respondent, she assembled Haldex pumps and engines. While assembling the pumps, she testified that she stacked rubber washers on a rack. The rack was five shelves high and she would stack four rubber washers on each shelf. She testified that she is 5'3" and the top shelf was at her neck level. She would assemble about 275-310 pumps in an eight hour day.

Petitioner also assembled engines, using power tools/guns to tighten bolts to the engines. The power guns hung on power lines. She would reach up for a power gun, tighten the bolts, and then return the gun above her head. She testified that the power lines were so high that she would sometimes have to jump to reach the gun. She testified that she would also have to torque 12 bolts on the top of each engine. Torqueing involved holding the wrench with her right hand, and pulling back. Petitioner testified that she would assemble 265-275 engines in an eight hour work-day.

Petitioner's normal shift was eight hours per day, but she often worked up to 12 hours per day. She testified that she had two breaks, 12 minutes each; and a 35 minute lunch. Petitioner testified that she is right-handed and would use the tools in her right hand but used her left hand to assist. She would work with arms at or above shoulder level, 80% of the work-day.

In 1998, Petitioner reported shoulder pain to Respondent's medical department. However, she explained that she was on rotating job duties at that time; and the pain went away when she was moved to a new position. Although Respondent moved Petitioner from job to job within the plant, she always had the same classification. Petitioner testified that all of the jobs involved the use of her right arm above shoulder level, for about 80% of the day.

In October 2007, Petitioner went to the plant medical department, reporting upper extremity pain. She was sent to a hospital in Maywood; and the physician there sent her to physical therapy. Petitioner testified that the pain improved and she was able to return to work.

On March 27, 2008, Petitioner again went to Respondent's medical department. She reported that her shoulder had been hurting the last couple of months because she was working a lot of overtime. She testified that she was in so much pain, it felt like her shoulder was about to burst. An x-ray of her right shoulder was performed which showed no fracture or dislocation. Dr. Ehni at Respondent's plant medical recommended that Petitioner attend physical therapy for her shoulder, which she did. PX1.

Dr. Ehni referred Petitioner to Dr. Ryon Hennessy at Orthopedic Specialists. On April 16, 2008, Dr. Hennessy stated most of Petitioner's symptoms were consistent with rotator cuff tendonitis. He performed an injection and recommended that she stay on light duty restrictions. On May 12, 2008, Dr. Hennessy recommended an MRI of her right shoulder which was performed on May 21, 2008. Dr. Hennessy diagnosed her with rotator cuff tendinopathy with mild impingement signs. She continued treating with Dr. Ehni in Respondent's medical department through June and July.

Petitioner worked light duty at this time, based on Dr. Ehni's recommendations. However, even with light duty, she was still required to use her right arm. She testified that she was using hammers, which caused pain. On June 17, 2008, Petitioner was taken off work by Respondent because no light duty was available.

As she was still experiencing right shoulder pain and swelling, Petitioner decided to seek a second opinion and presented to Dr. Morrell, at Midwest Sports Medicine, on July 24, 2008. Dr. Morrell opined that Petitioner's symptoms were caused by the repetitive nature of her job, building up to 275 engines per day. Dr. Morrell noted that "It is common to develop impingement syndrome due to the repetitive nature of her job duties, especially with working overhead." On August 14, 2008 she received an injection in her left shoulder by Dr. Morrell, who continued to conservatively treat Petitioner's right shoulder. PX3.

On September 15, 2008, Dr. Morrell noted that Petitioner was failing conservative treatment and noted that a right shoulder arthroscopy, with subacromial decompression and distal clavicle resection may be necessary. On October 3, 2008, Dr. Eugene Lopez, Dr. Morrell's colleague at Midwest Sports Medicine, evaluated Petitioner and noted that she had trouble combing her hair, putting on a belt, raising her arm above shoulder level and across her chest. Dr. Lopez recommended a right shoulder arthroscopy, subacromial decompression, distal clavicle resection, and possible rotator cuff repair. On October 17, 2008, Dr. Lopez performed the right shoulder arthroscopy, subacromial decompression surgery, with Dr. Morrell's assistance.

On December 22, 2008, Dr. Morrell noted that although Petitioner was improving post operatively in regards to her right shoulder, her left shoulder pain was increasing due to compensating for her right extremity injury. Dr. Morrell noted that it might take longer for Petitioner to return to work, due to

the demands of her job. Dr. Morrell injected her left shoulder with a corticosteroid on January 19, 2009 and Petitioner attended physical therapy during this time and was kept on light duty.

Respondent accommodated her light duty restrictions from January 11, 2009 through January 23, 2009. She was given light duty work the first week, photocopying materials. The second week she was switched to the second shift, working with washers. She testified that she was okay in this new position for about an hour, but soon after her shoulder swelled and became painful. Petitioner testified that her right shoulder was so swollen that a security guard brought a bag of ice for her. She stopped working on January 24, 2009 because Respondent could no longer accommodate her restrictions.

Petitioner continued to follow up with Dr. Morrell who kept her on the light duty restrictions. On June 10, 2009, Dr. Morrell recommended Petitioner take part in a work-conditioning program, which she did.

Deposition of Dr. Bryan Neal

Petitioner was examined by Dr. Bryan Neal, at the request of Respondent, on July 22, 2009 and testified by way of evidentiary deposition. He diagnosed Petitioner with right shoulder pain, right lateral epicondylitis; and subjective right upper extremity swelling. He stated that based on the medical records that he had reviewed, he believed her right lateral epicondylitis and subjective right upper extremity swelling was unrelated to her occupational activities. Dr. Neal opined that the etiology for her right shoulder pain was intrinsic, an underlying right acromioclavicular joint arthropathy, but stated that additional medical records could provide further information. Dr. Neal opined that the surgery performed by Dr. Lopez on Petitioner's right shoulder was reasonable and necessary. He stated that it was his "professional instinct" that she would be unable to return to work without restrictions.

On August 5, 2009, Dr. Morrell stated that Petitioner had plateaued with her physical therapy and work-conditioning programs. Dr. Morrell opined that unless Respondent was able to accommodate her work restrictions, she would not be able to return to work.

Dr. Neal re-evaluated the petitioner on October 17, 2013. The petitioner again complained of swelling in her right arm around the elbow joint. Measurements taken of the Petitioner's right arm did not reveal any difference in circumference between the right and left elbow. Dr. Neal also noted symptom magnification and lack of cooperative effort demonstrated during the physical examination. Through various tests, Dr. Neal documented inconsistent findings. Dr. Neal also reviewed surveillance of the Petitioner and noted that her complaints during his examination were inconsistent with the video obtained. He further opined that the petitioner's right shoulder complaints and subsequent surgery were not causally related to her job duties. He opined that the petitioner's right shoulder symptoms were due to a combination of metabolic issues due to Petitioner's diabetes and osteophytes under the acromioclavicular joint. He opined that the petitioner's architectures caused her pain and that her job duties did not cause, accelerate or aggravate the Petitioner's shoulder condition. He stated that the

Petitioner would have had those symptoms regardless of her work activities. RX1, pp. 34-40; RX1, pp. 51, 60 Dep. Ex2; pp. 12- 13; PX3.

Petitioner underwent an MRI of her right shoulder on August 10, 2009, which showed her rotator cuff was intact, with mild changes in the supraspinatus tendon consistent with her previous surgery. Based on the results of the MRI, Dr. Morrell recommended Petitioner undergo an functional capacity evaluation ("FCE"). Petitioner underwent an FCE on September 4, 2009, which found that she could work in a light duty capacity. The report stated that she could not perform her pre-injury job as an assembly operator. She could occasionally lift up to 15 pounds to waist height and 10 pounds bilaterally over shoulder height. She was told to limit repetitive overhead work with her right arm to no longer than ten (10) minutes.

On October 27, 2009, Dr. Morrell found that Petitioner had reached maximum medical improvement ("MMI") and could return to work with the restrictions stated in the FCE. Dr. Morrell's January 12, 2010 office note stated that Petitioner had returned to work and was required to lift heavy boxes and perform repetitive work. She was only able to tolerate this for about 45 minutes. Dr. Morrell modified her restrictions to no lifting greater than 10 pounds and no over the shoulder level work. Petitioner testified that the last date she worked for Respondent was in January 2010 but that she remained an employee, as of the date of trial. PX3.

Petitioner testified that at this time, she noticed that her shoulder would flare up, swell, and burn. Even if she would not use her arm at all, it would swell up. On February 2, 2010, Petitioner reported to Dr. Morrell that she was still having pain, working with light duty work restrictions. Her fingers would occasionally discolor or develop white spots. Dr. Morrell referred Petitioner to the Illinois Pain Institute for pain management treatment.

On February 10, 2010, Petitioner saw Dr. Yano and on February 16, 2010, Petitioner underwent an MRI of her cervical spine at Dr. Yano's request. On February 27, 2010, Dr. Yano diagnosed Petitioner with suprascapular neuritis, a herniated cervical intervertebral disc, cervical radicular symptoms, and complex regional pain syndrome ("CRPS"), involving her right upper extremity. Dr. Yano performed a right suprascapular nerve block. PX4.

On March 2, 2010, Dr. Morrell performed a cortisone injection in Petitioner's left shoulder and Petitioner continued to treat conservatively and attend physical therapy. In May 2010, Dr. Yano noted that Petitioner should undergo treatment for CRPS but Petitioner declined any further intervention.

On May 12, 2010, Dr. Morrell opined that Petitioner's restrictions were permanent and that she had reached MMI. Dr. Morrell restricted Petitioner to limited repetitive motion for 15 minute intervals; with 15 minute breaks and to not work more than four hours per day, four days per week.

Petitioner testified that Dr. Ehni also evaluated her for permanent restrictions. Petitioner testified that they had a private conversation at the plant medical department. He gave her a prescription for pain medication and told her that plant did not have anything light duty for her at that time.

Petitioner underwent a right upper extremity arterial Doppler study on December 24, 2010. It was read to show abnormal waveforms in the right brachial artery, which suggested increased vascular impedance to the flow. Petitioner saw Dr. Saleem on February 11, 2011, who diagnosed her as having persistent pain. On June 7, 2011, Dr. Morrell noted that Petitioner is on permanent disability and could not return to her job duties. Petitioner continued to follow-up with Dr. Morrell and treat conservatively. On December 13, 2011, Dr. Yano recommended an FCE, which was not authorized by Respondent. Petitioner continued treating conservatively about every six months with Dr. Morrell until the end of 2013. Petitioner testified, at the time of the hearing, that she was currently seeing Drs. Ward and Jackson in Tennessee. PX5 & 14.

Petitioner was sent by her attorney to Steve Blumenthal, for a vocational rehabilitation consultation, on December 30, 2012. Mr. Blumenthal took into account the results of the vocational evaluation testing and her past work history and determined that Petitioner would be able to work as a hostess, retail sales clerk, or hotel clerk, earning from $8.76 to $10.68 per hour. PX8.

Petitioner was sent for vocational rehabilitation at Vocamotive by Respondent. She attended training from March 2013 through October 2013. She testified that while working with Vocamotive, she went through job training, was sent to classes, worked on her resume; and searched for jobs. She looked for jobs on the computer and passed out her resume directly to employers. Petitioner had difficulty performing some of the activities due to pain and swelling in her arm. The vocational rehabilitation counselor working with her noted that her right arm, shoulder, and hand would become visibly swollen on multiple occasions and that the swelling was obvious. PX9, pp. 38, 46, 47.

Dr. Neal re-examined Petitioner on October 17, 2013 and diagnosed chronic right shoulder pain and right hand pain of unknown etiology. Dr. Neal stated that regardless of the etiology, her hand pain was unrelated to her work activities with Respondent. He opined that the root cause of her shoulder condition was due to intrinsic issues, probably genetically originating acromioclavicular joint arthrosis. He noted that she was displaying symptom magnification, a lack of effort and that there was no swelling in her upper right extremity. RX1, Dep. Ex. 3, pp. 28-32.

On October 29, 2013, Petitioner was hired at RadioShack in Montgomery and started working. Petitioner testified that she was paid $8.35 per hour, part time and that it would lead to a full time position. She had some difficulty performing the job due to the pain and swelling in her right arm. Petitioner left this job when she moved to Tennessee with her husband.

Deposition of Dr. Mary Kathryn Morrell, dated January 9, 2014

Petitioner's treating doctor, Mary Morrell, testified that Petitioner reported that she performed repetitive motions, at or above shoulder level, while working for Respondent. Dr. Morrell stated that she felt that Petitioner was honest about her complaints of pain and presented a reliable work history. Dr. Morrell opined that her condition of ill-being, in regards to her right upper extremity, was causally connected to her job duties while working for Respondent. PX12.

Deposition of Dr. Shingo Yano, dated October 10, 2014

Petitioner's treating doctor, Shingo Yano, testified by way of evidentiary deposition on October 10, 2014. Dr. Yano testified that he is a board certified specialist in anesthesiology and pain management, who treats patients with chronic pain problems. He opined that Petitioner was suffering from CRPS Type 1 and right shoulder pain. Dr. Yano explained that CRPS is a life-time diagnosis. Dr. Yano opined that Petitioner's repetitive motions at work resulted in her symptoms. He testified that he never had any indication that her reports of pain were inconsistent or not genuine. However, Dr. Yano admitted that he was not familiar with the Budapest Criteria and was not familiar with any recent research in this area. Dr. Yano's notes were reviewed with him and he did not make any changes to his physical findings as noted in his records. PX13, pp. 4-19.

Records review of Dr. Kiran Chekka

Dr. Kiran Chekka reviewed Petitioner's records, at the request of Respondent and testified by way of evidentiary deposition on June 25, 2015. Dr. Chekka testified that he never physically examined Petitioner however, he diagnosed her as having with chronic right shoulder and neuropathic pain but did not believe that she was suffering from CRPS. Dr. Chekka testified that after reviewing the Petitioner's medical records, it was his opinion that she did not suffer from CRPS. He was surprised that Dr. Yano did not know the Budapest Criteria for the diagnosis of CRPS, given the fact that Dr. Yano did his fellowship with the doctor that established the criteria. Dr. Chekka further testified that the Petitioner may have residual pain following surgery but the Petitioner did not have CRPS. He testified that her symptoms were an "unfortunate but not out of the bounds" response to the shoulder surgery performed by Dr. Lopez. He testified that there was no evidence of malingering in Petitioner's medical records and that her suprascapular neuritis and chronic shoulder pain were causally related to her work injury. RX2.

Drs. Morrell, Neal, and Chekka were given a functional job description for Petitioner's job, while she was working for Respondent. The report listed the essential job functions as: initiating the threading of bolts into top of engine block; reaching with cope to position camshaft, securing dampers onto engine blocks with hammer; utilizing hand held screw gun, torqueing oil cooler elbow, pulling completed engine on hoist; pushing piston and camshaft guides onto engine block; lifting the front cover to top shelf of cart; carrying 308 saddle from pallet to beginning of test line' and lifting trays of retainers with keepers off pallet. The "critical job demands" included: initiating the threading of bolts at 60 inches above ground, lifting 18 pounds to 55 inches above ground, pulling 51 feet-pounds of

horizontal force at shoulder height for 20 feet; pushing 55 feet-pounds of horizontal force at 44 inches above the ground; and torqueing with 71 feet-pounds of horizontal force at 40 inches above the ground. Petitioner testified that she is 5'3" tall. PX12, Dep. Ex. 2.

Petitioner testified that on some days her pain is reasonable, but other days she has constant throbbing pain. She testified that she can only use her arm in moderation; otherwise it swells and becomes painful. She takes medication and uses lidocaine patches for her pain 2-3 times per week. She also self-treats with ice packs, rubbing alcohol, and stretches. Petitioner testified that the heaviest weight she can lift is seven pounds. However, if she lifts something approximately seven (7) pounds multiples times, her shoulder will start to hurt and swell. Petitioner testified that she is able to bring an empty garbage can into the house after her husband takes out the full can. She testified that she sometimes is able to drive, shop, clean, dress, and cook, depending on her pain level at the time. The three, videotapes of Petitioner's activities, show her using her right arm in a fashion not inconsistent with her functional capacity evaluation, in fact the petitioner, who is right-handed, used her left hand to open and close the car door and the car trunk. Petitioner testified that she has not looked for a job in Tennessee because she does not know how long she would be able to last on a job. She testified that she has not reinjured her right arm since March 2008.

CONCLUSIONS OF LAW

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

The record reveals that Petitioner worked for Respondent performing assembly duties for Respondent at which time she developed right shoulder pain. The assembly duties, based upon Petitioner's unrebutted testimony, was arm intensive, physical, and required overhead arm use above shoulder level for about 80% of the day. Where an employer fails to contradict an employee's description of his or her job duties, the obvious conclusion is that the employee has provided an accurate description. *See Tolbert v. Ill. Workers' Comp. Comm'n*, 2014 IL App (4th) 130523WC, P42, 11 N.E.3d 453, 462. Petitioner's description of repetitive job duties is further corroborated in the job histories in her medical records and the functional job description report. In Illinois, there is no absolute threshold for a job to be considered "repetitive" enough to establish causal connection and there is no requirement that a certain percentage of an employee's day must be spent on a task to find repetitive trauma. *Edward Hines Precision Components v. Indus. Comm'n,* 356 Ill. App. 186, 193-194, 825 N.E.2d 773 (2nd Dist. 2005). When a worker's physical structure gives way under repetitive job-related stresses on the body, the injury is considered to arise out of and in the course of employment. *Interlake Steel, Inc. v. Industrial Comm'n.*, 130 Ill. App. 3d 269, 273, 474 N.E.2d 402, 406 (1st Dist. 1985). The Arbitrator finds that Petitioner has met her burden of proof in showing that she was

required to perform repetitive, arm intensive duties, the majority above shoulder level, while working for Respondent.

The credible evidence in the record establishes that Petitioner's symptoms manifested on March 27, 2008. The date of an accidental injury in a repetitive-trauma compensation case is the date on which the injury "manifests itself", or the date on which both the fact of the injury and the causal relationship of the injury to the claimant's employment would have become plainly apparent to a reasonable person. *Peoria County Belwood Nursing Home v. Industrial Comm'n.*, 115 Ill. 2d 524, 531, 505 N.E.2d 1026, 1029 (1987). To deny an employee benefits for a work-related injury that is not the result of a sudden mishap or completely disabling penalizes an employee who faithfully performs job duties despite bodily discomfort and damage. *Id* at 530. On March 27, 2008, Petitioner reported to Respondent's medical department with pain that had been developing gradually and had reached the point that she was no longer able to perform her job duties. From that date forward, Petitioner was no longer able to perform her required job duties. A reasonable person would have become aware of the severity of the injury on that date. Based upon the evidence presented, supported by Petitioner's credible testimony, Petitioner's medical records, and Respondent's job duty report, the Arbitrator finds that Petitioner performed repetitive activities with both arms overhead and had an accident which manifested on March 27, 2008, which arose out of and in the course of her employment with Respondent.

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

It is established law that at hearing, it is the employee's burden to establish the elements of his claim by a preponderance of credible evidence. *See, Illinois Bell Tel. Co. v. Industrial Comm'n.,* 265 Ill. App. 3d 681; 638 N.E. 2d 307 (1st Dist. 1994). This includes the issue of whether Petitioner's current state of ill-being is causally related to the alleged work accident. *Id.* A claimant must prove causal connection by evidence from which inferences can be fairly and reasonably drawn. *See, Caterpillar Tractor Co. v. Industrial Comm'n.*, 83 Ill. 2d 213; 414 N.E. 2d 740 (1980). Also, causal connection can be inferred. Proof of an employee's state of good health prior to the time of injury and the change immediately following the injury is competent as tending to establish that the impaired condition was due to the injury. *See, Westinghouse Electric Co. v. Industrial Comm'n*, 64 Ill. 2d 244, 356 N.E.2d 28 (1976). Furthermore, a causal connection between work duties and a condition may be established by a chain of events including Petitioner's ability to perform the duties before the date of the accident and inability to perform the same duties following that date. *See, Darling v. Industrial Comm'n*, 176 Ill.App.3d 186, 193 (1986).

Petitioner's treating physicians, Drs. Morrell, Lopez, and Yano, found that Petitioner's condition of ill-being, in regards to her right shoulder was causally related to her repetitive work duties for Respondent. Further, Respondent's expert, Dr. Chekka opined that Petitioner's chronic shoulder pain was causally related to her work injury. The only physician who found Petitioner's condition was not related to her work duties was Respondent's Section 12 examiner, Dr. Neal, who was also the only physician to find she was magnifying symptoms and not giving full effort in the examination. The

Arbitrator finds Drs. Morrell, Yano, Lopez and Chekka's opinions to be more persuasive than those of Dr. Neal. The Arbitrator places greater weight in these doctors' opinions, regarding the issue of causation. The Arbitrator notes that the petitioner apparently has a genetic condition with her right shoulder, which makes her more prone to have pathological medical issues however, the employer takes his employees as it finds them and this employee has worked for Respondent since 1994 and for several years thereafter, before she succumbed to this shoulder problem.

The Arbitrator further notes that Drs. Chekka, Morrell, and Yano, agree that Petitioner is suffering from chronic right shoulder pain. Dr. Chekka only differed in his opinion from Petitioner's treating doctors in regards to what was causing her chronic pain. Drs. Yano and Morrell opined that she was suffering from CRPS while Dr. Chekka opined that she was only suffering from suprascapular neuritis. The Arbitrator finds the opinions of Drs. Morrell and Yano more credible in this regard, as Dr. Chekka has never physically examined Petitioner.

The Arbitrator finds that Petitioner's condition of ill-being, with regards to her right shoulder chronic pain and suprascapular neuritis, is causally related to her work injury on March 27, 2008.

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?

Respondent disputed the medical expenses based upon liability. After determining that Petitioner's chronic shoulder pain is work-related, the Arbitrator finds the medical services provided for the conditions were reasonable. The Arbitrator notes that Petitioner was highly compliant with the treatment prescribed, missing and cancelling almost no prescribed physical therapy sessions. Respondent is liable for the unpaid medical bills from Dr. Morrell for $125.00 and Steven Blumenthal for $1,274.50, totaling $1,399.50.

K. What temporary benefits are in dispute? – TTD and Maintenance.

Respondent disputed temporary total disability ("TTD") and maintenance benefits based upon liability. As the Arbitrator finds that Petitioner's condition is work-related, the Arbitrator awards TTD benefits from June 17, 2008 through January 10, 2009 and January 24, 2009 through March 11, 2013, totaling 245 weeks of TTD benefits. Temporary total disability benefits generally are available only until an injured employee has recovered as fully as the nature of her injury permits but she may still be entitled to "maintenance" under Section 8(a) of the Act while she is in a prescribed rehabilitation program. *Connell v. Industrial Comm'n.*, 170 Ill. App. 3d 49, 55, 523 N.E.2d 1265, 1269 (1st Dist. 1988). Petitioner is therefore entitled to maintenance benefits from March 12, 2013, the date Respondent initiated vocational rehabilitation, through October 28, 2013, the day before Petitioner became employed by Radio Shack, totaling 33 weeks. The parties have stipulated that Respondent has paid $139,317.28 in TTD benefits, for which Respondent is entitled to a credit.

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

The Arbitrator finds Petitioner sustained a permanent injury to her right shoulder, preventing her from returning to work at her usual and customary employment as an assembler. Petitioner sustained an injury to her right shoulder and initially underwent arthroscopy surgery. She continued to have symptomology in her right upper extremity and therefore needed physical therapy and pain management. Her treating physicians, Drs. Morrell and Ehni, have stated that she has permanent work restrictions. Drs. Yano, Morrell and Chekka, have opined that she needs further treatment. At arbitration, Petitioner testified that she is still an employee of Respondent but they have been unable to accommodate her permanent work restrictions. Petitioner noted that she continues to have pain and swelling in her right upper extremity. Petitioner takes analgesics, utilizes lidocaine patches; and performs self-treatment measures when her symptoms become severe. The Arbitrator concludes Petitioner testified in a credible fashion, consistent with the medical records and other evidence; and is entitled to a wage differential under Section 8(d)(1). Also, her testimony was unrebutted.

The parties have stipulated that Petitioner would be making $25.98 per hour working for Respondent at the time of the hearing. The Arbitrator finds Petitioner is entitled to a wage differential based on the $8.35 per hour which she was being paid at Radio Shack beginning October 29, 2013. This hourly rate is consistent with the findings of her vocational assessment by Mr. Blumenthal. The fact that she terminated her employment with Radio Shack when she moved to Tennessee with her husband, is immaterial. An employee need not be working at the time of the hearing to be awarded an 8(d)(1) wage differential. *See McGuire v. Chrysler,* 01WC 60272 (Commission awarded a wage differential when the claimant was employable but not working at the time of the hearing, relying upon a labor market survey to award the 8(d)(1) wage differential). Petitioner is entitled to a wage differential of $470.13 per week for the duration of her disability, commencing October 29, 2013. Said amount was calculated by subtracting $8.35 from $25.98, multiplying by 40 hours per week, and then multiplying that figure by 2/3rds.

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
09WC 32818
SIGNATURE PAGE

Signature of Arbitrator

October 13, 2015
Date of Decision

OCT 13 2015

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

MARLENE RODRIGUEZ,

Petitioner,

15IWCC0811

vs.

NO: 09 WC 32968

ASG STAFFING, INC.,

Respondent.

DECISION AND OPINION ON REVIEW ON REMAND

In a decision dated December 17, 2013, the Appellate Court for the Third District of Illinois, issued an Order that held:

> (1) Claimant's choice of treatment did not exceed the two-physician choice limitation where one chain of medical care was a referral by respondent and another chain was a *bona fide* emergency; and (2) Commission's finding that claimant was entitled to 32-4/7 weeks of temporary total disability benefits is against the manifest weight of the evidence as the evidence failed to establish that claimant was unable to work during part of the period for which TTD benefits were awarded.

The court subsequently remanded the matter to the Commission for an entry of an order consistent with this disposition and for further proceedings pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980). The Commission remands this matter to the presiding arbitrator pursuant to this order. 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 September 9, 2011, Decision and Opinion of the Commission affirmed and adopted the June 8, 2010, 19(b) Decision of Arbitrator. In doing so, the Commission agreed with the Arbitrator that the medical services provided to Petitioner were both reasonable and necessary. The issue of whether Petitioner exceeded the choice of physicians as so stipulated in Section 8(a) of the Act was not explicitly addressed in either the Decision of Arbitrator or the Decision and Opinion of the Commission. Both found the medical services as provided to Petitioner to have been reasonable and necessary. Given the findings of reasonableness and necessity, it is implicit that the Commission found Petitioner's treatment remained within the choice limits prescribed by the Act. On this issue, the Decision of the Commission and the Order of court are consistent.

In affirming and adopting the 19(b) Decision of Arbitrator, the Commission awarded 32-4/7 weeks of TTD benefits to Petitioner. The 32-4/7 weeks represents the period of July 21, 2009, through August 19, 2009, and October 29, 2009, through May 17, 2010. The Arbitrator noted the parties stipulated that Respondent did not pay Petitioner any TTD benefits from July 21, 2009, the date of accident, through May 17, 2010, the date of the arbitration hearing. The Arbitrator noted further that Petitioner was unable to work, except for approximately two months, within that timeframe. The court noted the record showed Petitioner was authorized to return to work without following treatment on July 21, 2009, but did not attempt to return to work.

The same scenario was repeated again on July 23, 2009. On July 28, 2009, Petitioner was allowed to work within the restrictions prescribed to her by Dr. Reed. Petitioner, however, made no effort to return to work after obtaining the prescribed restrictions. On August 14, 2009, Dr. Reed ordered Petitioner off work for four weeks. The court, based on the record, concluded Petitioner demonstrated that she did not work but failed to prove that she was unable to work from the date of injury, July 21, 2009, through the date Dr. Reed took her off work completely, August 14, 2009. For this reason, the court reversed the Commission's awarding of TTD benefits for that period of time. The Commission modifies the TTD award accordingly.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $213.33 per week for a period of 29-3/7 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 $14,005.63 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 in the amount of $1,039.98 for all amounts paid, if any, to or on behalf of Petitioner on account

15IWCC0811

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 $21,300.00. 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: NOV 2 - 2015
KWL/mav
O: 7/21/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

STATE OF ILLINOIS)	☐ Affirm and adopt	☐ 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

AARON CONWAY,

Petitioner,

15IWCC0810

vs.

NO: 10 WC 02879

CITY OF CHICAGO,

Respondent.

DECISION AND OPINION ON REVIEW WITH SPECIAL FINDINGS

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 average weekly wage, benefit rate, medical expenses, nature and extent, and special findings, 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.

In order to qualify for a wage-differential award under section 8(d)(1) of the Act, a claimant must prove (1) a partial incapacity which prevents him from pursuing his "usual and customary line of employment" and (2) an impairment in earnings. 820 ILCS 305/8(d)(1) (West 1998); Gallianetti v. Industrial Commission, 315 Ill. App. 3d 721, 730 (2000). The purpose of Section 8(d)1 is to compensate an injured claimant for his reduced earning capacity, and if the injury does not reduce his earning capacity, he is not entitled to such compensation. Smith v. Industrial Commission, 308 Ill. App. 3d 260, 266 (1999). A claimant must prove his actual earnings for a substantial period before his accident and after he returns to work, or in the event that he is unable to return to work, he must prove what he is able to earn in some suitable employment. Smith, 308 Ill. App. 3d at 266.

Petitioner underwent a right knee arthrotomy and quadriceps tendon repair on February 16, 2010 (PX2). The Med Voc Rehabilitation reports reflect that Petitioner underwent a

15IWCC0810

functional capacity evaluation with NovaCare on December 15, 2010, placing him at the light to medium physical demand level, capable of standing, walking, and kneeling on an occasional basis. Petitioner testified that on January 24, 2011, Dr. Bach subsequently provided him with permanent work restrictions of no climbing, no ladders, no squatting or kneeling, and minimal walking, coinciding with his release from medical care. Petitioner testified that he was never offered a job within his work restrictions, that he continued to receive weekly benefits from Respondent, that he attempted to find work, and that he retired from Respondent on February 24, 2014.

While Petitioner met the first requirement for a wage differential, that he could no longer meet the physical demands of his usual and customary line of employment as a motor truck driver based upon his permanent work restrictions, the Commission finds Petitioner failed to prove an impairment in earnings. Instead the evidence reflects that Petitioner purposefully sabotaged Respondent's attempts to return him to gainful employment within his restrictions with Respondent, and then subsequently sabotaged MedVoc efforts to return him to gainful employment. Furthermore, as the Arbitrator noted, Petitioner tendered no documentary evidence of his job search efforts following his January 24, 2011 release to return to work with restrictions, nor did he offer any testimony from which the Commission could conclude he conducted a job search, being unable to identify any prospective employer that he had contacted.

With regard to Respondent's efforts to return Petitioner to gainful employment with Respondent, the Commission finds significant that Petitioner completed an August 26, 2011 Willingness & Ability Questionnaire for a Watchman position with Respondent and therein noted that he was unable to: 1) work in all types of weather conditions; 2) wear a security uniform including black work shoes/boots, safety vests, rain gear and hard hats; 3) maintain a clean and safe working area during his shift; 4) monitor security cameras, report incidents, check doors, check property perimeter, check vehicle gates, make sure exterior lighting is working, check perimeter of construction site, and complete security incident report; and 5) be assigned to various work locations around the city. (RX1) On cross-examination, Petitioner admitted that he had no restrictions with regard to those activities, that the questionnaire was an opportunity for him to return to work as a watchman for Respondent, that he answered "no" to several questions, which may have taken him out of the running, that he was not offered that job because in his own opinion he was not able to do that job, and that it is possible none of Dr. Bach's January 2011 work restrictions were included in any of the questions on the questionnaire. (T32-36, 50-55). As noted by the Arbitrator, Petitioner purposely and falsely answered the questions on the questionnaire to ensure that he would not be hired, stating on the form that he was physically unable to do things that no physician had restricted him from doing.

Petitioner's initial consultation with MedVoc Rehabilitation was on May 20, 2013, at which time Petitioner reported he was not sure he wanted to obtain employment as he was hoping to retire. (RX2, 06/06/13). Petitioner admitted on cross examination that he had no intention of searching for employment when he was contacted by MedVoc, as he intended to retire. (T41-44). Petitioner himself admitted that while MedVoc was attempting to secure him employment within his work restrictions, that he was not responsive or cooperative to those efforts, that he was sent job leads and asked to apply for jobs but did not do so. He admitted that between June 6, 2013 through March 21, 2014, he was non-compliant with the vocational efforts

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as he intended to retire. (T57-59).

The Commission finds that Petitioner failed to prove he is entitled to an award of a wage differential under Section 8(d)1, relying on the Arbitrator's significant finding that Petitioner did everything within his power to purposely thwart Respondent's efforts at returning him to gainful employment with Respondent and with vocational placement, that Petitioner's conduct demonstrated a clear and convincing lack of good faith, that Petitioner's job search efforts were completely absent, and that he had no intention of going back to work upon his treating physician's release for him to return to work with restrictions.

The evidence in the record, therefore, does not support a finding that the claimant was entitled to a wage differential award, *i.e.*, that he suffered a partial incapacity which prevents him from pursuing his usual and customary line of employment and that he has an impairment in earnings. The Commission, in considering a wage differential award under Section 8(d)(1), finds Petitioner failed to prove entitlement to same. Instead, the Commission awards PPD benefits under Section 8(d)(2), in the amount of 40% loss of use of the man as a whole. Accordingly, the Commission vacates the Arbitrator's 8(d)1 award of $361.24 per week, and finds that Petitioner sustained permanent partial disability to the extent of 40% of the man as a whole under §8(d)2 of the Act.

With regard to the issue of temporary total disability benefits, the Commission finds Petitioner is entitled to temporary total disability benefits of $ 842.81per week for 54-4/7 weeks, from December 22, 2009 through January 28, 2011, that being the period of temporary total incapacity for work under §8(b) of the Act, because the injuries sustained caused the disabling condition of the petitioner. In so finding, the Commission relies upon the parties stipulation contained within the request for hearing (ARB EX1), the off work slips issued by MercyWorks (PX4), and the January 24, 2011 office note of Petitioner's treating physician, Dr. Bach, placing Petitioner at maximum medical improvement with a permanent restriction of no climbing, no ladders, no squatting or kneeling, and minimal walking (PX3).

With regard to the issue of maintenance benefits, the Commission finds Petitioner's entitlement to same was terminated as of May 20, 2013, as the overwhelming evidence indicates that following that date, Petitioner was not engaged in directed or self-directed active job search, and Petitioner in fact was refusing to comply with the vocational assistance being offered to him. As noted above, Petitioner's initial consultation with MedVoc Rehabilitation was on May 20, 2013, at which time he reported he was unsure if he wanted to obtain employment as he was hoping to retire soon. (RX2, 6/6/13). On cross-examination, Petitioner testified he was unsure if he completed any job search logs following his May 20, 2013 meeting with MedVoc. He further admitted that he intended to retire, that he had no intention of searching for employment when he was contacted by MedVoc, that he failed to apply for job leads, and that he was non-cooperative and non-compliant with vocational efforts based upon his intention to retire. (T41-44, 57-59). On re-direct, Petitioner reiterated that he was non-cooperative with vocational efforts because he was planning on retiring, and that he had advised MedVoc he was not interested in looking for a job as he was retiring. (T48). Accordingly, the Commission finds that Petitioner is entitled to maintenance benefits of $842.81 per week for 120-3/7 weeks, from January 29, 2011 through May 20, 2013.

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We now address Petitioner's "Request for Special Findings." Prior to oral arguments before the Commission, Petitioner filed a timely "Request for Special Findings" pursuant to Commission Rule 7040.40(c). The Commission responds to each interrogator as stated below.

"Interrogatory 1: Did the Respondent, City of Chicago, make Petitioner a firm offer to work as a night watchman in its Water Department? The Commission finds no job offer was tendered.

"Interrogatory 2: Did Respondent, City of Chicago, make Petitioner a firm offer to work at any time from the date of Petitioner's restricted release to return to work to the date of Arbitration?" The Commission finds no job offer was tendered.

"Interrogatory 3: "That there is no evidentiary basis from the record to conclude that Respondent, City of Chicago, offered Petitioner a watchman position at its Water Department for $33.85 per hour for 40 hours per week." The Commission will not reply to Petitioner's statement as no question was presented.

Finally the Commission addresses a clerical error. On page two, sentence one, of the Arbitrator's findings, the Commission corrects the date of accident from "December 12, 2009" to "December 21, 2009."

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision filed on October 15, 2014 is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $842.81 per week for a period of 54-4/7 weeks, from December 22, 2009 through January 28, 2011, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $842.81per week for a period of 120-3/7 weeks, from January 29, 2011 through May 20, 2013, that being the period of maintenance un
der § 8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's finding that Petitioner is entitled to a wage differential award of $361.24 per week under §8(d)1 of the Act is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $758.53 per week for a period of 200 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the permanent partial disability to the extent of 40% loss

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of use of the man as a whole.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, including $48,512.07 for temporary total disability, and $136,535.22 for maintenance, for total credit of $185,047.29, to or on behalf of Petitioner on account of said accidental injury.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit in the amount of $4,363.50 under §8(j) of the Act; 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.

As this matter involves the City of Chicago, pursuant to Section 19(f)(2), no bond for the removal of this cause to the Circuit Court by Respondent is required. 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: NOV 2 - 2015
KWL/kmt
O-09/01/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0810

CONWAY, AARON
Employee/Petitioner

Case# 10WC002879

CITY OF CHICAGO
Employer/Respondent

On 10/15/2014, 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 0.04% 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:

2399 SILVERMAN, CLIFFORD A
18400 MAPLE CREEK DR
SUITE 700
TINLEY PARK, IL 60477

0010 CITY OF CHICAGO
MICHELLE S BRYANT
30 N LASALLE ST - 8TH FL
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 15IWCC0810

Aaron Conway
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # 10 WC 02879

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 **Ketki Steffen**, Arbitrator of the Commission, in the city of **Chicago**, on **August 4, 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 **December 12, 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 $**65,739.26**; the average weekly wage was $**1,264.22**.

On the date of accident, Petitioner was **62** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**48,512.07** for TTD, $**0** for TPD, $**136,535.22** for maintenance, and $**0** for other benefits, for a total credit of $**185,047.29**.

Respondent is entitled to a credit of $**4,363.50** under Section 8(j) of the Act.

ORDER

The Arbitrator finds that the medical bills are reasonable and related to the December 21, 2009 accident and awards the bills pursuant to section **8a** and section **8.2** (medical fee schedule) except for the medical bill from West Suburban Hospital for $4,363.50. The Arbitrator does not award said bill. As to the awarded bills, the respondent shall hold the petitioner harmless from any claims made by Blue Cross Blue Shield.

The Arbitrator awards a wage differential based on the hourly wage of the **watchman position**. Said differential is based on the stipulated that the hourly wage for a motor truck driver in the department of streets and sanitation ($ $33.85) and the hourly salary for a watchman ($20.31 or AWW of $812.40). The difference between $1,354.00 and $812.40 is $541.60 x .667= $361.24.

The Arbitrator awards a wage differential of $361.24.

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.

Kelli Steffen
Signature of Arbitrator

10/15/14
Date

OCT 15 2014

PROCEDURAL HISTORY

This matter was presented for a hearing on the merits before Arbitrator Ketki Steffen on August 4, 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 December 21, 2009; a date which predates the September, 2011 AMA guidelines amendment to the Act.

FACTUAL HISTORY

The Petitioner, Aaron Conway, was an employee of the respondent, City of Chicago, Department of Streets and Sanitation for 21 years. Over the course of those 21 years the petitioner testified that he worked in various departments and various positions. On December 21, 2009, the petitioner worked as a motor truck driver collecting refuge for the respondent.

He testified that he was getting out of his truck to use the restroom, when he slipped and fell on ice. He testified that he did the splits, when his left leg came down first and his right leg followed but his foot landed on ice and he fell on the ground. He was unable to get up and could not move. He testified that when he fell, he fell to his side and he fell into a fence. At the time of his fall he weight 290 lbs and was 6 feet 2 inches tall. Petitioner was 62 years old at the time of the accident and had no dependents.

The petitioner was taken by ambulance to Resurrection hospital where x-rays were taken and he was subsequently discharged from care. On December 22, 2009, the petitioner followed up with Mercyworks and was diagnosed with a right knee contusion and right thigh contusion. He was released to return to work and to continue with therapy prescribed by the hospital.

He continued to treat with Mercyworks and on December 31, 2009 an MRI of the right knee was ordered. On January 7, 2010 an MRI was performed and revealed a high grade quadriceps tendon tear. The petitioner eventually came under the care of Dr. Bach. Dr. Bach recommended surgery to repair a tendon rupture.

On February 16, 2010, Dr. Bach performed a right knee arthrotomy and quadriceps tendon repair. Petitioner underwent post-operative physical therapy and on December 15, 2010 the petitioner underwent an FCE. The FCE was deemed valid and recommended the petitioner participate in a 4-6 week aggressive work hardening program.

The petitioner underwent the work hardening program and on October 25, 2010, Dr. Bach released the petitioner to return to work sedentary work.

On January 24, 2011, Dr. Bach placed the petitioner at maximum medical improvement with permanent restriction of no climbing, no ladders, no squatting, no kneeling, and minimal walking.

The petitioner testified that Dr. Bach prescribed a cane for walking, but on cross examination recanted his statement that Dr. Bach prescribed the cane, but noted that it was Dr.Bach's assistant that prescribed the cane. The medical records do not support the prescription of the cane.

The petitioner testified that he asked the respondent to help him find a job, but was unable to recall who he spoke with. The petitioner entered into evidence a letter provided by the respondent requiring him to look for jobs online and in person and to keep job logs and submit them to the respondent (Px #1). The petitioner testified that he looked for work but did not bring his job logs into court. The petitioner was also unable to provide the name of any prospective employee that he had contacted over the course of his job search. He testified that he knew he was coming into court to testify about his attempts to look for work, but that he did not feel he needed to bring the job logs into court. The Petitioner was offered an opportunity to bring the job logs back to court, but declined.

The petitioner testified that the respondent never offered him a job within his restrictions and that he was never notified by any from the respondent, until vocational rehabilitation services were offered on June 6, 2013.

During cross-examination the petitioner acknowledged that he had been contacted by the respondent on several occasions regarding jobs. The petitioner stated that he was first contacted by the respondent for a watchman's position within the respondent's water department. The petitioner testified that he received a

willingness and ability questionnaire for the watchman position. He acknowledged his signature on the questionnaire and acknowledged that he had in fact completed the questionnaire.

The petitioner testified that there were several questions on the questionnaire that he stated he was unable to do things, but had not been restricted from doing. The petitioner was asked whether he was able to maintain a clean and safe working area, he responded that he was not able to. He also said that he was unable to work in all types of weather conditions or wear security uniforms.

The petitioner testified that based on his answers to the questionnaire it was fair to say that he was unable to perform the job duties of a watchman and that is why he did not get the position as a watchman. The petitioner also acknowledged that none of his actual restrictions provided by Dr. Bach said he was unable to do any of the activities he claimed.

The petitioner testified that he is a high school graduate and that he attended one year of junior college. He testified that his prior work experience included factory work, shipping and receiving and driving forklifts. He testified that he retired on February 24, 2014 and is currently receiving retirement pension benefits and not disability benefits.

Petitioner testified that he was also contacted by the respondent for a traffic technician position. He testified that he went downtown and tested for the position, but never heard anything further.

He testified that when he retired, it was not his intention to never work again and that he would look for work at a later time. However, when the petitioner was contacted by a vocational counselor at MedVoc he was non-compliant with the counselor's efforts to help him find work within his restrictions, but not with the respondent.

The petitioner testified that from June 6, 2013 through March 21, 2014, he was not compliant because it was his intention to retire, so he did not want to look for work. The respondent entered a group exhibit containing various letters sent to the petitioner, from MedVoc Rehabilitation, Ltd. concerning his non-compliance. Specifically, letters dated February 4, 2014 and March 21, 2014.

He testified that he still has pain in his right knee and that he "can't" keep his leg in one position without it hurting. He testified that he does not do a lot of walking up and down stairs. He also testified that he experiences buckling in his knee after walking about ¼ of a block.

He testified that he is not currently taking any pain medication or over the counter pain pills. He testified that he saw his primary care physician for pain in his leg, but that he did not bring his medical records or any medical evidence to support additional care and treatment.

The parties stipulated that the current pay for a motor truck driver is $33.85 per hour. The petitioner admitted into evidence a labor market survey dated March 20, 2014, indicated that the petitioner could make up to $14.25 per hour in a light assembly position. However, the petitioner failed to contact any of the prospective employers listed. The labor market survey indicated that the average wage range for the targeted position is $10.25 per hour to $12.25 per hour, but the median wage was $11.25.

In regards to the issue of causal connection, the Arbitrator finds:

Claimant has the burden of proof that his employment was a causative factor with respect to his disability. *Steiner vs. Industrial Commission*, 101 Ill. 2d. 257 (1984). Proof of the state of heath of the employee prior to and down to the time of injury and the change immediately following the injury and continuing thereafter is competent as tending to establish that impaired condition was due to the injury. *Plano Foundry Co. v. Industrial Commission*, 356 Ill. 186 (1934). Petitioner testified he had no prior problem with his right leg or knee and had been driving a refuse truck for the City some 15-16 years before December 12, 2009. Petitioner testified that he slipped on ice in the alley and fell to the ground when he was getting out of the garbage truck. He described his fall as doing "the splits" and stated that he felt a warm wet sensation in his leg.

Based on the surgical repair to the torn quadriceps found by Dr. Bach, (Pet. Ex. No. 2) a review of the medical records and opinions and the permanent restrictions of no climbing, no ladders, no squatting, no kneeling and minimal walking, the Arbitrator finds that the Petitioner has met his burden of proof to show that his present condition of ill-being is related to the accident of December 12, 2009.

In regards to (J), "Has Respondent paid all appropriate charges for all reasonable and necessary medical services?" the Arbitrator finds:

Petitioner alleges $4,363.50 bills due and owing for services rendered at West Suburban Hospital on December 21, 2009. The petitioner used his group insurance to pay for services rendered, but the petitioner's testimony was that he received emergency treatment from Resurrection Hospital not West Suburban Hospital. Even more, the petitioner failed to offer any medical records into evidence supporting the care and treatment provided by said provider.

The Arbitrator finds that the medical bills are not reasonable or related to the December 21, 2009 accident.

In regards to (L), "What is the nature and extent of the injury?" the Arbitrator finds:

The Arbitrator finds that Petitioner was permanently and partially disabled as a result of his work accident and has proven that he suffered a loss of earning capacity as a result of his injuries. The evidence shows that the Petitioner had the option of working as a watchman for the Respondent and that this position fit within his medical limitations and qualifications. The Petitioner, for his own private/personal reasons choose not to accept or pursue this employment. The watchmen position would have paid Petitioner $33.85 per hour or $1,354.00 per week. The parties stipulated that at the time of the hearing a garbage truck driver working for the Respondent would earn $33.85 per hour or $1,354.00 per week. (Pet. Ex. No. 5). The Petitioner has proven that he suffered a diminished earning capacity as a result of his work accident. The Arbitrator finds that the Petitioner is entitled to a wage differential benefit of $361.24.

The Arbitrator finds a wage differential award is more appropriate then a MAW award. The Arbitrator declines to find that the Petitioner should receive a MAW award because the Petitioner has demonstrated that he has been partially incapacitated and cannot return to his former vocation and this in turn has caused him to suffer diminished earning capacity. Our Supreme Court in *General Electric Company v. The Industrial Commission*, 89 Ill.2d 432, 433 N.E.2d. 671, 674 has found such earning loss calculation to be a sound basis in

the worker's compensation system. *Gallianette v. Industrial Commission of Illinois*, 315 Ill.App.3d 721, 734 N.E.2d 482 (2000). (Wage-differential awards are preferred) A claimant's voluntary decision to remove himself from the work force does not preclude a wage differential award. *Wood Dale Electric v. The Illinois Worker's Compensation Commission*, 2013 ILAP (1st) 113394 WC (2013); *Copperweld Tubing Products, Co. v. Illinois Workers' Compensation Commission*, 402 Ill.App.3d 630; 931 N.E.2d 762 (2010) and claimant need not be working at the time of trial *Copperweld, ibid.*

Section 8(d)1 of the Act provides provides that guidelines for the wage differential calculation.

"If after the accidental injury has been sustained, the employee as a result thereof becomes partially incapacitated from pursuing his usual and customary line of employment, he *shall*, except in cases compensation under the schedule set forth in paragraph (e) of this Section, receive compensation for the duration of his disability, subject to the limitations as to maximum amounts fixed in paragraph (b) of this Section, equal to 66 2/3% of the difference between the average amount which he would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident and the average amount which he is earning or is able to earn in some suitable employment or business after the accident." (Emphasis added.) 820 ILCS 305/8(d)1 (West 1992).

To qualify for a wage differential award, a claimant must prove: (1) a partial incapacity that prevents him from pursuing his usual and customary line of employment and (2) an impairment of earnings. 820 ILCS 305 Ill. App. 3d 488, 494, 867 N.E.2d 1063 (2007). Whether a claimant has satisfied each element is a question of fact to be resolved by the Commission, whose determination in this regard will not be disturbed on appeal unless it is against the manifest weight of the evidence. Morton's of Chicago v. Industrial Comm'n, 366 Ill.App.3d 1056, 1061, 853 N.E.2d 40, (2006). For a finding of fact to be contrary to the manifest weight of the evidence, an opposite conclusion must be clearly apparent. Durand v. Industrial Comm'n, 224 Ill. 2d 53, 64, 862 N.E.2d 918 (2006)

The facts in evidence show Petitioner's present physical condition preclude him from returning as a garbage truck driver for the City of Chicago. He suffered a complete quadriceps tendon tear and has permanent restrictions of no climbing, no ladders, no squatting or kneeling and minimal walking. (Pet. Ex. No. 2). Additionally, Mercy Works, Respondent's clinic, released Petitioner for sedentary duty only. (Pet. Ex. No. 4). Thereby, Petitioner has met his burden of proof, by a preponderance of the evidence, that he cannot pursue his usual and customary employment.

Petitioner has also carried his burden of proof, by a preponderance of the evidence that he suffered impairment in his earnings capacity as a result of his injury. The parties stipulated that at the time of the hearing a garbage truck driver working for the Respondent would earn $33.85 per hour or $1,354.00 per week. (Pet. Ex. No. 5). The Petitioner has proven that he suffered a diminished earning capacity as a result of his work accident.

The heart of the issues in this case rests upon a determination of how diminished the Petitioner's earning capacity was, following his accident and his restricted duty release. The Petitioner urges the court that said earning capacity be determined by the Labor Survey prepared by MedVoc Rehabilitation, Ltd. that finds that the mean wage for the positions targeted was $11.25 per hour or $450.00 per week. Respondent has proposed in the alternative that the wage differential be calculated based on a watchmen salary, a position which was ready and available and fit within the Petitioner's medical restrictions.

The Arbitrator finds that the evidence overwhelmingly shows that Petitioner was capable of working at the watchmen position where he could have earned $33.85 per hour or $1,354.00 per week. The Arbitrator finds that the evidence produced at trial shows that the watchmen job was within Petitioner's restrictions and that Respondent was willing and able to afford him the opportunity to take this job within his restrictions. Petitioner did everything within his power to purposely thwart Respondent's effort and his conduct demonstrates a clear and convincing lack of good faith. The evidence shows that Petitioner's job search efforts were completely absent and that, in fact, he had no intention of going back to work. Petitioner openly admitted as much in court through his testimony and conduct that it was his intention to not return back to employment as

he was just waiting to retire and receive his pension. The Arbitrator notes the following facts in support of this conclusion:

1. The petitioner job search records are completely absent. Petitioner has produced no proof of a job search nor could he provide even a minor detail of any job search. Petitioner testified that he asked the respondent to help him find a job, but was unable to recall who he spoke with. The petitioner entered into evidence a letter provided by the respondent requiring him to look for jobs online and in person and to keep job logs and submit them to the respondent (Px #1). The petitioner testified that he looked for work, but did not bring his job logs into court. The petitioner was also unable to provide the name of any prospective employee that he had contacted over the course of his job search. He testified that he knew he was coming into court to testify about his attempts to look for work, but that he did not feel he needed to bring the job logs into court. The Arbitrator offered the petitioner an opportunity to bring the job logs back to court, but he declined.

2. The petitioner was thoroughly impeached regarding his testimony that the respondent never offered him a job within his restriction and that he was never notified by anyone from the respondent, until vocational rehabilitation services were offered on June 6, 2013. After denying Respondent's efforts during direct exam, the the petitioner reluctantly acknowledged that he had been contacted by the respondent on several occasions regarding jobs.

3. The evidence shows that Petitioner purposely thwarted efforts by Respondent to place him in a suitable position. Petitioner was contacted by the respondent for a watchman's position within the respondent's water department. The petitioner received a willingness and ability questionnaire for the watchman position which he signed. Petitioner then purposely and falsely answered the questions on this form that would ensure that he would not be hired. He stated on this signed form that he was physically unable to do things that no physician had restricted him from doing. Additionally, Petitioner stated that he was unable to maintain a clean and safe working area. He also

said that he was unable to work in all types of weather conditions or wear security uniforms. On cross examination the petitioner also acknowledged that none of his actual restrictions provided by Dr. Bach said he was unable to do any of the activities he claimed.

4. Petitioner also testified in court that when the Vocational counselor tried to help him find employment he simply informed them that he planned on retiring.
5. In court petitioner testified that he was also contacted by the respondent for a traffic technician position. He testified that he went downtown and tested for the position, but never heard anything further.
6. He testified that when he retired, it was not his intention to never work again and that he would look for work at a later time. He also testified that from June 6, 2013 through March 21, 2014, he was not compliant because it was his intention to retire, so he did not want to look for work.
7. Petitioner was wholly non-compliant with vocational counselor at MedVoc as they attempted to place him in suitable employment. Specifically, letters dated February 4, 2014 and March 21, 2014 document these efforts.

Based on this clear evidence the Arbitrator is convinced that the watchmen position (not the labor market survey) is an appropriate gauge of Petitioner's earning capacity. The Arbitrator specifically finds that the Petitioner purposely dismissed the watchmen job opportunity before an offer could be made so that he would not have to return back to employment. The Petitioner also actively thwarted all of Respondent's other efforts to find appropriate employment within the Petitioner's restrictions. Nevertheless, the Arbitrator finds that the Petitioner is entitled to a wage differential award to the extent of the wage difference between his previous job as a motor truck driver ($33.85/hour, AWW $1,354.00) and a job as a watchman ($20.31/hour, AWW $812.40). The wage differential award between $1,354.00/week and $812.40/week is $541.60 x .667= $361.24.

Kelli Steffen
Signature of Arbitrator

10/15/14
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 Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

NORMA ECHEVARRIA-ORTA,

Petitioner,

15IWCC0813

vs.

NO: 10 WC 16559
10 WC 46784
10 WC 46785
10 WC 46786
10 WC 46787
10 WC 46788
10 WC 46789
10 WC 46790
10 WC 46791
10 WC 46792
10 WC 46793
10 WC 46794
10 WC 46795

ADVOCATE ILLINOIS MASONIC MEDICAL CENTER,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition 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, causation, medical expenses, temporary total disability and permanency, and being advised of the facts and law, reverses the Decision of the Arbitrator finding that Petitioner proved that she sustained accidental injuries arising out of and in the course of her employment on some of her alleged dates of accident, as stated below, and otherwise affirms and adopts the Decision of the Arbitrator finding that Petitioner failed to prove she sustained accidental injuries arising out of and in the course of her employment on the other alleged dates of accident which is attached hereto and made a part hereof.

The Petitioner has claimed multiple accident dates relative to alleged injuries to her bilateral hands and wrists. The Arbitrator determined that: "Petitioner established that she

sustained accidental injury arising out of and in the course of her employment with some cases; while other cases appear to be simply dates on which she had doctor's appointments." Other than denying the Petitioner's alleged accident dates of November 16, 2007 and June 12, 2009, the Arbitrator did not specify which dates of accident were compensable and for which benefits were awarded.

The Petitioner's statement of exceptions indicates that the Arbitrator found that Petitioner proved an accident on November 6, 2007. However, the "Findings" section of the decision (Arbitrator's Decision, p. 2) indicates that Petitioner *did not* sustain an accident that arose out of and in the course of her employment on November 6, 2007. The body of the decision does not specify any findings with regard to that particular date. It is unclear to the Commission how the Arbitrator awarded any benefits to Petitioner in this claim, since the Arbitrator failed to identify a singular compensable accident date.

The Commission affirms the denial of an accident arising out of and in the course of Petitioner's employment on November 16, 2007 (10 WC 46787) and June 12, 2009 (10 WC 46790), and further reverses the Arbitrator and finds that the Petitioner has failed to prove an accident arising out of and in the course of her employment on any of the remaining claimed dates of accident. As such, the Commission finds that Petitioner has failed to prove an entitlement to benefits for any of the alleged dates of accident.

The first alleged accident date is October 3, 2007 (10 WC 46784). On that date the Petitioner prepared an accident report (Petitioner's Exhibit 4) indicating she had a very painful right hand and inability to move her middle "trigger" finger. She saw Dr. Husain at the company clinic and reported a six month history of her right middle finger sticking. She reported spending 8 hours per day typing at work but no history of specific trauma. She noted the finger pain was increasing with mild numbness, and was worse after work. (Px4).

The second alleged date of accident is October 26, 2007 (10 WC 46785). The Petitioner testified that she returned to the company clinic and saw Dr. Satcher that day, and was advised not to use her right hand at work. Dr. Satcher's report (Px4) states that Petitioner's "original injury was 03/01/07 of the right middle finger." The report also indicates Petitioner "continues" to have symptoms in the 3rd and 4th fingers, and she reported palm pain that she felt was contributed to by a wrist splint. Trigger fingers were diagnosed in both fingers, and Petitioner was advised to see an ortho. (Px4).

The third alleged date of accident is November 6, 2007 (10 WC 46786). Petitioner initially saw Dr. Mercier at Chicago Orthopaedics & Sports Medicine at that time, noting right hand pain, particularly in the 3rd and 4th fingers, and indicated that she "does a lot of secretarial-type work on the job." (Px8). He diagnosed triggering in the 3rd finger, tenosynovitis in the 4th finger, and both were injected. The Petitioner returned to Dr. Mercier on November 15, 2007, reporting improvement in the fingers but reporting bilateral numbness in the arms, right greater

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than left. Noting a negative Tinels test bilaterally at the wrists and elbows, Dr. Mercier diagnosed bilateral carpal tunnel, and Petitioner requested EMG/NCV testing, which was prescribed. (Px8).

The fourth alleged date of accident is November 16, 2007 (10 WC 46787). The Commission cannot determine the significance of this date from the testimony and evidence presented.

The fifth alleged date of accident is June 6, 2008 (10 WC 16559). Again, the Commission cannot determine the significance of this date from the testimony and evidence presented.

The sixth alleged date of accident is June 19, 2008 (10 WC 46788). At that time Petitioner returned to Dr. Mercier indicating she had done well following injection, but that her right 4th finger had recurrent triggering. (Px8). A repeat injection was offered but declined by Petitioner as "too painful". Instead, a Medrol steroidal dosepak was prescribed. Dr. Mercier indicated if pain continued, her choices were re-injection, living with it or having surgery. (Px8).

The seventh alleged date of accident is October 7, 2008 (10 WC 46789). On that date she next visited Dr. Mercier, indicating her right 4th finger was only triggering occasionally, but she complained of pain at the volar 3rd and 4th fingers. Petitioner also for the first time noted complaints at the base of the left thumb, and intermittent pain at the left volar thumb, 2nd and 3rd fingers. (Px8). Dr. Mercier, noting no evidence of triggering of the left fingers, indicated the issue at the base of the thumb was likely mild early degenerative arthritis, and that otherwise there was likely some early tenosynovitis. (Px8). Dr. Mercier did not believe surgery was needed unless there was recurrent triggering, and advised conservative treatment and regular job duties. (Px8).

The eighth alleged date of accident is June 12, 2009 (10 WC 46790). On that date Petitioner alleges that she slipped and fell. She initially wasn't certain about the incident her attorney was questioning her about, indicating "Because I had so many" falls, and that she "had a lot of falls on the slippery floor." (Tr. 81-82). She stated that the floor was slippery near the reception area, her foot twisted and she fell to her knees, using her right hand to hold on. Her attorney noted to her that the medical records indicated she fell on both hands. She could not recall if she was off work after this, noting she had been off work so much. (Tr. 83-88).

The ninth alleged accident date is October 6, 2009 (10 WC 46791). Petitioner testified that she saw Dr. Mercier that day (Tr. 79-80), and his report indicates Petitioner was doing well following right carpal tunnel and 3rd trigger finger releases, but complained of the development of triggering in the right 4th finger and paresthesias distal to the PIP joint of the right 4th and 5th fingers. (Px8). Medrol dosepak was prescribed, and Petitioner was to follow up in three weeks, noting she was continuing to work. (Px8).

The tenth alleged date of accident is November 19, 2009 (10 WC 46792). Petitioner saw Dr. Mercier that day, reporting inflammation to her right 4th and 5th fingers. The doctor noted she

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"might have some early inflammatory problems in this area prior to triggering." The report noted a repeat EMG had been performed and repeated normal, showing improvement versus the previous study. Petitioner and Dr. Mercier had a long discussion regarding treatment options, which were not noted in the report, and Petitioner was to return if necessary. (Px8).

The eleventh alleged date of accident is March 6, 2010 (10 WC 46793). A review of the testimony and evidence in the record indicates no significance to this date.

The twelfth alleged date of accident is August 25, 2010 (10 WC 46794). The Petitioner visited Dr. Levi at the Orthopaedic and Rehabilitation Center on that date. She first sought treatment there on April 26, 2010. She reported complaints of bilateral hand numbness in the median nerve area, and triggering in the left 4th finger. (Px6). She also complained of on and off neck pain at night. While prescribing a repeat EMG and cervical x-rays, Dr. Levi opined that Petitioner would need a left 4th trigger finger release as well as possible bilateral carpal tunnel releases.

The thirteenth and final alleged date of accident is October 1, 2010 (10 WC 46795). Petitioner returned to Dr. Levi on that date complaining of locking of the left fingers. Dr. Levi indicated he did not see triggering. The Petitioner reported to Dr. Levi that her condition was work related, and that she had been treated through workers compensation by Dr. Mercier. Petitioner reported that a prior 3rd finger injection didn't work, and she just wanted surgery. Dr. Levi questioned why workers' compensation would not cover this if, as Petitioner indicated, they had covered the prior treatment, as it was part of the same problem. (Px6).

Other than the alleged slip and fall incident of June 12, 2009, each of the noted alleged accidents apparently involve claims for repetitive trauma. (see Tr. 163-164). The Petitioner did not testify to any other specific trauma to her hands, wrists or arms. As noted above, we affirm the Arbitrator's denial of the June 12, 2009 accident.

With regard to the alleged repetitive trauma injuries, the Commission finds that the Petitioner has failed to prove that she sustained repetitive trauma injuries which arose out of and in the course of her work duties while employed with Respondent.

Petitioner initially testified that 80% of her day was spent performing handwriting, while the other 20% was answering phones. (Tr. 36-39, 164-165). She indicated that, in working to assist Respondent's customers with bill payment issues, she would be involved with preparing a variety of monetary benefit applications on their behalf. (Tr. 39-42). She then testified that it was possible that she reported to Dr. Husain on October 3, 2007 that she typed at work for 8 hours per day. (Tr. 47-49). However, on cross examination she indicated she didn't recall telling Dr. Husain that she spent 80% of her day on the computer, "because it was a lot of writing." She did agree that she would not use her left hand when handwriting. (Tr. 195-197).

Petitioner testified that she also has to take care of "walk-in" customers which involves a lot of computer work. (Tr. 49-50). Petitioner testified that she would always discuss her work duties with Dr. Mercier when she would visit him, and that she complained she did too much handwriting. (Tr. 73-78).

On cross examination, Petitioner testified that she had no problems with her hands until 2007. (Tr. 164). She worked the 8 a.m. to 4:30 p.m. shift, with an hour lunch. She testified that sometimes mornings would be slower, and sometimes afternoons would be. She would invite the client/customer into her office, discuss their billing issue and determine how she could assist. She would counsel them on payment assistance programs that she felt they could qualify for. Sometimes they would come in with forms that were prepared, sometimes she would review and explain them to the client/customer, and other times she would prepare the forms herself. Sometimes they would pay the bill with Petitioner, other times she would walk them to a cashier.

When the bill system was down, which she indicated was "a lot", she walked any paying client/customers to a cashier. When she discussed an account with a client/customer, she pulled up that client/customer's account by entering a 7 digit number, and navigated the account via a mouse and keyboard. She reviewed account comments to determine the client/customer's prior discussions with her office, and entered notes regarding the current discussion. When she assisted in completing a form, she asked the client/customer salient questions in order to do so. (Tr. 166-176).

Petitioner would speak with other counselors and co-workers during the workday. She did not have to complete applications or forms for every client/customer she would see, noting they would sometimes come in to pick up forms or to ask a question, but she would have to enter notes into that person's account regarding the interaction. (Tr. 176-178).

Petitioner testified that her phone rang the entire day, and that Respondent wanted her to answer the phone even if she was meeting with a client/customer. Petitioner agreed that 12 to 20 calls per day sounded correct. Often a lot of questions were asked, and some callers kept her on the phone for a long time. She reviewed the caller's account on the computer where appropriate. Petitioner also took a number of internal phone calls. (Tr. 188-192).

Petitioner testified to preexisting conditions including fibromyalgia, stroke, anxiety and depression. (Tr. 154-158). Petitioner denied telling Dr. Mercier that she had feelings of numbness in half of her body in 2009, or being referred to a neurologist, stating she only saw her primary care physician for this. (Tr. 199-201). The October 27, 2009 report of Dr. Mercier states that Petitioner reported a numb feeling throughout the entire left side of her body, and that she was advised to have Dr. Pearson refer her to a neurologist for same (Px8).

Petitioner's supervisor, Socorro Torres, testified that Petitioner was one of three financial counselors under her supervision. Petitioner came into work at 8 a.m., go for coffee, and then went back to start her computer, which could be 20 to 30 minutes later. As to the job, counselors

introduced themselves to the client/customer, brought them into their office and reviewed their account by entering a 7 digit number on the computer. She noted they could have a billing issue, or be dropping off an application or other documentation. After reviewing their issue, the counselor discussed the steps needed to resolve the issue. (Tr. 7-15). The counselor then documents the visit by entering notes into the computer regarding the issue and what was done to resolve it. A counselor could also enter a payment if paid by credit card, but Torres testified Petitioner would generally give the information to a cashier to enter. (Tr. 15-17). Petitioner would sometimes visit with cashiers or other coworkers, and she would have a one hour lunch break. (Tr. 25-26).

Torres testified that counselors would on average see 15 to 25 client/customers per day, with Mondays and Fridays being the busiest days. She felt that Petitioner took longer than other counselors because she would not be ready to work at her desk by 8 a.m., and "it kind of backlogs everything else." (Tr. 26-28).

Torres testified that the applications in Respondent's Exhibit 5 and 6 were the most frequent forms used by financial counselors. The Medicaid application was completed by the counselor by hand or on the computer, and the counselor went through it with the client/customer to answer the questions. The client/customer completed the Charity Care applications themselves and reviewed them with the counselor, unless the patient needed assistance. (Tr. 17-21). Counselors would also receive phone calls. When a call was received regarding the cost of medical procedures, the counselor would look it up on the computer or obtain a master list from a cashier. Callers would also inquire about billing issues, which the counselor could review within their account. If called regarding charity applications, the counselor mailed out any documents the caller might need. (Tr. 21-24).

On cross examination, Torres testified that she was not around Petitioner on a daily basis. She would bring Petitioner and other counselors mailed-in applications, and after the counselors worked on them, she would review them for the Charity Committee. She agreed she had not been critical of Petitioner's performance in yearly reviews. (Tr. 43-45).

Petitioner testified that she declined to use a telephone headset that Respondent provided to her "because they slide", and it was uncomfortable. (Tr. 193-194). Torres testified that she did not recall Petitioner indicating this to her. (Tr. 56)

As noted, Respondent's Exhibits 5 and 6 contain examples of some of the forms/applications Petitioner testified she and/or her client/customers would generally complete, including Medicaid, Public Aid and Charity Care. The longest of these forms, significantly longer than the others, was the one for Public Aid. When Petitioner was asked if it was accurate that she only had to do one to two Public Aid applications per day, she indicated she was unable to answer the question, and that "if it wasn't one thing, it was another taking up the time." (Tr. 178-183). Petitioner also testified that when an outside vendor was brought in to assist with Public Aid applications, this didn't impact her job at all. (Tr. 193-194).

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Dr. John Fernandez examined Petitioner at the Respondent's request pursuant to Section 12 of the Act. Petitioner reported her upper extremity symptoms, and indicated that the symptoms increased when she was working. She described her work for Respondent involved primarily computer operation and handwriting. Dr. Fernandez testified that Petitioner reported her job involved a combination of clerical tasks, including paperwork, computer and telephone use. The Petitioner demonstrated her hand and arm positions to Dr. Fernandez. He diagnosed right ring finger tenosynovitis/trigger finger, and bilateral hand numbness of unknown etiology. As such, he could not link her work exposure to the development of symptoms. Out of five possible levels of scientific evidence, with the most scientific level being 1 and the least scientific being 5, he testified: "there's never really been a level of evidence above 3 or 4 that has linked carpal tunnel syndrome to things like data entry and keyboarding." (Rx2).

Dr. Fernandez opined that none of Petitioner's job duties - including keyboarding, handwriting, phone use and paperwork – in and of themselves cause carpal tunnel or trigger fingers. As such, he recommended that testing be performed to determine another possible cause, including things like multiple sclerosis, peripheral neuropathy, or a stroke. On cross examination he added that there are studies linking forceful gripping and grasping to conditions like carpal tunnel or trigger fingers, but that handwriting does not involve such forceful gripping. He explained how typing does not impact the flexor tendons in a way that would be similar to gripping. He also testified that "referred" paresthesias and numbness can happen in people with fibromyalgia or myofascial pain syndrome. The negative EMG testing by Dr. McGonagle (Rx3) further supported his opinion that there was no neurologic explanation for Petitioner's conditions. (Rx2).

The main physicians treating Petitioner in this case were Dr. Mercier (Px8) and the two Drs. Levi (Px6). While Dr. Mercier noted the Petitioner's description of her work duties, the Commission could not locate any opinion from him as to whether the conditions he treated were causally related to these job duties. In fact, Dr. Mercier at various times indicated he believed Petitioner's symptoms were mainly musculoskeletal in nature (January 26, 2009 EMG/NCV), that she had numb feelings throughout the entire left side of her body (October 27, 2009), that Petitioner specifically requested disability from work (August 23, 2012 and November 3, 2012), that it wasn't reasonable for Petitioner to consider social security disability based solely on her upper extremity conditions (September 17, 2012) and that "she is not interested in surgery. She is just interested in getting off work." (November 13, 2012). (Px9 & 10).

The only comment on causation we noted in the records of Dr. Roberto Levi and Dr. Gabriel Levi indicated that Petitioner stated that her condition was work related, that she had been treating through workers compensation with Dr. Mercier, and that it was not understood why further treatment was not being covered if the initial treatment was, as they involved the same conditions (October 1, 2010). Additionally, their record of December 27, 2011 indicates that there was no objective explanation for Petitioner's ongoing bilateral hand pain and weakness, and the physical therapist in June, 2011 indicated Petitioner was being examined for

fibromyalgia, that her pain had gone up her arm into the neck, and that she had more pain than would have been expected. Dr. Pearson, Petitioner's primary care provider, noted multiple issues with anxiety in Petitioner, involving both work and her personal life, going back to 2007. (Px9 & 10).

In reviewing the medical records, it appears that there is no opinion that truly ties Petitioner's alleged conditions to her work activities. There are definitely entries indicating Petitioner's belief that this was the case, but the evidence does not support her beliefs.

The Commission also wishes to note the difficulties that were created in this case by the Petitioner's decision to file twelve separate claims for essentially the same alleged repetitive trauma accident. While caution in pleadings is understandable, the result in this case appears to have been significant confusion in the testimony, including no evidence even being presented regarding the basis for at least two of these claims. There is nothing that would bar the Commission from making a determination of the proper accident date in this case, and modifying any claimed dates of accident to comport with the evidence presented. The multiple claimed accident dates ended up significantly muddying the record.

The Petitioner's testimony and reports to her physicians of how often she did various activities at work was conflicting, confusing and, ultimately, lacked credibility. The Petitioner has the burden of proving her case by the preponderance of the evidence. She failed to do so. She testified that she spent 80% of her day handwriting, but indicated to medical providers that she spent 80% of her day on the computer. She indicated that the preparation of various forms was an onerous burden on her. In reviewing the forms, none appear to involve significant data entry. Rather, the Petitioner completed these forms while reviewing the questions with her client/customers. It varied as to whether she was completing the forms or the client/customer was in any given situation. It appears to the Commission that she had a clerical job with varied activities, and relatively minimal data entry and handwriting. Additionally, the Petitioner indicated she would often be on the phone. Her testimony that her employer wanted her to answer phone calls while she was meeting with clients, noting that this would make either the person on the phone or the person in her office uncomfortable, does not make credible sense to the Commission. She was offered a telephone headset to use, but declined this because she said it slipped off her head. The idea that this could not somehow be adjusted is not believable. These allegations by Petitioner instead appear to the Commission to be a purposeful attempt to create facts to better support and augment her workers' compensation claim.

The Commission takes note of the tone of the Petitioner's testimony. It was consistently combative. This tone added to the Commission's belief that Petitioner is not credible. That combative tone must be viewed in light of the voluminous medical records that do not support the Petitioner. Essentially, our understanding of Petitioner's testimony is that she was always busy using her hands and arms to do one thing or another. This, in itself, does not prove a repetitive trauma injury impacting the wrists and arms.

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It is the finding of the Commission that the Petitioner failed to prove that she sustained an accidental injury, either traumatic or repetitive, on any of the thirteen alleged dates of accident by a preponderance of the evidence.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Petitioner has failed to prove that she sustained accidental injuries arising out of and in the course of her employment on any of the alleged accident dates at issue in the consolidated cases that are part of this decision. Based on this finding, the Commission further vacates the Arbitrator's awards of TTD, medical expenses and permanent disability benefits.

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

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

The 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:
TJT: pvc
O 09/1/15
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NOV 2 - 2015

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ECHEVARRIA-ORTA, NORMA
Employee/Petitioner

ADVOCATE ILLINOIS
Employer/Respondent

Case# **10WC016559**

10WC046784
10WC046785
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10WC046795

On 8/5/2014, 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 0.05% 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:

0206 GAINES & GAINES
GEORGE L GAINES
PO BOX 6345
EVANSTON, IL 60202

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
CHRISTOPHER GIBBONS
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

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STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

NORMA ECHEVARRIA-ORTA,
Employee/Petitioner

Case # 10 WC 16559

v.

Consolidated cases: 10WC46784-9; 10 WC 46790-5 see page 3

ADVOCATE ILLINOIS MASONIC MEDICAL CENTER,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **LYNETTE THOMPSON-SMITH**, Arbitrator of the Commission, in the city of **CHICAGO**, on **March 18, 2014 & May 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

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FINDINGS

On **11/6/2007**, 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*** not sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned $**45,030.96**; the average weekly wage was $**865.98**.

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

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

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

Respondent is entitled to a credit of **$16,500.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $577.32 from March 19, 2009 through May 3, 2009; from August 26, 2010 through December 8, 2010; October 25, 2012 through January 1, 2013, representing 37 weeks.

Respondent shall pay Petitioner permanent partial disability, in the amount of $519.59 for 102.5 weeks, as Petitioner's injuries caused 30% loss of use of the right hand and 20% loss of use of the left hand, pursuant to Section 8(e) of the Act.

Respondent shall pay to Petitioner the following amounts for medical bills pursuant to Sections 8(a) and 8.2 of the Act: Advanced Ambulatory Surgical Center, $16,500; Orthopedic & Rehab Center, $176.89; and Chicago Ortho Sports Medicine, $136.80.

Respondent shall be given a credit of $16,500.00, for benefits paid to Petitioner pursuant to 8(j) of the Act and $5,375.88 for non-occupational disability benefits paid to Petitioner pursuant to the Act.

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

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

15IWCC0813

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

	)	Case Nos.
Norma Echevarria-Orta	)	10 WC 16559,
	)	10 WC 46784,
Petitioner,	)	10 WC 46785,
	)	10 WC 46786,
vs.	)	10 WC 46787,
	)	10 WC 46788,
Advocate Illinois Masonic Medical	)	10 WC 46789
Center	)	10 WC 46790,
Respondent.	)	10 WC 46791,
	)	10 WC 46792,
		10 WC 46793,
		10 WC 46794 &
		10 WC 46795

FINDINGS OF FACTS

The disputed issues in these matters are: 1) accident; 2) causal connection; 3) medical bills; 4) temporary total disability; and the nature and extent of Petitioner's injuries. *See,* AXs 1-13.

Ms. Norma Echevarria-Orta, ("Petitioner"), worked for Advocate Illinois Masonic Medical Center, ("Respondent") for thirty-three (33) years as a financial counselor; and in that position she assisted patients with medical bill payment issues, insurance issues, Public Aid applications, and the charity care processes. The petitioner initially testified that she spent 80% of her day writing, using a pen and paper; and the other 20% setting up applications and filing documents. The petitioner testified she began noticing hand pain in 2007 and that she never had hand pain before that time.

***10 WC 16559, date of accident, June 6, 2008; 10 WC 46784 date of accident October 3, 2007;* 10 WC 46785, date of accident, October 26, 2007; 10 WC 46786, date of accident November 7, 2007; 10 WC 46787, date of accident, November 16, 2007**

Petitioner testified that she initially began to notice numbness in her right hand with "sticking" of the index and middle fingers. On October 3, 2007, she presented to Dr. Lulu Hasain of Employee Health at Illinois Masonic Hospital. An "Employee Report of Occupational Illness" was prepared and the doctor wrote that the hand was very painful, and that Petitioner complained of not being able to move the middle finger. Dr. Hasain further noted that Petitioner worked "eight hours per day typing on the computer at work." Trigger finger and pain in the inner hand was noted, and the petitioner was 'referred to occupational health. Citing work duties, and noting improvement after rest, the doctor ordered Petitioner to avoid use of the middle index finger. Petitioner returned to the clinic on October 26, 2007, at which time Dr. Serena Satcher wrote that Petitioner should wear a splint at night, massage the hand during the day and completely stop using the right hand for her activities at work. There was an indication that the doctor discussed Petitioner's situation with her supervisor and the petitioner was also advised to follow up with an orthopedic doctor. The petitioner was to avoid typing and use of her right hand. PX4, pgs 22-25

Petitioner testified she then sought treatment in the Occupational Health Department for her hand pain. The records indicate that on November 6, 2007, Dr. Satcher referred the petitioner to Dr. Mercier to address complaints of hand pain. Dr. Mercier diagnosed Petitioner with right middle finger tenosynovitis and administered a steroid injection. Petitioner continued to follow up with Dr. Mercier, complaining of numbness in both upper extremities. In November of 2007, Dr. Mercier, then diagnosed Petitioner with bilateral carpal tunnel syndrome and recommended an EMG study. The petitioner continued to work full duty while undergoing this treatment.

Citing Petitioner's work duties as a cause of her condition, Dr. Mercier examined her hand and treated her with cortisone injections into the MP joints of the ring and long fingers on the right. He diagnosed trigger finger of the right third finger, early tenosynovitis of the fourth finger and carpal tunnel syndrome. An EMG was ordered. PX8, pgs. 28-29

10 WC 46787, date of accident, November 16, 2007; 10 WC 46788, date of accident, June 19, 2008; 10 WC 46789, date of accdent october 7, 2008; 10 WC 46790, date of accident, June 12, 2009; 10 WC 46791, date of accident, October 6, 2009; 10 WC 46792, date of accident, November 19, 2009.

As of June 2008, Dr. Mercier found that Petitioner's complaints persisted and a Medrol Dosepak was prescribed. He advised either surgery, re-injection or living with the condition. Petitioner underwent physical therapy thereafter.

She returned to Dr. Mercier in June of 2008, complaining of intolerable pain in her left hand. A Medrol Dosepak was prescribed, and surgery, re-injection or "living with it" was advised. On June 19, 2008, Petitioner presented to Dr. Mercier for another cortisone injection into her right ring finger and he diagnosed her with trigger finger. Dr. Mercier recommended occupational therapy of which

Petitioner had six sessions. Those records indicate that Petitioner complained of pain and stated she could not write much and the computer made her hands tired. PX4; PX5; & PX8 p. 27.

The subsequent physical therapy notes indicate that Petitioner was discharged in August 2008, having experienced improvement in her symptoms and having been minimally compliant with her home exercise program. PX5.

In October of 2008, Petitioner's left hand complaints continued, including pain at the base of the thumb, the volar aspect of the thumb and the index and long fingers. Dr. Mercier characterized this condition as early tenosynovitis. He ordered additional, conservative care, finding that Petitioner might need surgery in the future, but at this point, she did not. Throughout this time, Petitioner continued to work. Dr. Mercier saw Petitioner again and noted that she may be developing early arthritis in the hands and the beginning of triggering in two other fingers. PX8 pgs. 15-27.

The petitioner underwent an EMG study on January 26, 2009, which was normal, although Dr. McGonagle noted that there could be minimal carpal tunnel in the right wrist. PX3.

On March 14, 2009, Petitioner underwent right carpal tunnel and trigger finger releases, with post-operative physical therapy. She returned to work on May 4, 2009, in a full duty capacity.

By October 6, 2009, Petitioner had developed another trigger finger on the right ring finger, with paresthesias, distal to the PIP joint of the right fifth finger. On October 27, 2009, the petitioner saw Dr. Mercier, complaining of numbness in her entire left side of her body starting from her head and through her toes. Dr. Mercier then referred Petitioner to Dr. Pearson for a neurology consult, which results were inconclusive. PX8-9.

On February 10, 2010, Petitioner attended an independent medical evaluation with Dr. John Fernandez. He diagnosed Petitioner with bilateral hand numbness and tingling with an unknown etiology; and he also diagnosed her with A-1 stenosing tenosynovitis of the right ring finger. He opined Petitioner's hand complaints were not caused by her work activities. RX2.

10 WC 46793, date of accident, March 6, 2010; 10 WC 46794, date of accident, August 25, 2010; 10 WC 46795, October 1, 2010.

Petitioner next followed up with Dr. Mercier on March 16, 2010, where she complained of continued pain in the right hand as well as left hand carpal tunnel symptoms. Dr. Mercier then referred Petitioner to Dr. Nagle for a second opinion however, Petitioner never presented to him. PX8.

Rather, Petitioner sought treatment with Dr. Yvonne Curran on April 23, 2010. Her examination of Petitioner revealed signs of segmental myoclonus. On April 26, 2010, Petitioner saw Dr. Robert Levi, who indicated that he had the suspicion that she had carpal tunnel syndrome. PX5.

A subsequent May 17, 2010 EMG study was normal. Dr. Curran saw Petitioner again on June 6, 2010, who confirmed her findings of spinal myoclonus. She ordered an MRI study of Petitioner's cervical and thoracic spine. That study revealed degenerative changes in the thoracic spine and cervical spine.

On August 25, 2010, Petitioner again presented to Dr. Levi, complaining of left hand, left middle finger and left ring finger pain. Dr. Levi noted that the most recent EMG study was negative, but stated that he found clear symptoms of carpal tunnel syndrome in Petitioner's right hand. He noted the petitioner had not been taking the prescribed anti-inflammatory medication and he issued Petitioner an off-work slip. Also, he did not understand why her workers' compensation claim had been denied as he as treating this problems as a continuation of Petitioner's initial complaints. PX6.

Petitioner followed up with Dr. Levi on October 1, 2010. At this examination, he diagnoses Petitioner with bilateral carpal tunnel syndrome and trigger finger of the right ring finger. Petitioner subsequently refused an additional injection into the hand.

On October 25, 2010, Petitioner underwent a right ring finger trigger release with Dr. Levi and then followed up with physical therapy. She was returned to work on a restricted basis on December 8, 2010.

On February 22, 2011, Dr. Levi noted he believed Petitioner had persistent bilateral carpal tunnel syndrome but further indicated that she had disc bulging in the cervical spine.

On June 1, 2011, Petitioner saw Dr. Tambar for a rheumatologic consult. He concluded that Petitioner's complaints of pain were more likely to be fibromyalgia than an autoimmune disease. He prescribed medication and requested a follow up in two months. On June 27, 2011, Petitioner saw Dr. Rana for a pain consult. Dr. Rana recommended Petitioner undergo an epidural steroid injection to her cervical spine.

In May and July of 2011, Petitioner followed up with Dr. Levi who now was stating Petitioner's symptoms were a result of cervical radiculopathy.

Petitioner then missed the next six follow-up appointments with Dr. Levi. In December of 2011, Dr. Levi reviewed Petitioner's MRI films and attempted to address her complaints of bilateral hand pain and weakness. Dr. Levi concluded that he did not see any objective findings on her MRI or clinical examination to indicate why she would have bilateral hand pain and weakness. However, it was his

opinion that a negative EMG did not deny pathology; a positive EMG only confirms it; and that the MRI of the cervical region, ruled out that area being the problem. PX6, pg. 110.

Petitioner then sought treatment in August and September of 2012 with Dr. Mercier. She continued to complain of hand pain and it was noted that she was working in a full duty capacity. She requested that Dr. Mercier find her disabled from employment. Dr. Mercier ordered another EMG/NCV study to address her complaints. This study was also normal on the right side and demonstrated mild carpal tunnel syndrome on the left side. The petitioner indicated to Dr. Mercier she was concerned with her ability to work and was applying for Social Security disability. Dr. Mercier noted that her hand condition would not qualify her for Social Security disability. PX8.

In November 13, 2012, Dr. Mercier noted that "the patient comes in today with disability forms.... She is not interested in surgery. She is just interested in getting off work. The patient has been disabled by her internist and is wanting confirmation of her disability. We did fill out a FMLA form." The doctor ordered an MRI of both hands and stated that she was disabled for short-term disability, possibly one month". PX8.

On January 3, 2013, Petitioner saw Dr. Mercier, complaining of severe pain and requested a decrease in her work restrictions from six hours per day to allow her to work eight hours a day. Dr. Mercier noted the petitioner's orthopedic tests were "coming back fairly normal with only mild carpal tunnel syndrome of the left".

At trial, the petitioner testified that she developed hand pain and numbness in 2007. She also stated that she did a lot of work on the computer. She did note that she was right-handed and would write with her dominant hand. However, she also noted that due to pain in that hand, she would do other things with her left hand. The petitioner testified she had a hard time blow drying her hair and opening medicine bottles due to hand pain. She also complained of back and knee pain. Although the petitioner initially testified she used her hand for writing 80% of her working day, she also gave a detailed description on cross-examination of her job duties, which involved meeting with patients and counseling them regarding medical bill issues. She would look up the accounts of each patient and talk to him or her as they sat by her desk. She would assist them by asking questions and filing in the answers in the appropriate forms. Some of the forms used were entered into evidence as Respondent's Exhibits 5 and 6.

The petitioner also answered the telephone and counseled patients over the telephone. She also reviewed mail and answered mail related to financial counseling. The petitioner worked from 8:00 a.m. until 4:30 p.m. She had a one-hour lunch break. She would also interact with co-workers during the day, according to Petitioner only for work-related issues.

The petitioner used her hands to write, use a computer and manipulate paper in an office setting. The petitioner testified she would fill out one to two Public Aid applications per day, perhaps help with eight to ten charity care applications per day and would answer between 12 and 20 phone calls per day.

Petitioner did testify that she advised her doctors her job involved extensive writing and use of a keyboard. In addition, the petitioner did testify to one specific trauma accident. On June 12, 2009, she fell while walking to the cafeteria. According to the petitioner, she was not carrying anything and she fell to her knees.

Respondent's Witness

The petitioner's supervisor, Socorro Torres, testified that she was the direct supervisor of the petitioner and had been so since 1994 or 1995. She testified that she was familiar with the duties of a financial counselor and, in particular, with the work activities of the petitioner. She corroborated the petitioner's testimony regarding her job activities. She stated financial counselors would use their hands to look up account information on the computer, input notes regarding patient accounts, use a pen to fill out forms and perform all of the other hand activities associated with clerical work. She also testified that the petitioner would fill out one (1) to two (2) financial aid forms per day, field twelve (12) to twenty (20) phone calls per day, process mail and interact with co-workers. Ms. Torres described the pace at which the petitioner worked as being slower than that of other financial counselors. She also testified that the petitioner would get coffee at the start of her shift and would have trouble with her computer. The petitioner also testified that her computer frequently crashed and that she was unable to work with the computer during those periods. Petitioner testified that she considered this witness to be personally biased against her.

On February 10, 2010, Respondent sent the petitioner to Dr. John Fernandez for an independent medical evaluation. Dr. Fernandez diagnosed Petitioner with 1) bilateral hand numbness and tingling, etiology unknown; and 2) right ring finger A-1 stenosing tenosynovitis. Dr. Fernandez opined that Petitioner's hand complaints were not related to her work activities as her medical condition was not consistent with any workplace trauma and her job duties were not associated with the development of carpal tunnel syndrome or stenosing tenosynovitis. He also testified that he recommended Petitioner undergo a complete physical examination in order to investigate any systemic causes of her complaints, such as multiple sclerosis, peripheral neuropathy or stroke, noting Petitioner's history of prior strokes. Following this independent medical evaluation, Respondent sent Petitioner a letter indicating no additional benefits would be paid pursuant to the Workers' Compensation Act.

The records of the disability council indicate that they paid non-occupational benefits for several periods as Petitioner continued to treat with Dr. Mercier.

Petitioner also introduced the testimony of Susan Entenberg, her vocational counselor. Ms. Entenberg testified that she interviewed Petitioner once by telephone and authored a report in which she opined the petitioner was totally, permanently, disabled from working due to her age, experience and physical restrictions.

15IWCC0813

CONCLUSIONS OF LAW

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

The Illinois Supreme Court has held that a claimant's testimony standing alone may be accepted for the purposes of determining whether an accident occurred. However, that testimony must be proved credible. *Caterpillar Tractor vs. Industrial Commission*, 83 Ill.2d 213, 413 N.E.2d 740 (1980). In addition, a claimant's testimony must be considered with all the facts and circumstances that might not justify an award. *Neal vs. Industrial Commission*, 141 Ill.App.3d 289, 490 N.E.2d 124 (1986). Uncorroborated testimony will support an award for benefits only if consideration of all facts and circumstances support the decision. *See generally, Gallentine v. Industrial Commission*, 147 Ill.Dec 353, 559 N.E.2d 526, 201 Ill.App.3d 880 (2nd Dist. 1990), *see* also *Seiber v Industrial Commission*, 82 Ill.2d 87, 411 N.E.2d 249 (1980), *Caterpillar v Industrial Commission*, 73 Ill.2d 311, 383 N.E.2d 220 (1978). It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence, and assign weight to the witness' testimony. *O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253, 403 N.E.2d 221, 223 (1980); *Hosteny v Workers' Compensation Commission*, 397 Ill.App. 3d 665, 674 (2009).

It is axiomatic that the injured worker must prove by a preponderance of the weight of the evidence that her accident arose out of and in the course of her employment. The "arising out of" component speaks to risk and the needed association of an employment risk to the resultant injury. "For an injury to 'arise out of' the employment, its origin must be in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury [citations omitted]." *Caterpillar Tractor Company v. Industrial Commission*, 129 Ill. 2d 52, 58; 549 N.E.2d 665 (1989). This is true whether an injured worker is claiming injury due to a single identifiable trauma or due to a more insidious repetitive trauma. *Peoria County Bellwood Nursing Home v. The Industrial Commission*, 115 Ill. 2d 524; 505 N.E.2d 1026 (1987). In short, the petitioner's employment must be a causative factor.

In this case, as a financial counselor, the petitioner would sit at a desk and interact with patients, and also use a computer to look up their accounts and enter notes, and use a pen to fill out, or help fill out forms. The evidence showed that the petitioner would use her right hand to fill out Public Aid forms and process charity-care applications, on a daily basis. She handled approximately twelve (12) to twenty (20) phone calls per day, processed mail, and accepted payments. She testified that her job duties hurt her hands although there was testimony that and the work appeared to be self-paced and she was provided help, when there was a backlog of patients. She did this activity for thirty-three (33) years.

Regarding the medical evidence, Dr. Fernandez testified that claimant did not have carpal tunnel syndrome and that her hand pain and finger triggering were not the result of her work place activities. Petitioner presented the opinions of her treating doctors' testimony in support of her claims. An employee seeking benefits for gradual injury due to repetitive trauma must meet the same standard of proof as a claimant alleging a single, definable accident. *Nunn v. IWCC*, Ill. App. 3d 470; 510 N.E.2d 502 (1987). Claimant must prove a precise, identifiable date when an accidental injury manifested itself, i.e., the date on which both the fact of the injury and the causal connection to a claimant's work would have become plainly apparent to a reasonable person. *Nunn*, citing *Peoria County Bellwood.*

In this case, the petitioner's treating physicians took a history of her of hand pain being associated with her work duties, and they issued work restrictions.

The Arbitrator finds that the petitioner did establish that her job duties presented a risk of injury due to repetitive trauma. The Arbitrator finds that Petitioner proved, by a preponderance of the evidence, a causal connection between the condition of ill-being of her hands and her work place duties.

The Arbitrator further finds that Petitioner established that she sustained accidental injury arising out of and in the course of her employment with some cases; while other cases appear to be simply dates on which she had doctor's appointments.

On 1) October 3, 2007, 2) October 26, 2007, 3) November 6, 2007, Petitioner alleges injury and is treating for pain in her right hand; 4) on November 16, 2007, Petitioner simply followed-up with Dr. Mercier with a cortisone shot and physical therapy; and there was no accident, per se; 5) on June 6, 2008, Dr. Mercier was still treating the petitioner and advised surgery or for her to "live with it" as she had continued complaints; 6) June 19, 2008, appears to be a date that the petitioner presented for medical treatment; 7) on October 7, 2008, petitioner's left hand complaints began; 8) June 12, 2009, Petitioner slipped and fell on her knees. and this accident is not compensable; 9) October 6, 2009, Petitioner developed another trigger finger on the right ring finger; 10) November 19, 2009 was a follow-up with Dr. Mercier, who found inflammation in her right 4th and 5th fingers; 11) March 16, 2010 was another follow-up with Dr. Mercier; 12) on August 25, 2010, Dr. Mercier found development of trigger symptoms in Petitioner's left middle and ring fingers; and 13) on October 1, 2010, Petitioner presented to Dr. Levi with complaints for her 4th finger on her left hand sticking, as well as complaints of pain in her right hand.

The Arbitrator also finds that Petitioner failed to prove she sustained an accidental injury arising out of and in the course of her employment when she slipped and fell on June 12, 2009. No evidence of an employment risk was introduced.

It is within the province of the Commission to determine the factual issues, to decide the weight to be given to the evidence and the reasonable inferences to be drawn there from; and to assess the credibility of witnesses. *See, Marathon Oil Co. v. Industrial Comm'n*, 203 Ill. App. 3d 809, 815-16 (1990). And it is the province of the Commission to decide questions of fact and causation; to judge the credibility of witnesses and to resolve conflicting medical evidence. *See, Steve Foley Cadillac v. Industrial Comm'n*, 283 Ill. App. 3d 607, 610 (1998).

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

It is established law that at hearing, it is the employee's burden to establish the elements of his claim by a preponderance of credible evidence. *See, Illinois Bell Tel. Co. v. Industrial Comm'n.*, 265 Ill. App. 3d 681; 638 N.E. 2d 307 (1st Dist. 1994). This includes the issue of whether Petitioner's current state of ill-being is causally related to the alleged work accident. *Id.* A claimant must prove causal connection by evidence from which inferences can be fairly and reasonably drawn. *See, Caterpillar Tractor Co. v. Industrial Comm'n.*, 83 Ill. 2d 213; 414 N.E. 2d 740 (1980). Also, causal connection can be inferred. Proof of an employee's state of good health prior to the time of injury and the change immediately following the injury is competent as tending to establish that the impaired condition was due to the injury. *See, Westinghouse Electric Co. v. Industrial Comm'n*, 64 Ill. 2d 244, 356 N.E.2d 28 (1976). Furthermore, a causal connection between work duties and a condition may be established by a chain of events including Petitioner's ability to perform the duties before the date of the accident and inability to perform the same duties following that date. *See, Darling v. Industrial Comm'n*, 176 Ill.App.3d 186, 193 (1986).

Petitioner has proven, by a preponderance of the evidence, that her current condition of ill-being, regarding her hands, is causally related to her work.

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 for the Petitioner on the issues of accident and causal connection, the Arbitrator hereby finds that the medical services, which Petitioner received, were reasonable and necessary, based on the testimony elicited at trial and the treating records and deposition testimony in evidence. Specifically, Dr. Fernandez' characterization of the great difficulty Petitioner has with opening her hand and the significant loss of strength, Dr. Pearson's finding that Petitioner cannot perform work involving use of her hands to write and type extensively, and Petitioner's credible difficulty with activities of daily living suggests a condition warranting the care given to the petitioner.

The following bills are awarded with payment to be made pursuant to Sections 8(a) and 8.2 of the workers' Compensation Act (the "Act"): Advanced Ambulatory Surgical Center, $16,500; Orthopedic & Rehab Center, $176.89; and Chicago Ortho Sports Medicine, $136.80.

K. What temporary benefits are in dispute?

Petitioner claims entitlement to temporary total disability ("TTD") benefits from 3-19-2009 through 5-3-2009, 6-13-2009 through 7-16-2009, 8-26-2010 through 12-8-2010, 10-25-2012 through 1-1-2013, representing 44 & 1/7 weeks. The period of June 13, 2009 through July 16, 2009 is for the slip and fall accident which was deemed non-compensable. Respondent paid either TTD or benefits under Section 8(j) of the Act, for a portion of the claimed periods, totaling $17,239.20. It is the Arbitrator's determination that the Petitioner's time off work during most of these periods, was reasonable and necessary; and causally related to the work injury and aggravations. Her treating physicians took petitioner off work, for these periods, due to the injuries or aggravations, recent surgeries or Respondent's inability to provide work within Petitioner's restrictions. Therefore, Petitioner will be awarded temporary total disability benefits from 3-19-2009 through 5-3-2009, 8-26-2010 through 12-8-2010 and 10-25-2012 through 1-1-2013 representing 37 weeks. The parties had agreed that the respondent has paid $16,500.00 in medical bills through its group medical plan and $5,375.88 in non-occupational indemnity benefits. *See*, AX1, 2, 8, 9 & 13.

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

The Petitioner claims to be permanently, totally disabled, in the odd-lot category. Arbitrator finds that the Petitioner has not proven, by a preponderance of the evidence, that she is permanently, totally, disabled, pursuant to Section 8(f) of the Act. The Petitioner is awarded 30% of the right hand and 20% of the left hand.

15IWCC0813

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
10 WC 16559; 10WC46784-9; 10 WC 46790-5
SIGNATURE PAGE

L. Thompson

Signature of Arbitrator

August 5, 2014
Date of Decision

AUG – 5 2014

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

Geoffrey Anyagafu,
Petitioner,

vs. NO: 12 WC 06725

15IWCC0808

Chicago Carriage Cab Co. and the Illinois Guaranty Fund,
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 additional compensation and attorneys' fees and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The case was originally presented under Section 19(b) to Arbitrator Doherty. On May 8, 2012, the Arbitrator found Petitioner sustained an accidental injury arising out of and in the course of his employment on October 7, 2010. As a result Petitioner was temporarily totally disabled from October 7, 2010 through May 8, 2012 for 82-6/7 weeks, was entitled to the medical expenses to date and Respondent was responsible for paying for the physical therapy and for the hand surgery consultation recommended by Drs. Odeluga and Singh. Respondent was entitled to a credit of $44,855.00 for temporary total disability payments. While it was noted that Petitioner had not received temporary total disability benefits since December 1, 2011, no penalties petition was filed and no penalties were awarded. Respondent appealed the Arbitrator's decision and on December 31, 2012 the Commission affirmed the Arbitrator's decision.

A second Section 19(b) was filed and this case was again before Arbitrator Doherty. On January 29, 2014, Arbitrator Doherty issued a second decision in which she found that Petitioner

was temporarily totally disabled for an additional 26-1/7 weeks spanning from June 8, 2013 through December 17, 2013, Petitioner was entitled to the medical expenses to date and Respondent is liable for the care recommended by Dr. Coats. The Arbitrator found Respondent was entitled to a temporary total disability credit of $103,593.85, but the Arbitrator found Petitioner had not received temporary total disability since June of 2013 and as such was entitled to $5,460.00 for nonpayment of temporary total disability from June 18, 2013 through December 17, 2013, which was the date of second Section 19(b) Arbitration hearing. As a result of Respondent's failure to pay temporary total disability benefits Petitioner was awarded $5,460.00 under Section 19(l) of the Act, $9,622.13 under Section 19(k) of the Act, which represents 50% of the unpaid temporary total disability and $3,848.85 in attorneys' fees under Section 16 of the Act, which represents 20% of the unpaid temporary total disability.

On February 27, 2014, Respondent filed a Petition for Review placing at issue Section 19(l) and 19(k) penalties and Section 16 Attorneys' Fees.

On or about July 2014 Respondent's Insurance Carrier, Freestone Insurance Company, declared bankruptcy. Per the representation of the parties, the carrier was liquidated on August 5, 2014. The Illinois Guaranty Fund thereafter assumed the defense of Respondent. The stay has been lifted by the bankruptcy court and Respondent's Petition for Review is currently before the Commission.

Based on the above events along with reviewing the record and file for the above captioned claim, the Commission finds that it is in agreement with the arbitrator's assessment of additional compensation and attorneys' fees under Sections 19(l), (k) and 16 of the Illinois Workers' Compensation Act; However, given the language contained in Section 534.3 (b) of the Illinois Insurance Guaranty Fund Act, the Commission believes it is precluded from assessing additional compensation and attorneys' fees under Sections 19(l), (k) and 16 of the Act against the Illinois Insurance Guaranty Fund.

IT IS THEREFORE ORDERED that additional compensation and attorneys' fees under Sections 19(l), (k) and 16 of the Act, are hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $736.20 per week for a period of 26-1/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for all medical treatment and care recommended by Petitioner's treating physician to date, including the care recommended by Dr. Coats, pursuant to Sections 8(a) and 8.2 of the Act.

15IWCC0808

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.

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 $103,593.85 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: NOV 2 - 2015

MB/jm

O: 9/3/15

43

Marie Basurto

David L. Gore

Stephen Mathis

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

ANYAGAFU, GEOFFREY
Employee/Petitioner

Case# **12WC006725**

15IWCC0808

CHICAGO CARRIAGE CAB CO
Employer/Respondent

On 1/29/2014, 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 0.06% 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:

1067 ANKIN LAW OFFICE LLC
JOSHUA RUDOLFI
162 W GRAND AVE SUITE 1810
CHICAGO, IL 60654

2542 BRYCE DOWNEY & LENKOV LLC
BRIAN J HINDMAN
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

15IWCC0808

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)

GEOFFREY ANYAGAFU
Employee/Petitioner

v.

CHICAGO CARRIAGE CAB CO.
Employer/Respondent

Case # 12 WC 6725

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 **12/17/2013**. 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. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☒ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **10/7/2010**, 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 $**57,424.12**; the average weekly wage was $**1,104.31**.

On the date of accident, Petitioner was **45** years of age, ***married*** with **4** dependent children.

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

Respondent shall be given a credit of $**103,593.85** 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

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $736.20/week for 26-1/7 weeks, commencing 6/18/2013 through 12/17/2013, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 10/7/2010 through 12/17/2013, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $103,593.85 for temporary total disability benefits that have been paid.

Medical benefits

Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred to date in connection with the care and treatment of his causally related conditions pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid. SEE DECISION

Prospective Medical Care

Respondent shall authorize and pay for all medical treatment and care recommended by Petitioner's treating physicians to date, including the care recommended by Dr. Coats, pursuant to Sections 8 and 8.2 of the Act.

Penalties

Respondent shall pay to Petitioner penalties of $3,848.85 as provided in Section 16 of the Act; $9,622.13, as provided in Section 19(k) of the Act; and $5,460.00 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.

15IWCC0808

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 D. Merkley
Signature of Arbitrator

1/29/14
Date

ICArbDec19(b)

JAN 29 2014

STATEMENT OF FACTS

This matter was previously tried on May 8, 2012 on the Petitioner's Section 19(b) and Section 8(a) Petition for TTD benefits and medical care before this Arbitrator. A copy of the transcript of those proceedings was offered into evidence as Petitioner's Exhibit #1. The previous testimony is hereby incorporated into this hearing. The Arbitrator made specific findings in that previous hearing that were affirmed and adopted by the Illinois Workers' Compensation Commission (hereinafter "Commission") on December 31, 2012, a copy of which was offered into evidence as Petitioner's Exhibit #2. It was determined that the Petitioner's current condition of ill-being was causally related to his undisputed October 7, 2010 work injury. Further, the Commission made specific awards for medical bills, temporary total disability benefits (TTD), and prospective medical care in the form of physical therapy and a hand surgery consult. (Pet. Ex. #2)

The Petitioner testified that following the previous hearing he underwent physical therapy at ATI Physical Therapy from August 20, 2012 through December 5, 2012. (Pet. Ex. #4) The Petitioner sought follow up care with Dr. Odeluga, his primary care physician, on January 16, 2013. (Pet. Ex. #5) At that visit the Petitioner's medications were continued and the Petitioner was continued off work. (*Id.*)

The previous 19(b)/8(a) decision awarding prospective care in the form of physical therapy for Petitioner's left shoulder condition and a hand surgery consult for his right hand complaints was affirmed and adopted by the Commission on December 31, 2012 and the period for an appeal to the Circuit Court of Cook County expired on January 20, 2013. (Pet. Ex. #2)

On February 27, 2013 the Petitioner followed up with Dr. Odeluga and was referred to Dr. Robert Coats for an orthopedic evaluation due to continued diagnosis of left brachial plexopathy following a gunshot wound to the left side of his neck. PX 5. The Petitioner was again continued on his medication. PX 5. Petitioner saw Dr. Coats on March 15, 2013. PX 6. Dr. Coats noted that the Petitioner complained of tingling and numbness in both hand and pain in his left shoulder. (*Id.*) Dr. Coats diagnosed the Petitioner with left upper extremity brachial plexopathy, right carpal tunnel syndrome, left cubital tunnel syndrome, and left shoulder impingement and adhesive capsulitis. (*Id.*) Dr. Coats opined that the Petitioner would benefits from injections to both carpal tunnels and physical therapy for the left shoulder before determining whether or not surgery would be warranted for the shoulder. (*Id.*) Dr. Coats recommended an MRI of the left shoulder and placed the Petitioner off work. (*Id.*) X-rays taken of the left shoulder and cervical spine showed no acute findings and mild degenerative changes of the AC joint and cervical spine. PX 6.

On April 12, 2013 the Petitioner had injections performed by Dr. Coats to his right and left carpal tunnels, left cubital tunnel, and left shoulder. PX 6. Physical and occupational therapy was again recommended and the Petitioner was continued off work pending re-evaluation in 6 weeks. (*Id.*) Petitioner was prescribed Lyrica and Celebrex. PX 6.

On May 7, 2013 the Respondent sent the Petitioner for a Section 12 exam with Dr. Kenneth Candido, an anesthesiologist and pain doctor. RX 1, p. 4. Dr. Candido testified via

evidence deposition. (Rsp. Ex. #1) Dr. Candido reviewed Petitioner's prior medical records including the April 2012 EMG/NCV (previously relied upon by Dr. Singh in his diagnosis of brachial plexopathy presented at the first 19(b)8(a) hearing), the March 15, 2013 note from Dr. Coats and the x-rays taken on March 15, 2013 of Petitioner's cervical and left shoulder. RX 1, p. 20. Dr. Candido performed a physical exam of Petitioner noting abnormal findings of the left upper extremity, including a reduced range of motion. Dr. Candido found no evidence of atrophy in the muscles associated with a brachial plexus injury. RX 1, p. 30-32. Petitioner complained primarily of weakness of the left arm and pain in the left shoulder. RX 1, p. 33. Dr. Candido reviewed the EMG/NCV from 4/24/12 and determined that it showed "electrical evidence consistent for a brachial plexopathy with chronic evidence seen in the inferior trunk versus medial cord portion of the plexus and early acute changes suggestive in the proximal myotomes. There was also evidence of a superimposed left cubital tunnel syndrome and a mild carpal tunnel syndrome on the left. Right side, right wrist showed evidence of a severe carpal tunnel syndrome." When asked if he felt there was anything "peculiar" about these findings he responded "... the EMG findings showed an area of a lesion or a disruption or difficulty in the brachial plexus which was not consistent with my physical examination. My physical examination was consistent with an axillary nerve problem. That comes from a different area of the brachial plexus, primarily the posterior cord which was not identified by the EMG as having any involvement whatsoever and [sic] any brachial plexopathy. And also the symptoms and signs on examination were more consistent with a superior trunk problem from the C5 and the C6 cervical spine nerve roots. Again, these were not identified during the EMG/nerve conduction velocity study which, to me, was a disparity, meaning that my clinical findings did not correlate at all with the examination findings by the individual who conducted the EMG/nerve conduction velocity study. So I suggested that an independent neurological assessment might clarify this apparent disparity or discrepancy." RX 1, p. 34-35. Dr. Candido diagnosed "a left arm partial brachial plexopathy status post gunshot wound to the neck resolving or resolved." RX 1, p. 35. He further opined that this "resolved or resolving" brachial plexopathy is related to the gunshot wound to the neck." RX 1, p. 36.

Dr. Candido further agreed that Petitioner has bilateral carpal tunnel but that the condition is not related to the gunshot wound as carpal tunnel is peripheral neuropathy due to compression at the wrist level and not to an injury at the shoulder level or brachial plexus. RX 1, p. 37,52. He further agreed that Petitioner has cubital tunnel syndrome also not related to the gunshot wound as it is due to "double crush" syndrome which is an unrelated phenomena at play causing neurological disruption in the same nerve. RX 1, p. 38,52. Dr. Candido further noted that he found no atrophy on exam and that if Petitioner were suffering from a sustained significant neurological injury from the gunshot wound he would have severe atrophy of the upper extremity. RX 1, p. 38-39. Further, Dr. Candido found signs of symptom magnification when Petitioner refused to move his left arm on exam as compared to surveillance video evidence of Petitioner performing these maneuvers. RX 1, p. 39. The Arbitrator notes that Dr. Candido was given the same video of activity on 12/14/11 and 12/21/11 which was previously viewed and considered by the Arbitrator in the first Decision. Dr. Candido also took his own photos of Petitioner attached as deposition exhibits which depicted Petitioner performing maneuvers with both arms. Dr. Candido testified that Petitioner's depiction in these photos were inconsistent with what he saw Petitioner performing on video under surveillance. RX 1, p. 50. Finally, Dr. Candido determined that in his opinion Petitioner was able to drive and that he could

return to light duty while also undergoing an FCE to determine his precise limitations. RX 1, p. 44.

On cross-exam, Dr. Candido testified that he saw Petitioner driving his personal auto on the video and not a taxi. He further testified that Petitioner could return to his job as a cab driver although he was not provided a job description and did not know the requirements of a taxicab driver or the physical examination requirement. RX 1, pp. 59-60. Finally, Dr. Candido testified that Petitioner has "a limited function of the left upper extremity but the extent of which I don't think has been qualified or clarified due to the conflicting examination findings by myself, by his stated degree of limitation, and by what has been observed during the surveillance..." RX 1, p. 67

On May 24, 2013 the Petitioner followed up with Dr. Coats and reported some improvement in his shoulder and hand pain with the injections but only temporarily. (Pet. Ex. #6) Petitioner reported continued complaints of left shoulder pain, stiffness and weakness, as well as paresthesias in the left upper extremity. Petitioner was continued on Lyrica and Celebrex. Dr. Coats noted "He is still quite guarded with physical examination today. I really cannot do any significant passive range of motion to even fully assess strength and mobility in the left upper extremity, so I will have him continue with his medications and continue with therapy." Petitioner was to return in 6 to 8 weeks. RX 6. The Petitioner was again kept off work. (*Id.*)

The Petitioner testified that after receipt of Dr. Candido's Section 12 exam he did attempt to return to work. As a taxicab driver, he must pass a physical mandated by the City of Chicago. On July 29, 2013 the Petitioner saw Dr. Odeluga for the purpose of this physical. Dr. Odeluga performed a physical examination and completed a Physical Examination Certification certifying that the Petitioner is not capable of safely driving and operating a public passenger vehicle. (Pet. Ex. #7)

The Petitioner followed up with Dr. Coats on July 30, 2013. (Pet. Ex. #6) Petitioner reported continued left shoulder pain. Dr. Coats noted "left shoulder pain doing much better some pain off and on pain level ranges from 4-8 on certain movements to jut putting on a little pressure." PX 6. On exam, Dr. Coats noted, "visual inspection of the left upper extremity reveals o gross deformity or muscle atrophy. Active and passive range of motion is better and more tolerable since previous injection and therapy. He still has pain with impingement maneuvers and still has discomfort with Jobes testing." The diagnosis was left shoulder pain and impingement syndrome of left shoulder." Petitioner was again prescribed physical therapy and received another subacromial injection. The Lyrica was continued but the Celebrex was discontinued. Petitioner was to return in 4 to 6 weeks. Dr. Coats noted that if Petitioner was still symptomatic "we may need to order an arthrogram." PX 6.

The Petitioner testified that the Respondent has not authorized physical therapy and that he wishes to have it performed immediately. The Petitioner testified that he did receive TTD benefits for a period starting in February 2013 but that those benefits stopped in June 2013 when the Respondent received the IME report of Dr. Candido. According to ARB EX 1, Respondent paid TTD through 6/18/13. Petitioner testified that he wishes to get healthy and return to work.

The Petitioner testified that he feels worse at the present time than he did when he testified at the first hearing. The Respondent produced no witnesses at trial.

CONCLUSIONS OF LAW

F. WHETHER PETITIONER'S CURRENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY

The Arbitrator finds that the Petitioner's current condition of ill-being is causally related to the undisputed October 7, 2010 work injury. Pursuant to the Arbitrator's Decision in the first 19(b)/8(a) Petitioner's condition of ill-being, namely brachial plexopathy and right carpal tunnel, was found causally related to the gunshot wound at work. Accordingly, Petitioner was awarded prospective treatment in the form of continued physical therapy for the left shoulder and a hand surgery consult. Petitioner testified that he attended some physical therapy after the first Decision was rendered. Petitioner testified that he resumed treatment with Dr. Odeluga in February 2013 who referred him to Dr. Coats. Petitioner has continued to treat with Dr. Coats in 2013. PX 5, PX 6, PX 3. Respondent paid TTD through 6/18/13. ARB EX 1. The Arbitrator notes that Dr. Coats continues to treat Petitioner for the originally diagnosed left shoulder brachial plexopathy.

In connection with the first Section 19(b)/8(a) hearing Respondent sent Petitioner for a Section 12 exam with Dr. Virkus. Dr. Virkus opined that Petitioner's left shoulder pain and complaints were likely not related to the gunshot wound. In the first Decision, the Arbitrator placed greater weight on the proffered opinion of treating physician Dr. Singh who clearly and logically opined that the diagnosed the left shoulder brachial plexopathy and bilateral CTS following the EMG/NCV of April 2012 were causally related to the gunshot wound. Respondent sent Petitioner to another Section 12 exam on May 7, 2013, this time with Dr. Candido, a pain specialist and anesthesiologist. RX 1. Dr. Candido diagnosed "a left arm partial brachial plexopathy status post gunshot wound to the neck resolving or resolved." RX 1, p. 35. He further opined that this "resolved or resolving" brachial plexopathy is related to the gunshot wound to the neck." RX 1, p. 36. However, based on his exam of Petitioner and his comparison of the physical exam results to his viewing of the December 2011 surveillance video, he opined that Petitioner was at MMI for his left shoulder complaints and that he could return to driving a cab. Dr. Candido testified that Petitioner has "a limited function of the left upper extremity but the extent of which I don't think has been qualified or clarified due to the conflicting examination findings by myself, by his stated degree of limitation, and by what has been observed during the surveillance..." RX 1, p. 67.

In finding continued causal connection for Petitioner's left arm condition, the Arbitrator initially notes that Petitioner diagnosis of brachial plexopathy remains unchanged. Petitioner continues to need additional care authorized by Dr. Coats and continues off work per Dr. Odeluga. In light of the treating physician's opinions and Petitioner's credible testimony at trial regarding continued pain and inability to fully use his left arm, the Arbitrator finds the opinion of Dr. Candido on Petitioner's MMI status and his ability to return to driving a cab unpersuasive. The Arbitrator further notes that Dr. Candido based his opinion in part upon surveillance footage of the Petitioner operating a personal vehicle and moving about in December 2011. This surveillance is presumably the same footage produced at the first hearing in which this Arbitrator

found that the surveillance essentially bolstered the Petitioner's claim. The referenced dates of activity on the video in December 2011 correspond with the dates reviewed on video submitted at the first trial. The Arbitrator again notes that the surveillance viewed at the first trial showed the Petitioner operating his vehicle without using his left arm in any persuasive capacity as stated in the first Decision. The Arbitrator notes that no new video was submitted at the second trial and the video referred to by Dr. Candido was not introduced at his deposition.

Further, Dr. Candido opined that the Petitioner could return to work as a taxi cab driver based on his interpretation of Petitioner's movements in this referenced video and Dr. Candido's personal knowledge of the job requirements of a cab driver. Dr. Candido was not unaware of the physical exam necessary to be certified, nor did Dr. Candido have a formal job description available. Further, the fact that the Petitioner underwent this physical and failed lends credence to the Petitioner's credible testimony and the opinions of the Petitioner's doctors. The Petitioner's credible testimony that his condition has not improved since the previous hearing coupled with the limited amount of treatment received since the decision became final in February 2013 establishes that the Petitioner's current condition of ill-being is causally related to the undisputed October 7, 2010 work injury.

Accordingly, the Arbitrator's causation opinion has not changed since the first trial and the Petitioner's current condition of ill-being remains causally related to the undisputed work injury.

G. WHAT WERE THE PETITIONER'S EARNINGS?

The Petitioner's earnings were $57,424.12, yielding an average weekly wage of $1,104.31. This is the wage that was agreed upon in the previous hearing. (Pet. Ex. #2). The issue of wage was accordingly not addressed on review to the Commission. Respondent produced no new or additional contrary evidence on this issue at this second trial. Further, the Respondent is estopped from raising this issue as it was previously decided in a hearing between the same parties and same controversy.

J. WERE THE MEDICAL SERVICES PROVIDED TO THE PETITIONER REASONABLE AND NECESSARY AND HAS THE RESPONDENT PAID ALL APPROPRIATE CHARGES, AND K. IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE

Respondent objected to the issue of medical expenses based on liability and specifically on the opinion of Dr. Candido. ARB EX 1. Based on the Arbitrator's findings on the issue of continued causal connection, the Arbitrator further finds that the Petitioner's medical treatment has been reasonable and necessary and the Respondent has not paid all appropriate charges. The Petitioner was specifically awarded a hand surgery consult and physical therapy in the previous trial. (Pet. Ex. #2) Following that trial the Petitioner underwent physical therapy with ATI Physical Therapy. (Pet. Ex. #4) Once the previous decision became final, Petitioner continued his care with Dr. Coats in February 2013 for his left shoulder and carpal tunnel complaints. PX 6. The Petitioner has undergone the exact treatment that was previously awarded by the Arbitrator and affirmed by the Commission. As that Decision is final, the Respondent cannot attempt to attack the reasonableness or necessity of the treatment previously awarded. Accordingly, the Arbitrator finds that Respondent is to pay Petitioner the reasonable and

necessary medical expenses incurred in the care and treatment of his casually related conditions as previously awarded in the first trial as well as the expenses incurred in the care and treatment of his causally related conditions to date pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid.

On the issue of prospective care, the Arbitrator finds that based on the finding in this Decision of continued causal connection for Petitioner's conditions, Respondent shall authorize and pay for the continued treatment as prescribed by treating physicians, Drs. Odeluga and Coats, including continued physical therapy, pursuant to Sections 8 and 8.2 of the Act.

L. WHAT TEMPORARY BENEFITS ARE IN DISPUTE- TTD

The parties stipulated that Respondent has paid $103,593.85 in TTD benefits to date. ARB EX 1. Respondent paid TTD through 6/18/13. Based on the finding of causal connection and on the records of Petitioner's treating physicians, the Arbitrator finds that Petitioner was temporarily totally disabled for an additional period of 26-1/7 weeks commencing 6/18/13 through 12/17/13.

M. SHOULD PENALTIES AND FEES BE IMPOSED UPON THE RESPONDENT.

The Arbitrator finds that the Petitioner is entitled to penalties under Sections 19(k), 19(l) and to attorney's fees under Section 16 of the Act for the Respondent's unreasonable and vexatious conduct in delaying and failing to pay TTD benefits to Petitioner after 6/18/13. The Arbitrator notes that the record is not clear on what, if any, medical bills have not been paid since the first 19(b) hearing and therefore, the assessment of penalties and fees is based solely on the non-payment of TTD.

The Respondent does not dispute that the Petitioner sustained a compensable workers' compensation injury on October 7, 2010. The Arbitrator finds that in terminating Petitioner's TTD benefits as of 6/18/13, Respondent unreasonably relied on the opinion of Dr. Candido. In so finding, the Arbitrator notes that Dr. Candido primarily based his opinion on evidence previously submitted, considered and rejected by the Arbitrator at the first 19(b) hearing in 2012, specifically including the surveillance video heavily relied on by Dr. Candido. The Arbitrator notes that nothing changed between the first trial and the current trial. Petitioner did not even receive the treatment ordered by the Arbitrator after the first 19(b) hearing before Respondent sent Petitioner for another Section 12 exam with a new examining physician. Respondent's reliance on the opinion of Dr. Candido regarding Petitioner's ability to return to work was unreasonable and vexatious given the lack of a new basis for his opinion and the resultant non-compliance with the prior 19(b) Decision.

Accordingly, Petitioner is awarded penalties under Section 19(l) in the amount of $5,460.00, representing $30.00 for 182 days from June 18, 2013 through December 17, 2013. Petitioner is awarded penalties under Section 19(k) equivalent to 50% of the total unpaid TTD or $9,622.13 and attorneys fees under Section 16 equivalent to 20% of the unpaid TTD or $3,848.85.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maria Redieske,
Petitioner,
vs.
United Parcel Service,
Respondent,

NO: 12 WC 08065

15IWCC0809

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 6, 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: NOV 2 - 2015

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
o:9/3/15
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

REDIESKE, MARIA
Employee/Petitioner

Case# **12WC008065**

15IWCC0809

UNITED PARCEL SERVICE
Employer/Respondent

On 1/6/2015, 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:

2489 LAW OFFICE OF JIM BLACK
JASON ESMOND
308 W STATE ST SUITE 300
ROCKFORD, IL 61101

2284 LAW OFFICE OF LAWRENCE COZZI
MAUREEN DUNSING
27201 BELLA VISTA PKWY #410
WARRENVILLE, IL 60555

15IWCC0809

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MARJA REDIESKE
Employee/Petitioner

v.

UNITED PARCEL SERVICE
Employer/Respondent

Case # **12** WC **8065**

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 **George Andros**, Arbitrator of the Commission, in the city of **Rockford, Illinois**, on **12/11/14**. 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 **9/12/11**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**50,111.36**; the average weekly wage was $**963.68**.

On the date of accident, Petitioner was **41** 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

The Arbitrator finds the Petitioner did not sustain an accident that arose out of and in the course of employment ; Benefits under the Workers Compensation 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.

/s/ George J Andros
Signature of Arbitrator

January 3rd, 2015
Date

JAN 6 - 2015

FINDINGS OF FACT & CONCLUSIONS OF LAW 12 WC 8065

Petitioner testified that she worked for United Parcel Service (UPS) for 17 years. She was a training and compliance specialist; her duties included training seasonal employees in compliance regulations. She testified a good portion of her job was data entry on the computer. She testified that she was terminated from UPS on September 12, 2011 for dishonesty, and falsification of her time cards. Petitioner filed her application for adjustment of claim with the Illinois Workers' Compensation Commission on March 2, 2012.

Petitioner stated that she started having pain in her right arm at least two years prior to her alleged date of accident, then upon cross-examination admitted the symptoms went as far back as 2007. She stated that she told her direct supervisor, John Divine, about her arm complaints, as well as four other supervisors, Kristy McKnight, Dwayne Phettaplace, Sherri Belley, and Trisha Boughton, sometime in 2010. She could not recall when or where these conversations took place, and did not testify as to the content of the conversations. She did not file a report for a workplace injury at any time, though she admitted she knew that was the proper protocol. She admitted on cross-examination that she believed her work duties caused or contributed to her symptoms in 2007, and again in 2010.

Petitioner testified that she was trying to get through "peak," or the busy season before Christmas, before seeking treatment for her arm symptoms through her own group health insurance. Petitioner also admitted she had group health insurance during the entire 17 years she worked at UPS, including in 2007 when the symptoms started, and 2010 when she allegedly told her supervisors about her symptoms. She further confirmed that she sought treatment in 2007 with her family care physician, Dr. Gonzales, for the same upper extremity symptoms.

After she was terminated Petitioner testified she hoped her arm symptoms would subside. She finally sought treatment with Dr. Rudisill in March 2012. Dr. Rudisill recommended therapy, which she did not do until May 2013. Petitioner stated physical therapy made her symptoms worse. She started treating with Dr. Chu in October 2013, and eventually underwent an ulnar nerve decompression, followed by physical therapy. She was fully discharged to regular duty work as of March 27, 2014.

Petitioner testified that she returned to work at new employment at Toubl Servies in April or May 2014. Currently, Petitioner can generally do her regular activities. She will get a "jolt" once in a while if she puts her elbows on a table, or hits her elbows. She no longer has issues of numbness and/or tingling in her upper extremities.

Amanda Papson testified on behalf of UPS. She has worked for UPS for 18 years, and has been a security supervisor for the last eight of those years. As a supervisor if an employee makes complaints of pain or injury the protocol is to file an accident report regardless of whether the employee asks for a formal report. Ms. Papson was a part of the investigation that led to Petitioner's termination. The security department received a tip, and pulled records to compare to Petitioner's time cards. There were multiple discrepancies found, from a few minutes, to hours. Ms. Papson testified that the investigation ultimately revealed that Petitioner had been falsifying her time cards, and Petitioner was therefore terminated from her employment for dishonesty.

The records of Dr. Rudisill (Pet Exh. 1)show that Petitioner presented for treatment on March 7, 2012 with complaints of bilateral shoulder pain. The records show that the onset of pain was one year prior. (P 9). At that time, Petitioner had normal range of motion in both wrists and elbows, and normal upper extremity strength. (P 10-11). Dr. Rudisill recommended icing and Naprosyn, along with occupational therapy for possible ulnar nerve impingement and early carpal tunnel syndrome. (P 11). X-rays of the right elbow and right wrist were unremarkable. (P 19-20).

Petitioner first saw Dr. Iqbal at Illinois Neurological Institute on August 22, 2013, complaining of numbness and tingling in both hands, and pain in both elbows for the past five years. Pet. Exh.2, (P 28). Dr. Iqbal recommended an EMG, and conservative treatment. (P 34). Her EMG/NCS findings were "normal." (P 52). On September 16, 2013, Petitioner was referred to neurosurgery for possible decompression and transposition of the ulnar nerve of the right elbow as physical therapy was not helping. (P 41-42). Dr. Chu evaluated Petitioner on October 7, 2013. His letter to Dr. Iqbal indicates that Petitioner presented with bilateral hand and arm pain for "many years." (P 48). He also noted that the EMG/NCS findings were "normal." (P 52). Dr. Chu's assessment was possible early bilateral ulnar neuropathy; however, he was "reluctant" to offer surgical intervention in the absence of significant EMG/NCS findings. He suggested elbow pads, and a repeat EMG/NCS in two months. (P 52).

The records of Dr. Chu include EMG results from testing done November 26, 2013, which were now consistent with right cubital tunnel syndrome. Pet.Exh.3 (P 127). On December 16 Petitioner had complaints of burning pain, numbness and tingling for the last four to five years, and underwent a right ulnar nerve decompression. (P 66). She had follow-up visits on December 27, 2013, and January 2, 2014, and was doing well. (P 74, 83). On February 13, 2014 Petitioner was doing well, and the numbness and tingling had almost resolved. (P 109). She was to continue occupational therapy and light duty restrictions. (P 111). On March 27, 2014, Petitioner no longer had numbness or tingling in the right hand, and had nearly completed occupational therapy. She was released from any restrictions. (P 119-120).

The Report of Dr. Jeffrey Coe, IME (Pet. Exh. 4) shows that he is an occupational medicine physician, practicing with Occupational Medicine Associates of Chicago, Ltd . (P 129). He reviewed the Petitioner's prior medical records, and performed an examination on June 27, 2012. Petitioner told Dr. Coe her shoulder and arm symptoms had developed over the past two or three years. (P 130). Dr. Coe notes measurements of Petitioner's biceps, forearms, wrists, and hands, which are all nearly equal. Dr. Coe found normal range of motion of both wrists, a mildly positive Tinel sign in the bilateral wrists, and positive Phalen signs in both wrists. (P 131). Dr. Coe opined that Petitioner suffered repetitive strain injuries to both upper extremities, caused by use of a mouse and keypad during her work activities. (P 132).

The report of Dr. Ryon Hennessy, IME (Resp. Exh. 1) shows that he is an orthopedic surgeon, practicing with Orthopedic Specialists, S.C. (P 1, 7). He performed a section 12 exam for Respondent on January 21, 2013. Petitioner reported that her symptoms of numbness, tingling, and pain in her elbows, hands, and fingers, began sometime in 2007. She denied any specific incident causing the symptoms. (P 2).

Petitioner stated she had treated with her family physician, Dr. Gonzales in Beloit, Wisconsin for the same upper extremity complaints in 2007. (P 2). Dr. Hennessy performed a physical examination, finding that motions of the elbows, wrists, and fingers were all normal. Median nerve compression tests were positive bilaterally, though the Tinels signs to the carpal tunnels and Guyons canals were negative. She had slightly increased two-point pin discrimination to the fifth digits. (P 5-6).

Dr. Hennessy opined that Petitioner's ongoing complaints had no causal relationship to her work duties at UPS. He bases that opinion on the fact that Petitioner made no report of any injury for six months after she was terminated, and that she stated symptoms had gone on for four years prior to her termination. In that time frame, Petitioner did not report a work injury or seek medical care. He also noted that Petitioner had no overt objective findings such as atrophy or weakness, further supporting the lack of causal connection. (P 6-7).

In support of the Arbitrator's decision relating to the issue of (C), whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent plus issue (F) whether the alleged Accident is causally Related to the Condition of ill Being , the Arbitrator makes the following findings:

None of Petitioner's treatment records include any probative nor persuasive opinions/finding that Petitioner's work activities caused or contributed to her bilateral upper extremity symptoms or diagnoses. When she initially sought medical attention with Dr. Rudisill in 2012, Petitioner's medical records show that she denied any particular activity had brought on her symptoms. By her testimony, Petitioner related her symptoms to her work at UPS; however, no treating physician ever rendered such an opinion.

Dr. Hennessy found no causal connection between Petitioner's work activities and her bilateral upper extremity symptoms. His opinion was based the fact that Petitioner made no report of any injury until six months after she was terminated, despite stating she had symptoms since 2007, or four years prior to her termination. The Arbitrator notes that while the Petitioner stated that after she was terminated she was unable to seek treatment due to her lack of insurance; however, Petitioner also admitted she had group health insurance for all 17 years she was employed at UPS, and yet had not sought treatment for those symptoms since 2007, which serves to undermine her persuasiveness in that regard. Dr. Hennessy also based his opinion on the lack of objective findings such as atrophy or weakness. (RX1, 6-7).

The report of Petitioner's section 12 examiner provides the sole opinion of a causal connection between Petitioner's repetitive strain injuries and her work duties. Doctor bases his findings entirely upon subjective reports. Doctor provides no objective basis for his opinion regarding causation. (PX4, 132). As such, the Arbitrator does not find the opinion of Dr. Coe persuasive in this particular case. The Arbitrator adopts the opinion of Dr. Hennessey in this particular case. However, said reliance is of no precedential value for cases heard in future.

Based on the totality of the evidence, the Arbitrator finds as a matter of fact and as a conclusion of law the Petitioner did not sustain an accident in the course and scope of the employment. Moreover, there is no causation between any alleged accident and the Petitioner's current condition of ill being, if any.

In support of the Arbitrator's decision relating to the issue of (D), what was the date of accident, the Arbitrator makes the following finding:

Petitioner alleges repetitive-trauma injuries to her bilateral upper extremities, culminating on her last day of employment at UPS, September 12, 2011. "[A]n employee suffering from a repetitive-trauma injury must still point to a date within the limitations period on which both the injury and its causal link to the employee's work became plainly apparent to a reasonable person." Durand v. Indus. Comm'n, 224 Ill. 2d 53, 65, 862 N.E.2d 918, 924 (2006). "The date on which the employee became unable to work, due to physical collapse or medical treatment, helps determine the manifestation date." Id at 68-69. "The manifestation date is not the date on which the injury and its causal link to work became plainly apparent to a reasonable physician, but the date on which it became plainly apparent to a reasonable employee." Id at 72.

The manifestation date can be determined several ways: (a) the date the employee actually became aware of the physical condition and its relation to work through medical consultation; (b) the date the employee requires medical treatment; (c) the date on which the employee can no longer perform work activities; or (d) when a reasonable person would have plainly recognized the injury and its relation to work. Id; By her own testimony and medical records, Petitioner was aware of her bilateral symptoms in 2007, she sought medical treatment for those symptoms with Dr. Gonzales in 2007, and she believed her symptoms were caused or aggravated by her work activities in 2007.

As such, based on these factors as set out in Durand, Petitioner has failed to establish an accidental injury to her bilateral upper extremities which manifested on September 12, 2011These factors all support the Arbitrator's finding that no injury manifested itself on September 12, 2011.

Based on the totality of the evidence, the Arbitrator finds once again as a matter of fact and as a conclusion of law and the prior finding that no accident occurred that arose out of and in the course of Petitioner's employment by Respondent; The Arbitrator further finds no injury manifested on the Petitioner's alleged date of injury, September 12, 2011.

In support of the Arbitrator's decision relating to the issue of (E), was timely notice of the accident given to Repondent, the Arbitrator makes the following finding:

Petitioner testified that she believed her work duties contributed to her upper extremity symptoms to her work duties in 2007, yet admitted she never reported a work injury or any of her symptoms to her supervisor at that time. The Arbitrator notes that Petitioner stated in 2010, three years after her symptoms began, she discussed her injuries with five separate supervisors at UPS, she could not recall when or where those discussions occurred, nor did she testify regarding the content of the discussions. On the other hand, Ms. Papson of UPS testified that supervisors are required to file a report of a work injury, even if just mentioned by an employee.

Based upon the totality of the evidence, the Arbitrator finds as a matter of fact and a conclusion of law that no notice under the Act was given to Respondent under section 6 of the Act. Based upon the Above, not further issues need to be addressed herein.

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

Nicholas Rasinskis,

Petitioner,

vs. NO: 13WC 38138

Southwest Airlines,

Respondent,

15IWCC0815

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, prospective medical, 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. 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 6, 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.

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.

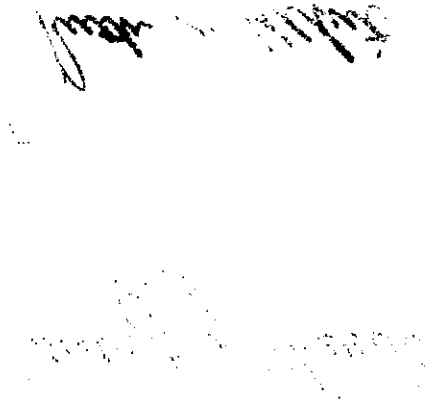
Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 3 - 2015
o102815
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White



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

RASINSKIS, NICHOLAS
Employee/Petitioner

Case# **13WC038138**

SOUTHWEST AIRLINES
Employer/Respondent

15IWCC0815

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:

2208 CAPRON & AVGERINOS PC
DANIEL F CAPRON
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

0766 HENNESSY & ROACH PC
DANIEL F WELLNER
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

15IWCC0815

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)

Nicholas Rasinskis
Employee/Petitioner

v.

Southwest Airlines
Employer/Respondent

Case # 13 WC 38138

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 21, 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. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **July 8, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**32,758.16**; the average weekly wage was $**629.58**.

On the date of accident, Petitioner was **25** years of age, ***single*** with **1** dependent child.

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

Respondent shall be given a credit of $**27,701.52** for TTD.

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $419.72/week for 66 5/7 weeks, commencing July 12, 2013 through October 21, 2014, as provided in Section 8(b) of the Act, with Respondent receiving credit for the $27,701.52 in benefits it paid prior to trial. Arb Exh 1.

Prospective Care

Respondent shall authorize and pay for prospective care in the form of lumbar fusion surgery.

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

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

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

Molly C Mason
Signature of Arbitrator

11/6/14
Date

ICArbDec19(b)

NOV 6 - 2014

Nicholas Rasinskis v. Southwest Airlines
13 WC 38138

Arbitrator's Findings of Fact

Petitioner, who was 26 years old as of the hearing, testified he has worked for Respondent for four years. He is employed as a ramp supervisor. He runs a "zone" consisting of six gates. He oversees the loading and unloading of freight as well as conventional luggage.

The parties agree that Petitioner sustained an accident at work on July 8, 2013. Arb Exh 1. Petitioner acknowledged undergoing a brief course of chiropractic care for back stiffness about 1 ½ years prior to this accident. The back stiffness did not stem from any injury. He saw a chiropractor at Midwest Chiropractic for about four or five weeks. At the end of this four- or five-week period, he felt fine. He denied undergoing any additional back treatment between the time he finished the chiropractic care and the accident of July 8, 2013.

Petitioner testified that his accident occurred in the back "bin," or cargo area, of a plane while he and a co-worker were offloading a large cargo box. Petitioner testified he had worked an entire shift before the accident. He was working beyond the end of his shift because the plane was late in arriving.

Petitioner described the cargo box as 3 feet wide, 5 feet long and weighing about 200 pounds. Petitioner and his co-worker were sliding the box along the floor, moving toward the bin door. The door is about 4 or 4 ½ feet square. Petitioner was moving backward, pulling the box, while his co-worker was facing forward, pushing the box. Petitioner testified he was on his feet but was "hunched over" because the bin ceiling is only 4 feet high. Petitioner testified he is 5 feet, 9 inches tall. As Petitioner was backing up, he struck his back against the corner of the bin door. He testified this door is made of metal. He felt an immediate onset of pain unlike any pain he had previously experienced.

Petitioner testified he first underwent treatment on July 11, 2013. He went to Concentra on that date, at Respondent's direction, and saw Dr. Charlotte Albinson. The doctor's note of that date reflects that Petitioner complained of pain in his mid and lower back secondary to striking his back against the metal door of a cargo hold on July 8, 2013. The note also reflects that Petitioner denied prior back problems. On skin examination, Dr. Albinson noted no abrasions or ecchymoses. On lumbar spine examination, she noted tenderness to palpation in the right paraspinal T10-12 area, left paraspinal L2-L3 area and in the midline at L1-L2. She described forward bending as "limited due to pain." She described Petitioner's gait as "steady." She ordered lumbar spine X-rays, which she described as negative on preliminary reading. She noted that the radiologist's report was pending. No X-ray report appears in the Concentra records. PX 1. She diagnosed a lumbar contusion. She prescribed Naproxen and instructed Petitioner to return in four days. She directed Petitioner to stay off work the rest of his shift and then resume light duty with no lifting over 10 pounds and no bending more than 5 times per hour. PX 1.

Petitioner testified he presented Dr. Albinson's restrictions to Respondent but was not accommodated.

Petitioner returned to Concentra on July 15, 2013. On this occasion, he saw Dr. Erica Salaman, D.O. Dr. Salaman noted that Petitioner "was hit in the back by a bin door on 7/8/2013" and complained of "an awful lot" of back pain, especially with bending and walking. She also noted that Petitioner reported deriving no relief from the Naproxen. She indicated that Petitioner denied paresthesias and radicular symptoms. She also indicated that Petitioner's "physical therapy visits were not set up yet."

On thoracic spine examination, Dr. Salaman noted no ecchymoses, no pain on motion, no point tenderness, no palpable spasm and a full range of motion. On lumbar spine examination, she noted mild spasm bilaterally, negative bilateral leg raising, no ecchymoses, no external trauma, no tenderness, a normal gait, symmetric reflexes, a normal range of motion and normal sensation. She also noted the following positive Waddell's signs: axial loading, distraction, regional testing, simulated testing, tenderness and overreaction.

Dr. Salaman prescribed a Medrol Dose-Pak, Cyclobenzaprine and Biofreeze gel. She released Petitioner to light duty with no lifting over 25 pounds, no bending more than 5 times per hour, no pushing/pulling over 25 pounds of force and no functioning in a "safety sensitive" position. She instructed Petitioner to return on July 22, 2013. PX 1.

Petitioner saw his family physician, Dr. Levy, the following day, July 16, 2013. The doctor's history reflects that Petitioner was injured at work on July 8, 2013 when he hit a door with his back while unloading cargo. The doctor noted that Petitioner complained of non-radiating pain in his mid and low back.

On examination, Dr. Levy noted no ecchymoses, no swelling, negative straight leg raising, a limited range of lumbar spine motion secondary to pain and tenderness to palpation in the right and left flank areas, medial low back and over the spinal column.

Dr. Levy diagnosed thoracolumbar back pain and a rib contusion. He prescribed Ibuprofen and took Petitioner off work. He instructed Petitioner to return in one week. PX 2.

Petitioner returned to Dr. Levy on July 25, 2013. The doctor noted that Petitioner's pain was unchanged but that Petitioner was "getting some mobility back." Dr. Levy's examination findings were essentially unchanged. He prescribed physical therapy and instructed Petitioner to return in two weeks. PX 2.

On July 30, 2013, Petitioner underwent an initial physical therapy evaluation at Athletico. The evaluating therapist noted a history of low back chiropractic care a year earlier and a right-sided lower back injury at work on July 8, 2013, as Petitioner was "moving backward on his knees moving a 200-pound piece of rate [sic] from the belly of an airplane" and "ran into

the side of a door." The therapist indicated that Petitioner had two consecutive days off following the injury but remained in pain. He also indicated that Petitioner reported no improvement since the injury and denied any signs of bruising across the right side of his lower back. PX 2.

On August 7, 2013, the physical therapist wrote to Dr. Levy and reported that Petitioner was "noticing little change in his low back symptoms." The therapist recommended that Petitioner continue therapy for another two to four weeks. PX 2.

Petitioner returned to Dr. Levy's office on August 12, 2013 and saw Kathleen Raschka. On that date, Petitioner again complained of persistent back pain and stiffness. He rated his minimum pain level at 2/10 and his maximum level at 9/10. He indicated he was attending therapy three times weekly. Raschka noted no new findings on examination. She prescribed a lumbar spine MRI and continued therapy and medication. PX 2.

On August 26, 2013, the therapist recommended Petitioner be discharged from therapy because he was "making no functional improvements." PX 2.

Petitioner underwent the recommended lumbar spine MRI on September 11, 2013. The MRI, performed without contrast, showed lumbar spondylosis, mild bilateral foraminal stenosis at L5-S1, "due to low-grade anterolisthesis of L5 on S1 vertebra with posterior disc slip associated with mild central extrusion pointing cranially with endplate spurring and facet joint hypertrophy," and minimal bilateral foraminal stenosis at L4-L5 due to mild disc bulge with endplate spurring and facet joint hypertrophy. PX 2.

Petitioner returned to Dr. Levy on September 18, 2013 and denied any improvement. On re-examination, Dr. Levy noted no swelling, no ecchymoses, normal reflexes, mild bilateral flank tenderness, negative straight leg raising and positive double straight leg lowering test.

Dr. Levy reviewed the MRI and indicated Petitioner was not able to return to work. He continued the Ibuprofen, prescribed Norco and referred Petitioner to Dr. Espinosa. PX 2.

Petitioner saw Dr. Espinosa on October 15, 2013. The doctor is affiliated with Neurological Surgery & Spine Surgery, S.C. His letterhead describes him as a board certified neurosurgeon and former associate professor of neurosurgery.

Dr. Espinosa recorded the following account of the work accident:

> "[Petitioner] is a 25-year-old man that injured his lower back while at work on July 8, 2013. He was moving a heavy box weighing approximately 200 pounds; he was backing up in an airplane while pulling the box when accidentally hit his lower back against a cargo bin door that was behind him. He noticed immediate low back pain. The pain was rated at the

> time as a 9/10. He has had no leg symptoms and has had no bladder or bowel dysfunction since the accident."

With respect to Petitioner's past history, Dr. Espinosa noted that Petitioner had experienced low back pain a year and a half earlier that "resolved spontaneously and with chiropractic treatment." He indicated Petitioner was "totally asymptomatic before the incident of July 8, 2013." He noted Petitioner had not worked since July 11, 2013 due to the injury.

On lumbar spine examination, Dr. Espinosa noted forward flexion of 60 degrees, hyperextension of 25 degrees, negative straight leg raising (in the lying, sitting and reverse positions), no sciatic notch tenderness, normal heel and toe walking, negative Patrick's and Fabere testing, a normal gait, no paraspinal muscle spasm, normal strength in the lower extremities, normal sensation to pin and no inconsistent behavioral responses.

Dr. Espinosa indicated he reviewed both the MRI film and report. He interpreted the MRI as showing "herniated discs at the L4-L5 level of approximately 4 mm with annular tear and L5 pars defect bilaterally with a central disc extrusion at L5-S1 and Grade 1 spondylolisthesis." He also noted an annular tear at the L5-S1 level. He indicated he called Chicago Ridge Radiology to alert them that the report "does not state there is a pars defect of L5 bilaterally." He indicated the pars defect would be more readily apparent on a CT scan.

Dr. Espinosa addressed causation and treatment needs as follows:

> "[Petitioner] has mechanical low back pain primarily from the L5-S1 spondylolisthesis and a large extruded L5-S1 disc fragment. He has had 4 weeks of physical therapy with some improvement in his condition. The pain is controlled while at rest but, with physical activity, increases to about 9/10. I recommend that he has a CT scan of the lumbar spine to confirm the L5 pars defect bilaterally as the cause of the L5-S1 spondylolisthesis. The two disc herniations are due to the incident at work of July 8, 2013 but the pars defect of L5 and the L5-S1 spondylolisthesis are not due to the accident of July 8, 2013; there [sic] are pre-existing conditions. He is having pain from the herniated discs, the L5 pars defect and the L5-S1 spondylolisthesis. The most definitive treatment for his condition is a fusion at both the L5-S1 and L4-L5 levels. He in my opinion would benefit from a 2-level fusion at L4-L5 and L5-S1."

Dr. Espinosa indicated that Petitioner planned to undergo the CT scan and return to him afterward. PX 3.

On October 16, 2013, Dr. Safvi of Chicago Ridge Radiology issued the following addendum to his previous MRI reading: "There is low-grade anterolisthesis of L5 on S1

vertebra. There is questionable high T2/STIR signal defect in the pars interarticularis, possibly suggestive of a fracture. CT scan is suggested for further evaluation." PX 4.

On October 22, 2013, Dr. Levy re-examined Petitioner and noted that Petitioner wanted to see Dr. Earman in order to obtain a second opinion. He prescribed a lumbar spine CT scan and started Petitioner on Meloxicam. PX 2.

Petitioner returned to Dr. Espinosa on November 6, 2013, after undergoing the CT scan on October 25, 2013. [The CT scan report is not in evidence]. Dr. Espinosa noted that Petitioner complained of low back pain and intermittent right lower extremity pain, varying in intensity from 6-9/10.

Dr. Espinosa indicated he reviewed the CT scan. He interpreted the scan as "clearly show[ing] the bilateral L5 pars defect." He addressed treatment needs as follows: "Because [Petitioner] has herniations at both L4-L5 and L5-S1, we would recommend a transforaminal lumbar interbody fusion at both levels." He discussed the risks and benefits of this surgery with Petitioner and noted that Petitioner was awaiting an IME. PX 3.

At Respondent's request, Petitioner underwent an examination by Dr. Walsh on November 12, 2013. In his report of November 17, 2013 (RX 1), Dr. Walsh indicated he reviewed the records from Concentra, Dr. Levy's note of July 16, 2013, the physical therapy notes from Athletico and copies of the X-rays, MRI scan and CT scan in connection with his examination.

Dr. Walsh indicated that Petitioner denied any history of back problems before the work accident. The doctor's description of the accident is consistent with Petitioner's testimony. He indicated Petitioner was offloading in the belly of the plane when he backed into a door and "noted a cracking sensation in his lower back."

Dr. Walsh noted that Petitioner primarily complained of back pain but was also experiencing occasional giving way in his right leg. He indicated Petitioner was currently taking one or two tablets of Hydrocodone per day. He noted Dr. Espinosa's surgical recommendation.

Dr. Walsh described Petitioner as able to move about the examination room with ease. On examination, he noted diffuse tenderness to palpation in the paraspinal muscles, hyperextension to 20 degrees with pain and no other abnormalities.

Dr. Walsh opined that the records he reviewed "support the diagnosis of a contusion of the lower back as a result of [Petitioner] coming into contact with the aircraft at the bin door on July 8, 2013." Dr. Walsh found it "not at all likely" that any of the MRI findings stemmed from this accident. He described the MRI findings as "more likely than not" pre-existing. He opined that Petitioner "most certainly does not require a 2-level fusion because his back came in contact with a bin door." He indicated that any surgery proposed by Dr. Espinosa "more likely than not is for [Petitioner's] pre-existing condition [and] not caused, aggravated or accelerated

by the work injury." He further indicated that Petitioner does not require any additional care or diagnostics due to the back contusion. RX 1.

Petitioner first saw Dr. Earman on December 16, 2013. Dr. Earman is affiliated with Orthospine Center, Ltd. He recorded the following account of the work accident:

> "[Petitioner] presents today complaining of low back pain with onset of July of 2013 while he was at work. He was walking backwards having [sic] a cart took him forward and subsequently walked into the door of the plane which struck him on the right side of the low back."

Dr. Earman indicated that Petitioner denied any radicular symptoms.

On initial examination, Dr. Earman noted forward flexion of only 30 degrees, hyperextension to 10 degrees, side bending of 15 degrees bilaterally, negative straight leg raising bilaterally, slightly decreased sensation over the L5 distribution on the right and tenderness over the sciatic notches and SI joints.

Dr. Earman obtained lumbar spine X-rays, including flexion-extension views. He interpreted the films as showing a "spondylitic spondylolisthesis" causing a "great deal of angular instability" at L5-S1, an obvious pars defect "which does appear to be displaced with range of motion," mild degenerative changes at L5-S1 and at least 3-4 millimeters of anterior shaft of L5 on S1.

Dr. Earman prescribed an LSO brace along with stabilization exercises. He indicated Petitioner would likely require a fusion if he failed to improve. He instructed Petitioner to stay off work. PX 4.

Petitioner returned to Dr. Earman on January 28, 2014 and indicated that the exercises were helping to an extent. The doctor recommended formal therapy and indicated a fusion at L5-S1 might be necessary. PX 4.

Petitioner underwent an initial therapy evaluation at Athletico on February 20, 2014. PX 4.

Petitioner returned to Dr. Earman on March 7, 2014 and complained of severe pain across the lower lumbar spine. The doctor discussed various treatment options, including a fusion, with Petitioner and instructed Petitioner to remain off work. PX 4.

On March 12, 2014, a therapist at Athletico reported that Petitioner had made some gains in terms of flexibility and lifting but was experiencing increased back pain. PX 4.

On April 4, 2014, Petitioner returned to Dr. Earman and complained of increasing back pain secondary to his exercise regimen. The doctor indicated a fusion might be needed if Petitioner failed to progress. He continued to keep Petitioner off work. PX 4.

Petitioner returned to Dr. Earman on May 9, 2014. The doctor noted that Petitioner "has been undergoing physical therapy but has really not improved." He indicated that Petitioner was still complaining of lower back pain radiating to his right leg. He again recommended a decompressive laminectomy and possible fusion at L5-S1. He indicated he planned to leave the L4-L5 level undisturbed, on the theory that fusing both levels could prevent Petitioner from resuming heavy duty. He tentatively scheduled the surgery for June 18, 2014 and instructed Petitioner to remain off work. PX 4.

On June 9, 2014, Dr. Earman noted that Petitioner was tentatively scheduled to undergo surgery pending authorization by workers' compensation. He noted that Petitioner denied any improvement and was still taking pain medication. He continued to keep Petitioner off work. PX 5.

On July 15, 2014, Dr. Earman noted that Petitioner was no longer able to attend therapy due to a pending IME. On re-examination, he noted positive straight leg raising on the left at about 45 degrees. He instructed Petitioner to continue therapy and remain off work. PX 5.

On August 22, 2014, Dr. Earman noted that Petitioner remained symptomatic and was awaiting an IME. He directed Petitioner to remain off work. PX 5.

At Respondent's request, Petitioner saw a different Section 12 examiner, Dr. Bauer, on August 27, 2014. Dr. Bauer is affiliated with the Center of Brain and Spine Surgery.

Dr. Bauer's initial history reflects that Petitioner was well until July 8, 2013, when he struck his back against the corner of a metal door while moving backward inside a cargo hold. Later in his report, however, Dr. Bauer noted that Petitioner had a history of back pain for which he had seen a chiropractor about a year earlier.

Dr. Bauer indicated he reviewed records from Concentra, Dr. Levy, Dr. Espinosa and Dr. Earman, along with Dr. Walsh's report.

Dr. Bauer indicated that Petitioner was currently taking Hydrocodone and complained of non-radiating back pain.

Dr. Bauer commented that Petitioner "did not appear to be in discomfort" during the examination. He described Petitioner as walking normally and being able to remove his shoes and socks without difficulty.

On examination, Dr. Bauer noted no spasm, minimal tenderness, forward flexion to 60 degrees with a complaint of low back pain, minimal discomfort with extension, intact strength,

no sensory loss and negative straight leg raising to 90 degrees, "other than some tightness of the hamstring muscles."

Dr. Bauer interpreted the MRI as showing degenerative disc disease at the two lowest disc levels, a suggestion of a Grade 1 spondylolisthesis and spondylolysis at L5-S1 and annular tears at L4-L5 and L5-S1, without central or foraminal stenosis. He interpreted the CT scan as confirming the Grade 1 spondylolisthesis and spondylolysis and mild narrowing of the disc space at L4-L5.

Dr. Bauer opined that the Grade 1 spondylolisthesis and degenerative disc disease pre-existed the work injury. He further opined that the nature of the work injury "would suggest a back contusion." He noted that the initial treating physician, Dr. Albinson, noted no ecchymoses at the site of injury.

Dr. Bauer viewed Petitioner as having small annular tears but "no significant disc herniation." He indicated that the age of the tears could not be determined but that, given the mechanism of injury, it was unlikely they occurred as a result of the work accident.

Dr. Bauer found Petitioner to be at maximum medical improvement in terms of the work accident. He indicated that, if Petitioner were to undergo a fusion, he would agree with Dr. Espinosa that it should be performed at both L4-L5 and L5-S1.

Dr. Bauer characterized the therapy at AthletiCo in mid-2013 to be appropriate. He indicated no further treatment for the contusion was warranted. RX 2.

On September 25, 2014, Dr. Earman noted that Petitioner complained of persistent low back pain radiating into his buttocks. On re-examination, he noted positive straight leg raising bilaterally at 45 to 50 degrees. He noted that Petitioner had "pretty much failed" therapy, medication and injections. He opined that Petitioner "has an aggravation of the under current [sic] condition which is going to require surgical stabilization." He instructed Petitioner to remain off work pending surgical approval. PX 5.

Dr. Bauer issued an addendum on October 2, 2014, after reviewing a description of the physical requirements of a ramp agent job. Based on Petitioner's symptoms and continued pain, he found Petitioner "not capable of returning to work as a ramp agent." He indicated that Petitioner's inability to resume this job "would not be related to his work injury of July 8, 2013." He reiterated that Petitioner had reached maximum medical improvement with respect to the work injury. RX 3.

Petitioner testified he wants to undergo the fusion that Dr. Earman has recommended. His treatment has been in a holding pattern because the fusion has not been authorized. Since the work accident, he has never been symptom-free. He has not sustained any other injuries since the accident. He has not worked anywhere since July 12, 2013, when he presented the Concentra restrictions to Respondent and was told he could not be accommodated.

Under cross-examination, Petitioner testified he told the physicians at Concentra, along with Drs. Levy and Espinosa, that his back struck a door. He told Dr. Earman he walked backward into a door. He was truthful with Respondent's examiners, Drs. Walsh and Bauer. He last saw Dr. Earman about a month before the hearing. Dr. Earman did not change any of his previous recommendations at that visit. He has received benefits since he has been off work.

No witnesses testified on behalf of Respondent.

Arbitrator's Credibility Assessment

The fact that Petitioner works in a supervisory capacity for Respondent weighs in his favor, credibility-wise.

Petitioner's testimony concerning the mechanism of injury was detailed and credible. Petitioner made it clear he was "hunched over," pulling a 200-pound box toward him in a cargo area with a 4-foot ceiling, before he struck his back against the cargo door. While all of these details do not appear in the histories recorded by the various physicians who treated and examined Petitioner, those histories are largely consistent with Petitioner's account.

Of all the physicians involved in this case, only one, Dr. Salaman of Concentra, noted positive Waddell's signs. Even then, Dr. Salaman recommended treatment and significant work restrictions. PX 1.

Respondent maintains that Petitioner failed to disclose his pre-accident chiropractic care to the Concentra physicians and Dr. Walsh. The Concentra records do not state that Petitioner denied pre-accident back treatment. Rather, they describe Petitioner's medical history as "non-contributory or negative to [the claimed] injury based upon review of [a] comprehensive questionnaire." Since no such questionnaire is included in the records that Concentra produced pursuant to Petitioner's subpoena (PX 1), the Arbitrator cannot conclude that Petitioner misrepresented his medical history. The Arbitrator notes that other records, including the physical therapy notes, Dr. Espinosa's notes and Dr. Bauer's report, clearly reflect that Petitioner acknowledged undergoing a course of chiropractic care about a year before the accident. The Arbitrator also notes that Dr. Walsh indicated he reviewed the physical therapy records.

The Arbitrator found Petitioner to be a credible witness.

Did Petitioner establish a causal connection between his undisputed accident of July 8, 2013 and his current condition of ill-being?

The Arbitrator finds that Petitioner met his burden of proof on the issue of causation. In so finding, the Arbitrator relies on the following: 1) Petitioner's credible testimony that he recovered fully from the back stiffness for which he underwent a brief course of chiropractic

care about a year and a half before the work accident; 2) the fact Petitioner was able to perform his relatively strenuous physical duties before the accident; 3) Petitioner's credible testimony concerning his positioning and the activities he performed immediately before the accident; 4) Petitioner's credible testimony that he experienced an immediate onset of pain after the accident; 5) the radiographic studies; 6) Dr. Espinosa's causation-related opinions; and 7) Dr. Bauer's concession that the MRI showed annular tears at two levels and that Petitioner requires a lumbar fusion.

The Arbitrator assigns no weight to Dr. Walsh's causation-related opinions. Dr. Walsh noted that Petitioner was moving backward, maneuvering cargo inside the belly of a plane, when he struck his back yet he characterized Petitioner's injury as merely a contusion.

Based on the foregoing, the Arbitrator finds that Petitioner established causation as to his current lumbar spine condition of ill-being and the need for a lumbar fusion.

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims he was temporarily totally disabled from July 12, 2013 through the date of hearing, October 21, 2014. In reliance on Dr. Walsh's opinions, Respondent maintains Petitioner's temporary total disability ended on November 17, 2013. Arb Exh 1.

The Arbitrator finds Petitioner was temporarily totally disabled from July 12, 2013 through October 21, 2014, a period of 66 5/7 weeks. In so finding, the Arbitrator relies on the following: 1) Petitioner's credible testimony that he presented the Concentra work restrictions to Respondent on July 12, 2013 but was not accommodated; 2) Dr. Levy's treatment records; 3) Dr. Espinosa's treatment records and surgical recommendation; 4) Dr. Earman's treatment records, "off work" notes and surgical recommendation; and 5) Dr. Bauer's opinions as to work capacity and the need for a fusion. The Arbitrator finds that Petitioner's spinal condition of ill-being remained unstable as of the hearing. Interstate Scaffolding v. IWCC, 236 Ill.2d 132 (2010).

Is Petitioner entitled to prospective care?

Both of Petitioner's treating surgeons have recommended a lumbar fusion, although they disagree as to whether one or two levels should be fused. Respondent's second examiner, Dr. Bauer, agrees with the need for a fusion (at two levels) but does not view the need for the surgery as accident-related.

The Arbitrator, having found in Petitioner's favor on the issue of causation, and noting the foregoing opinions, finds that Petitioner is entitled to prospective care in the form of lumbar fusion surgery. The Arbitrator leaves it to Petitioner to sort out the relative risks and benefits of a one- versus two-level fusion with his treating surgeon.

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Nina Carter,

Petitioner,

vs. NO: 14 WC 11971

15IWCC0814

Children's Habilitation Center,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability ("TTD"), medical expenses, prospective medical expenses, 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 further remands this case to the Arbitrator for further proceedings for a determination of permanency if any.

So that the record is clear, and there is no mistake as to the intentions or actions of this Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical / legal perspective. We have considered all of the testimony, exhibits, pleadings and arguments submitted by the Petitioner and the Respondent. One should not and cannot presume that we have failed to review any of the record made below. Though our view of the record may or may not be different than the Arbitrator's, it should not be presumed that we have failed to consider any evidence taken below. Our review of this material is statutorily mandated and we assert that this has been completed.

The Commission affirms and adopts the Arbitrator's decision in all respects, except with regard to TTD, the award of prospective medical treatment, and the amount of medical expenses awarded. For the reasons set forth below, the Commission modifies the Arbitrator's decision and

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finds that Petitioner was at maximum medical improvement ("MMI") on October 8, 2014. The Commission further modifies the award of TTD awarded to March 25, 2014 through March 30, 2014, and April 21, 2014 through October 8, 2014, but not thereafter.

The Petitioner was injured at work when a 2-foot wide hospital-type air compressor fell on her foot on March 24, 2014. The Petitioner sought treatment with Dr. Joseph Thometz, an orthopedic specialist, who diagnosed her with a right foot contusion Dr. Thometz also opined that Petitioner's main problem was a neurapraxia from the contusion with dysesthesias related to the injury, and that she had symptoms indicative of Complex Regional Pain Syndrome ("CRPS"). He ultimately recommended pain management with Dr. Howard Robinson on August 25, 2014. She had not treated with Dr. Robinson as of the December 2, 2014 hearing due to a lack of authorization by Respondent. (Px1, Tr. 32-33)

The Petitioner underwent a Section 12 examination with Dr. George Holmes, an orthopaedic specialist, on July 17, 2014. Dr. Holmes agreed with Dr. Thometz that Petitioner suffered a contusion to her right foot. However, Dr. Holmes disagreed with Dr. Thometz regarding Petitioner demonstrating signs of CRPS because her pain was not consistent with that diagnosis. He noted that Petitioner had normal x-rays that were negative for a fracture, but that having Petitioner under-go an EMG or bone scan could be beneficial to determine if there was any pathology related to her symptoms. He also opined that Petitioner could return to work in a full-duty status. During the examination, Dr. Holmes noted an absence of instability, swelling, or atrophy in her right foot. (Rx1)

Both a bone scan and EMG were ultimately completed, and Dr. Holmes completed an addendum report dated October 8, 2014. He noted that he concurred with the radiologist's interpretation of the May 2, 2014 MRI results of Petitioner's right foot that it was a normal MRI. (Rx1). Dr. Holmes noted that the report from the EMG on Petitioner's right foot indicated that it was a normal EMG with "no electrical evidence of any active right…neuropathy." (Id.). Petitioner's bone scan results showed an increased uptake in both of Petitioner's feet, but it was noted that: "The right foot is far more benign in terms of uptake on the bone scan than the left foot." Petitioner's injury was to her *right* foot. (Id.) Dr. Holmes also wrote:

> "(a)fter review of the EMG, bone scan, and the MRI, there is no conclusive evidence that this claimant has sustained any neurologic damage to her foot. There is no evidence that the claimant has sustained a Lisfranc injury to the foot. There is no indication that the patient, as a result, has sustained any significant contusion or soft tissue injury to the foot as well. Therefore, the current diagnosis is that the patient has essentially a normal examination and normal orthopaedic examination of her foot." (Id.)

Dr. Holmes also reviewed the surveillance video of Petitioner walking in a normal shoe and opined that since she was walking "with a normal gait with regular shoes," it supported his opinion that Petitioner had already reached MMI. (Rx2). He subsequently opined that the diagnostic findings supported his contention that Petitioner had already reached MMI and could return to work without restrictions. (Rx1)

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Petitioner returned to work on a light duty status on March 31, 2014. Due to pain in her right foot, she left early that day. She was kept off of work between April 3, 2014 and April 13, 2014. She was then placed on sedentary work restrictions on April 14, 2014. She did not work again until April 16 and April 17, 2014 when she worked for a few hours and thirty minutes, respectfully. She testified that she left early both days: The first day may have been for a family emergency or for pain in her foot, and the second day was because the supervisor of housekeeping told her that she was authorized to leave. Petitioner also testified that she attempted to work "every day," but that she was told that light duty work was not available for her. A letter to Petitioner dated April 21, 2014 indicated that Petitioner could only return to work for the Respondent once Petitioner could return to work full duty. This was based on a lack of availability for Petitioner to work light duty because she could not work in the basement on light duty due to her asthma. (Tr. 46-59).

Respondent's CEO, Pamela Schaetzle, also testified at trial. Ms. Schaetzle testified that Petitioner worked for a brief time on April 16th and April 17th, but that Petitioner left early for non-right foot related problems: April 16th was due to Petitioner's husband going to a hospital emergency room, and April 17th was due to Petitioner receiving a phone call and stating that she had to leave. Ms. Schaetzle also testified that it was inaccurate that Petitioner had attempted to return to work light duty every day since her accident, as Petitioner had testified. Petitioner did not return to work or call the Respondent about returning to work on April 18, 2014 or any time thereafter. (Tr. 87-93).

To be entitled to TTD, a claimant must prove not only that she did not work, but that she was unable to work. *Gallentine v. Industrial Com., 201 Ill. App. 3d 880 (Ill. App. Ct. 2d Dist. 1990).* Here, Petitioner has not shown that she was incapable of working. We find that Petitioner could have worked light duty for Respondent during the dates that she was authorized by a medical professional to work, but voluntarily chose not to. We find Ms. Schaetzle's testimony to be more credible than the Petitioner's testimony regarding Petitioner's attempted to return to work after April 17th and the availability of light duty work for Petitioner.

The Petitioner's lack of credibility is also a factor in the Commission's decision. The Petitioner testified that the pain in her right foot worsened from March 24, 2014 to December 2, 2014, and that her foot hurt her all day, every day. She also testified that she only wore her post-operative shoe on her right foot and never wore a regular shoe. However, the Commission reviewed videotape evidence of the Petitioner walking May 16, 2014 and concurs with Dr. Holmes assessment that Petitioner was seen walking in a regular shoe and had a normal gait. (Rx1, Tr. 29-31, 34-36).

By her testimony Petitioner attempted to lead the Commission to believe that her pain was so great that she could neither wear a normal shoe nor work. This is proven to be false by the video evidence presented by Respondent. Her testimony is at best disingenuous.

Based upon the totality of the evidence and the factual findings above, we find that Dr. Holmes' opinion that Petitioner merely suffered a contusion is more compelling than Dr. Thometz's opinion that Petitioner suffered from CRPS. The absence of any objective evidence to support Petitioner's ongoing pain complaints is particularly compelling. Given that the

Commission finds Dr. Holmes findings to be more persuasive, the Commission finds that Petitioner was at MMI as of October 8, 2014, the date of Dr. Holmes addendum report to the Section 12 examination.

Based upon the finding of MMI on October 8, 2014, the Commission denies prospective medical treatment, vacates the award of $250.00 in medical expenses to Family Christian Health Center from Petitioner's November 4, 2014 visit, and terminates TTD after October 8, 2014.

Petitioner filed a Motion to Strike Respondent's Reply Brief alleging undue influence. The Commission denies said Motion as it considers the filing of the Reply Brief to be harmless error. The Commission has based its Decision upon the record.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $253.00 per week for a period of 25 and 2/7 weeks, commencing March 25, 2014 through March 30, 2014, and April 21, 2014 through October 8, 2014, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner reasonable and necessary medical services, pursuant to the fee schedule, of $250.00 to Family Christian Health Center, and $90.00 to Dr. Thometz, as provided in §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 Petitioner failed to prove entitlement to prospective medical treatment.

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 Petitioner's Motion to Strike Respondent's Reply Brief filed on May 29, 2015 is hereby denied.

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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: NOV 2 - 2015

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

TJT/ gaf
O: 9/1/15
51

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

CARTER, NINA
Employee/Petitioner

Case# **14WC011971**

CHILDREN'S HABILITATION CENTER
Employer/Respondent

15IWCC0814

On 12/19/2014, 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 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2208 CAPRON & AVGERINOS PC
STEPHEN SMALLING
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

2965 KEEFE CAMPBELL BIERY & ASSOC
JOE D'AMATO
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

15IWCC0814

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)

Nina Carter
Employee/Petitioner

v.

Children's Habitation Center
Employer/Respondent

Case # **14** WC **11971**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen Friedman**, Arbitrator of the Commission, in the city of **Chicago**, on **December 2, 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. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **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*** 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 $**18,252.00**; the average weekly wage was $**351.00**.

On the date of accident, Petitioner was **46** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of $**1,590.29** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**1,590.29**.

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 $253.00/week for 33 1/7 weeks, commencing March 25, 2014 through March 30, 2014 and April 21, 2014 through December 2, 2014, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $**1,590.29** for TTD paid.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $500.00 to Family Christian Health Center and $90.00 to Dr. Thometz, as provided in Sections 8(a) and 8.2 of the Act. Further, Respondent shall pay prospective medical to include the initial evaluation with Dr. Robinson as directed by Dr. Thometz and pay all reasonable and necessary charges incurred therewith, and any further reasonable necessary and causally connected treatment thereafter.

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

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

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

Signature of Arbitrator

December 19, 2014
Date

ICArbDec19(b)

DEC 19 2014

Statement of Facts

Petitioner Nina Carter was employed by Respondent Children's Habilitation Center on March 24, 2014. Respondent provides care for special needs children. Petitioner testified that she had been employed by Respondent for 14 years. Petitioner testified that she was employed as a team assistant. Her job duties were to bath, clothe, and lift the children. She assisted with making beds, and conducting activities. Petitioner testified that before the accident, she did not have any prior injury to her right foot. She did not have any physical limitations with respect to her right foot. Petitioner testified that on March 24, 2014 she was making a bed when a large metal compressor fell on her right foot. Petitioner testified that the compressor struck her on the top of the foot.

Petitioner testified that she was taken to Ingalls Occupational Health on the date of the accident. The records of Ingalls Occupational Health were admitted as Petitioner's Exhibit 2. The March 24, 2014 record contains a consistent history of accident with complaints of pain and swelling in the right foot. The physical examination notes mild swelling. Petitioner walked with a limp and was unable to put weight on the right foot. X-rays did not show a fracture. Petitioner was diagnosed with a contusion. She was placed on restricted duty with no standing or walking. Petitioner was seen in follow up on March 27, 2014. The examination noted that she could move with moderate difficulty. There was still swelling and tenderness to palpation noted. Petitioner was advised to use a cane for safe ambulation and a post op shoe for comfort. She was advised to continue work restrictions. Further x-rays were discussed if she did not improve. Petitioner was seen on April 3, 2014. She continued to complain of pain and swelling. The examination did not note swelling, but continued tenderness. Petitioner advised she was transferring her care to her personal physician. She was continued on light duty and advised to use the post op shoe and cane.

Respondent offered Petitioner work within her restrictions (Resp. Ex. 4). The work consisted of folding and stacking laundry. Petitioner testified that she was given a wheelchair that was too small and was taken to the basement to perform the light duty job duties. Petitioner testified that she was left alone in the basement. There was no bathroom in the basement. Petitioner testified that there were no doors or windows. Petitioner testified that she needed to be taken by the maintenance man because she could not operate the freight elevator door by herself. Petitioner testified that she worked about two hours and then had the maintenance man take her to see Pam. Pam Schaetzle, CEO and administrator for Respondent testified that Petitioner left work on March 31, 2014 due to pain in her right foot.

Petitioner testified that she saw her own doctor, Julie Austin, at Family Christian Health Center on April 1, 2014. The records of Family Christian Health Center were admitted as Petitioner's Exhibit 3. Petitioner was seen by Julie Austin on April 1, 2014. The records reveal that she is an APRN (advanced practice registered nurse). Petitioner complained of significant right foot pain, burning and tingling. The examination noted moderate swelling and significant tenderness. The recommendations were to use NSAIDs, see an orthopedic doctor and remain off work until evaluation by a specialist. Repeat x-rays were ordered. Petitioner returned to Family Christian Health Center on April 15, 2014. The note reflects review of multiple physical and health problems including the right foot injury. Ms Austin authored a note stating Petitioner should not work in the basement due to her asthma and that she should not be left unattended due to her injury.

Petitioner testified that she was referred by Ms. Austin to Dr. Thometz. Dr. Thometz' records were admitted as Petitioner's Exhibit 1. Petitioner first saw Dr. Thometz on April 14, 2014. She complained of constant burning pain with hypersensitivity. Dr. Thometz stated that the x-rays showed no acute changes. His examination noted swelling with marked hypersensitivity. His impression was a contusion to the right foot. He ordered an MRI. He noted signs of contusion to the superficial peroneal nerve with neuralgia. He placed Petitioner on sedentary work restrictions.

Petitioner returned to restricted work for Respondent on April 16, 2014. Ms. Schaetzle testified that Petitioner was set up to fold laundry in the physical therapy room on the first floor. Petitioner worked for three hours. Petitioner testified that her foot began to hurt and she left to see the doctor. Petitioner returned on April 17, 2014, but left within half an hour because of a personal emergency. Ms. Schaetzle testified that Petitioner did not complain about her foot at that time. Petitioner did not return to work thereafter.

Petitioner received a letter from Respondent concerning continued light duty dated April 21, 2014 (Petitioner's Exhibit 5). Ms. Schaetzle testified that this letter was drafted by Respondent's attorney and under her authority. The letter stated that Petitioner would only be able to perform the temporary job folding laundry in the basement, and since Julie Austin's April 15, 2014 note says Petitioner should not work in the basement, the work is no longer being offered. Petitioner is advised to provide a fitness for duty certification when she can perform the essential functions of her regular job. Ms. Schaetzle testified that restricted work could still be available, but that it would be offered only in the basement.

Petitioner's MRI was performed on May 2, 2014 (Pet. Ex. 3, pg 31). It was read as unremarkable. Dr. Thometz saw Petitioner on May 7, 2014. He opined that her main problem was a neuropraxia from the contusion. He prescribed Lidoderm patches and physical therapy. On June 16, 2014, Dr. Thometz notes that Petitioner has not made progress in therapy. Stretching made her pain worse. He notes a little soft tissue swelling and loss of motion with hypersensitivity. His impression is a nerve contusion with symptoms suggesting a complex regional pain type syndrome in response to the nerve injury. Dr. Thometz suggests referral to Dr. Robinson. He states Petitioner is not capable of work at this time. Dr. Thometz' records include follow up visits through September 15, 2014. He continues to diagnosis CRPS and recommends referral to Dr. Robinson for pain management. He continues to restrict Petitioner to sedentary work. Petitioner testified that she last saw Dr. Thometz on November 4, 2014. Petitioner testified that his recommendations remain the same.

Respondent placed Petitioner under surveillance. The video and reports were admitted as Respondent's Exhibit 2. The surveillance covered four days. The Arbitrator has viewed the video which totals approximately 35 minutes. The Petitioner was seen briefly on May 16, 2014 when she walked from her car into a private reception. She is seen to be wearing regular shoes. Petitioner testified that she was going to her daughter's graduation and wanted to look nice. She testified that she took her shoes off when she got inside. Petitioner was also filmed on July 13, 2014 walking from her home to her vehicle and then returning to her home. She is wearing the post op shoe in this video. This video does not clearly view Petitioner's feet and legs as she enters her home and climbs or descends the stairs into the house.

Petitioner was sent by Respondent for an examination with Dr. George Holmes on July 17, 2014 (Resp. Ex. 1). Dr. Holmes diagnosis is a possible neuritic type of pain. He notes that the objective parameters appear to belie the level of subjective complaints. He did view the surveillance video and reports. He opines that the symptoms are not consistent with RSD or CRPS. He stated that Petitioner may benefit from an EMG and bone scan. He stated Petitioner did not need any restrictions and does not need to be off work based upon the objective data.

The EMG study was performed on September 4, 2014. It was read as normal. The bone scan was performed on September 2, 2014. The impression was inflammatory/stress related changes-both feet and right knee (Pet. Ex. 1).

Dr. Holmes authored an addendum report on October 8, 2014. He reviewed the MRI, EMG and bone scan and opined that there is no conclusive evidence that Petitioner sustained any neurologic damage to her foot. The current diagnosis is an essentially normal examination of her foot. Dr. Holmes opined that Petitioner was at maximum medical improvement and could return to work without restrictions (Resp. Ex. 1).

Petitioner testified that she continues to have sharp pain in her foot. She does not wear regular shoes. She can't go down stairs normally. She cannot walk long distances. She cannot bend her toes backwards. When she wears shoes it compresses her foot and hurts. Petitioner testified that she still wants to see Dr. Robinson. Petitioner testified she has been terminated by Respondent.

Conclusions of Law

In support of the Arbitrator's decision with respect to F (Causal Connection), the Arbitrator finds as follows:

Petitioner sustained an undisputed accident on March 24, 2014 with injuries to her right foot sustained when a heavy air compressor fell and struck the top of her foot. The medical histories and complaints of pain and swelling of her right foot provided to all of the medical providers are consistent with the trauma suffered. The Petitioner was examined and treated at Ingalls Occupational Health Center and Family Christian Health Center before coming under the care of Dr. Thometz. At both facilities, it was deemed that the Petitioner had sustained injuries to her right foot necessitating the imposition of work restrictions, prescribing of medication and ongoing treatment. The Petitioner was subsequently examined by Dr. Thometz who after examining her on numerous occasions concluded that she was suffering from neurapraxia from the contusion to the foot with associated dysesthesias. Physical examinations revealed swelling and pain through the foot with medications providing no relief. Dr. Thometz opined that she had a nerve condition with symptoms suggesting a complex regional pain type syndrome in response to the nerve injury and recommended she be seen by Dr. Robinson, a pain physician for further treatment options.

Dr. George Holmes, Respondent's independent examiner, examined the Petitioner on a single occasion on July 17, 2014. Dr. Holmes opinion, based upon his examination and subsequent review of the diagnostic testing, is that there is no objective or "conclusive" evidence of neurologic damage to Petitioner's foot.

The Arbitrator has had the opportunity to observe the Petitioner and finds her testimony as to complaints of pain to be credible. The Arbitrator has reviewed the videotape surveillance and finds nothing therein to contradict Petitioner's ongoing complaints of pain and reliance on use of the post-op shoe. The video of Petitioner's activity is so minimal and the view of Petitioner's gait so limited, that no reasonable conclusions on the Petitioner's physical ability can be drawn to contradict her testimony and the treating medical records. The Arbitrator also finds Petitioner's explanation for wearing regular shoes in the May 16, 2014 video plausible.

Given the foregoing, the Arbitrator finds the medical opinions and diagnosis of Dr. Thometz to be more persuasive than those of Dr. Holmes. Dr. Thometz has had the opportunity to examine the Petitioner on numerous occasions. Dr. Thometz has recommended additional evaluation by a pain specialist to treat Petitioner's ongoing complaints of pain.

Based upon the totality testimony, the medical evidence and exhibits submitted in this matter, the Arbitrator finds that the Petitioner's current condition of ill-being is causally related to the accidental injuries sustained on March 24, 2014 arising out of and in the course of her employment with Respondent.

In support of the Arbitrator's decision with respect to J (Medical) and K (Prospective Medical), the Arbitrator finds as follows:

Petitioner's Exhibit 4 consists of unpaid medical expenses incurred at Family Christian Health Center for visits dated April 1, 2014 and April 15, 2014 totaling $500.00. The Exhibit further reflects unpaid medical expenses incurred with Dr. Thometz of $90.00 for services on September 15, 2014. Based upon the Arbitrator's

decision with respect to causal connection above, the Arbitrator finds that the treatment from Family Christian Health Center was reasonable, necessary and causally connected to the accidental injuries sustained on March 24, 2014. The Arbitrator finds that the treatment received from Dr. Thometz was reasonable, necessary and causally connected to the accidental injuries sustained on March 24, 2014.

Accordingly, the Arbitrator finds that the charges incurred totaling $500.00 from Family Christian Health Center and the $90.00 by Dr. Thometz for treatment on September 15, 2014 were reasonable and necessary. Respondent shall pay reasonable and necessary medical services of $590.00 as provided in Sections 8(a) and 8.2 of the Act.

Based upon the Arbitrator's decision with respect to causal connections, the Arbitrator also has found the Petitioner's current condition of ill-being is causally related to the injury which continues to disable the Petitioner from engaging in her regular work activities. Dr. Thometz has opined that she needs to be evaluated by a pain specialist in order to ascertain what additional treatment, if any, is reasonable and necessary to address her ongoing complaints of pain. The Arbitrator finds the opinion of Dr. Thometz more persuasive than that of Dr. Holmes.

The Arbitrator therefore also finds that the Petitioner is entitled to prospective medical treatment and orders the Respondent to authorize the initial evaluation with Dr. Robinson as directed by Dr. Thometz and pay all reasonable and necessary charges incurred therewith, and further reasonable necessary and causally connected treatment thereafter.

In support of the Arbitrator's decision with respect to K (Temporary Compensation) the Arbitrator finds as follows:

Based upon the Arbitrator's decision with respect to causal connection including the Arbitrator's finding that Dr. Thometz' opinions are more persuasive that those of Dr. Holmes, the Arbitrator finds that, as a result of the accidental injuries sustained by Petitioner on March 24, 2014, she has been restricted to sedentary duty since the date of the accident. Respondent offered a Petitioner a limited duty position on March 31, 2014 folding laundry in the basement of their facility. As of March 31, 2014, light duty within Petitioner's restrictions was available. Petitioner performed the restricted work assignment on March 31, April 16 and April 17. However, Respondent withdrew the offer of restricted duty in the correspondence sent to Petitioner on April 21, 2014, advising Petitioner that the position was no longer available (Pet. Ex. 5). Petitioner and Ms. Spaetzle testified that the meaning of the letter was that Petitioner would need to be able to perform the essential functions of her regular job duties to return to work thereafter.

It is a well-settled principle that when a claimant seeks TTD benefits, the dispositive inquiry is whether the claimant's condition has stabilized, *i.e.*, whether the claimant has reached maximum medical improvement. *Interstate Scaffolding, Inc. v. Ill. Workers' Comp. Comm'n*, 236 Ill. 2d 132, 142, 923 N.E.2d 266, 271, 2010 Ill. LEXIS 12, 11, 337 Ill. Dec. 707, 712 (Ill. 2010). In accordance with the Arbitrator's decisions with respect to causal connection and prospective medical, the Arbitrator finds that Petitioner is still restricted to sedentary work by Dr. Thometz and has not yet reached maximum medical improvement.

The Arbitrator finds that Petitioner is entitled to temporary compensation for the period from March 25, 2014 through March 30, 2014 and from April 21, 2014 through December 2, 2014, a period of 33 1/7 weeks.

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WATTS, LEROY Case# **14WC010644**

Employee/Petitioner

PRAIRIE FARMS DAIRY

Employer/Respondent

On 11/10/2015, 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 0.34% 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

2396 KNAPP OHL & GREEN
L DAVID GREEN
PO BOX 446
EDWARDSVILLE, IL 62025

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

LEROY WATTS
Employee/Petitioner

v.

PRAIRIE FARMS DAIRY
Employer/Respondent

Case # **14** WC **10644**

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 **09/25/2015**. 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 _____

FINDINGS

On **11/30/2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**43,231.00**; the average weekly wage was $**831.37**.

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

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

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

Respondent shall be given a credit of $**8,810.42** for TTD, $**-0-** for TPD, $**-0-** for maintenance, and $**-0-** for other benefits, for a total credit of $**8,810.42**.

Respondent is entitled to a credit of $**7,492.63** under Section 8(j) of the Act. Respondent shall keep Petitioner safe and harmless from any and all claims or liabilities that may be made against him by reason of having received such payments only to extent of such credit.

ORDER

Respondent shall pay reasonable and necessary medical services of $8,591.74, as provided in Section 8(a) of the Act. Said services are to be paid consistent with the medical fee schedule.

Respondent shall pay Petitioner permanent partial disability benefits of $**498.82**/week for 48.375 weeks, because the injuries sustained caused the 22-1/2% loss of **use of the right leg**, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

11/6/15
Date

ICArbDec p. 2

NOV 1 0 2015

ATTACHMENT TO ARBITRATOR'S DECISION
(14 WC 10644)

STATEMENT OF FACTS:

Petitioner is a fifty (50) year old "box crew/stacker" or a warehouseman for Respondent, Prairie Farms, where he has worked continuously on a full time basis since December 2008. His job duties are to box-up gallon milk jugs, stack them, and load them into trucks.

According to Petitioner, on November 30, 2013 he was walking backwards in a cooler pulling a stack of milk when he slipped and fell forwards, striking his chest and his right knee. Petitioner gave immediate notice and a written "Incident Report" was completed which Petitioner wrote, "stacking gallons fell forward landing on chest and knee was injured." (PX 6)

Records submitted show Petitioner sought immediate medical attention, going to the Methodist Medical Center emergency room that night. (PX 4, pp.2-16) There, his history in the "Triage" portion of the records show, "Patient states that while at work he fell and now has pain to right knee. Patient states that he works at Prairie Farms." (p.3) In the "Clinician History of Present Illness" portion of the record it's noted, "...The patient states that this problem is job related...Injured in a fall...Lost balance and fell...Patient complains of pain over the right knee. Local soft tissue swelling over the right knee...Suffered a "twisting" knee injury. (p.4) An examination revealed mild to moderate swelling of the right knee. Petitioner was diagnosed with a sprain of the right knee. (p.5) Petitioner returned to regular duty work.

Petitioner was evaluated at IWIRC on January 10, 2014. (PX 3) He gave a history that on November 30, 2013 at 1:00 a.m. he was pulling a stack of milk out of the cooler, lost his footing, and fell forward striking his right knee on a crate and the floor. IWIRC diagnosed a right knee contusion/strain, ordered physical therapy, and allowed Petitioner to continue working with self-modifications to his job. (PX 3, p.2)

Petitioner returned to IWIRC on January 17, 2014 with continuing right knee complaints. It was noted he was working on regular duty work restrictions. Also noted was that physical therapy was pending authorization. By February 27, 2014, Petitioner reported that his right knee symptoms had not improved and that he thought the right knee was getting worse. The medical provider noted that Petitioner missed three office visits and refused to go to physical therapy since he "knows" it will not help. Physical therapy recommendation was continued and a MRI of the right knee to rule out ligamentous pathology was prescribed. (PX 3, p.5)

On March 4, 2014 it was recorded that Petitioner indicated his knee pain was getting worse. It was noted that neither the MRI nor the physical therapy had been performed as IWIRC continued to wait for authorization from Respondent's carrier. Petitioner was given activity restrictions of light duty with occasional lifting up to 20 pounds. (PX , p.7) Petitioner testified that he was not offered restricted duty and began receiving temporary total disability benefits.

On March 12, 2014, the right knee MRI was performed. (PX 5) The study demonstrated a horizontal tear of the body and posterior horn of the medial meniscus; diffuse chondromalacia, and a small joint effusion. On March 13, 2014, Petitioner was assessed with right knee medial meniscal tear and referred for an orthopedic consult at Midwest Orthopedic. (PX 3, p.9)

Petitioner initially saw Dr. Mike Gibbons on April 10, 2014. He gave a history of slipping and falling on a wet floor on November 30, 2013 while stacking boxes. Petitioner thought he twisted and landed on his right knee, but since the accident happened so fast, he was not 100% sure. Petitioner reported immediate medial pain in the knee and had subsequent swelling. Dr. Gibbons diagnosed Petitioner with a right knee medial meniscus

tear and mild medial compartment chondrosis. Dr. Gibbons concluded that conservative treatment had failed, and recommended right knee arthroscopy. (PX 2, pp. 60-61)

On May 23, 2014 Petitioner underwent surgical repair of his torn medial meniscus in the form 1.) right knee arthroscopy with partial medial meniscectomy; and 2.) chrondroplasty medial femoral condyle. (PX 2, pp.55-56) On June 2, 2014, Dr. Gibbons saw Petitioner post-operatively and recommended physical therapy "since he is a little behind as far as range of motion and overall rehab is concerned." (PX 2, p.25) On July 3rd, a physician's assistant saw Petitioner and kept him off work until July 14, 2014 so that he could complete his physical therapy. (PX 2, pp.10-11)

Petitioner testified that he did return to work, full duty, on July 14, 2014. He testified that initially upon returning to work he had knee pain and difficulty performing his job, but that his supervisor "worked with him."

Petitioner was evaluated at his attorney's request by Dr. Frank Russo on February 23, 2015. (PX 1, dep. p.7) His history to Dr. Russo was consistent with the prior medical records and his arbitration testimony. Dr. Russo opined that horizontal meniscus tears are more commonly associated with trauma. (dep. p.13) Dr. Russo testified that he reviewed all of the treatment records from Methodist Hospital, IWIRC, and Midwest Orthopedic. (dep. p.14) In his exam that day, Dr. Russo noted obvious swelling of the right knee (2 cm circumference greater than the uninjured left knee), tenderness in the medial compartment, limited range of motion with flexion in the right knee, and an altered gait with reduction of weight bearing on the right foot. (dep. p.18) Dr. Russo diagnosed Petitioner with right medial meniscus tear status post arthroscopic partial meniscectomy and a small chondral lesion of the right medial femoral condyle, status post chondroplasty. (dep. p.20)

Dr. Russo opined that the November 30, 2013 work accident caused the meniscal tear and either caused or aggravated the condylar condition. He also opined that the November 30, 2013 accident necessitated the surgery in May 2014. Dr. Russo did an impairment rating which yielded a 2% impairment to the lower extremity. (dep. pp. 21-23)

Petitioner denied any prior injuries to his right knee. He testified on direct that he had several other work-related injuries in the past 7 years but none involving his right knee. Records submitted show that he prepared an "Incident Report" claiming that he injured his right knee on November 23, 2013 when he "...was stacking gallons of HOMO and was walking backwards and fell with product." (RX 4, p.1) On November 25, 2014, Petitioner prepared an "Incident Report" indicating, "I was pulling stacks across the moving chains and slipped when putting product away. Kyle Henderson seen the incident and helped me off the floor on the chains." Petitioner indicated his right knee has "tightened up." (PX 6, p.2) On July 16, 2015, Petitioner reported a work injury to the knee. A "Workers' Compensation Claim Form" prepared show Petitioner indicated that his "foot slipped off moving chain allowing knee to twist." (RX 4, p.2)

Petitioner testified as to his current symptoms in his right knee. He has pain with walking, especially when he walks backwards while pulling milk crates. He occasionally wears a knee brace. He takes over-the-counter "Aleve" for pain. His right knee now bothers him at work, but he works through the pain. On cross-examination, Petitioner denied that he was non-compliant with his physical therapy, although he admitted that he probably re-scheduled a few times. He admitted to being in a car accident in August 2015 but denied injuring his right knee. Petitioner stated he injured his right middle shin. Records submitted show Petitioner was seen in the emergency room at Unity Point where it was recorded Petitioner "...hit the back of his head on the seat and also suspected he hit his right anterior shin because he now has swelling and pain to this area."(RX 5, p.29)

In Support of the Arbitrator's decision regarding (F) Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds as follows:

Petitioner's testimony shows that on November 30, 2013 he was walking backwards in a cooler pulling a stack of milk when he slipped and fell forwards, striking his chest and his right knee. Petitioner gave immediate notice and a written "Incident Report" was completed. Petitioner wrote, "stacking gallons fell forward landing on chest and knee was injured." Petitioner sought immediate medical attention, going to the Methodist Medical Center emergency room that night. The "Triage" portion of the records show, "Patient states that while at work he fell and now has pain to right knee. Patient states that he works at Prairie Farms." The "Clinician History of Present Illness" portion of the record show "...The patient states that this problem is job related...Injured in a fall...Lost balance and fell...Patient complains of pain over the right knee. Local soft tissue swelling over the right knee...Suffered a "twisting" knee injury." Petitioner began treating at IWIRC on January 10, 2014 where he provided a history that on November 30, 2013 at 1:00 a.m. he was pulling a stack of milk out of the cooler, lost his footing, and fell forward striking his right knee on a crate and the floor. IWIRC diagnosed a right knee contusion/strain. Due to continual complaints, a MRI of the right knee to rule out ligamentous pathology was ordered. The MRI when completed demonstrated a horizontal tear of the body and posterior horn of the medial meniscus; diffuse chondromalacia, and a small joint effusion. After an assessment of right knee medial meniscal tear, Petitioner was referred for an orthopedic consult at Midwest Orthopedic.

Petitioner initially saw Dr. Mike Gibbons on April 10, 2014. He gave a history of slipping and falling on a wet floor on November 30, 2013 while stacking boxes. Petitioner thought he twisted and landed on his right knee, but since the accident happened so fast, he was not 100% sure. Dr. Gibbons diagnosed right knee medial meniscus tear and mild medial compartment chondrosis. The doctor recommended right knee arthroscopy which was carried out on May 23, 2014.

The only medical opinion specifically addressing the issue is that of Dr. Russo, who found a causal connection between the torn meniscus and chondral injury and the November 30, 2013 accident. Dr. Russo opined that horizontal meniscus tears are more commonly associated with trauma. Dr. Russo testified that he reviewed all of the treatment records from Methodist Hospital, IWIRC, and Midwest Orthopedic. This opinion is consistent with the treatment records and Petitioner's testimony.

Based on the above, the Arbitrator finds that the preponderance of evidence dictates that a causal relationship exists between Petitioner's right knee condition of ill-being and accident sustained on November 30, 2013.

In Support of the Arbitrator's decision regarding (L) What is the nature and extent of the injury, the Arbitrator finds as follows:

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

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

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

(i) The reported level of impairment;

(ii) The occupation of the injured employee;
(iii) The age of the employee at the time of the injury;
(iv) The employee's future earning capacity; and
(v) Evidence of disability corroborated by medical records.

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

i. Petitioner presented an AMA report which indicated a 2% impairment rating of the lower extremity and 1% of a person indicating residual loss of function with normal range of motion. The AMA evaluator noted his physical examination grade modifier was a +1 based on findings of significant tenderness and swelling at the knee joint. The Arbitrator accords weight to this factor

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

ii. Petitioner returned and continues to perform his full duty work, albeit with discomfort. The Arbitrator accords some weight to this factor.

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

iii. Petitioner was 48 years old at the time of injury. Because of the length of time Petitioner will live with his permanent disabilities, the Arbitrator gives some weight to this factor

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

iv. There is no evidence that Petitioner's earning capacity has been affected. As such, the Arbitrator accords no weight to this factor.

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

v. Petitioner underwent surgical repair of his torn medial meniscus in the form 1.) right knee arthroscopy with partial medial meniscectomy; and 2.) chrondroplasty medial femoral condyle. Records submitted show Petitioner was last seen by physician on February 23, 2015, that being the IME physician, Dr. Russo. At that time, Dr. Russo noted obvious swelling of the right knee (2 cm circumference greater than the uninjured left knee), tenderness in the medial compartment, limited range of motion with flexion in the right knee, and an altered gait with reduction of weight bearing on the right foot. Dr. Russo diagnosed Petitioner with a right medial meniscus tear status post arthroscopic partial meniscectomy and a small chondral lesion of the right medial femoral condyle, status post chondroplasty. Petitioner testified to residual complaints of pain, especially when he walks backwards while pulling milk crates. He occasionally wears a knee brace. He takes over-the-counter "Aleve" for pain. His right knee now bothers him at work, but he works through the pain. The Arbitrator accords weight to this factor.

The Arbitrator had the opportunity to review the medical records and observe Petitioner's testimony. The Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 22-1/2% loss of use of the right leg under 8(e) of the Act.

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, the Arbitrator finds as follows:

Petitioner's Exhibit 7 is a compilation of outstanding medical bills and a health insurance lien. The first balance is from Midwest Orthopedic Center, Dr. Gibbons and physical therapy; the next two bills are for the emergency room physicians on November 30, 2013 and March 3, 2014; the next bill is from DJO Global for a post-operative knee mobilizer/icer prescribed by Dr. Gibbons on May 15, 2014; the next bill is from Associated Anesthesiology for the surgery on May 30, 2014; the next bill is from OSF for pre-operative services on April 25, 2014; the next OSF bill is for a Doppler study necessary for surgical clearance, performed on May 21, 2014; the final OSF bill is the facility charge for the surgery on May 23, 2014; the next bill is from Central Illinois Radiology for the knee x-rays taken on November 30, 2013; and the next bill is for pre-operative labs done on May 15, 2014.

Having found the issue of causal connection in favor of Petitioner, the Arbitrator awards the bills enumerated above. Said bills are to be paid consistent with the medical fee schedule.

The Arbitrator notes that also included in Petitioner's Exhibit 7 is a BlueCross BlueShield lien in the amount of $7,182.63. This is Petitioner's health insurance which he has through his employment with Respondent. Respondent is entitled to an 8(j) credit for this lien. The lien includes payments to Methodist Medical Center, the emergency room physicians, Midwest Orthopedic Center, Central Illinois Pathology, Heartcare Midwest, OSF, Associated Anesthesiology, and OSF Medical Group. Respondent shall keep Petitioner safe and harmless from any and all claims or liabilities that may be made against him by reason of having received such payments only to extent of such credit.

The total medical bills and lien award is $8,591.74.

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

SPOONMORE, TINA Case# **14WC029766**

Employee/Petitioner

ILLICO INC D/B/A SPRING VALLEY SHELL

Employer/Respondent

On 11/9/2015, 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 0.28% 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:

5475 BERTRAND LAW OFFICE
LOUIS BERTRAND
613 FIRST ST SUITE 100
LASALLE, IL 61301

0210 GANAN & SHAPIRO PC
AMY L TURNBAUGH
210 W ILLINOIS ST
CHICAGO, IL 60654

STATE OF ILLINOIS)
)SS.
COUNTY OF LaSalle)

☐ 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)

Tina Spoonmore
Employee/Petitioner

v.

Illico Inc D/B/A Spring Valley Shell
Employer/Respondent

Case # 14 WC 29766

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

FINDINGS

On the date of accident, **July 15, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**15,283.32**; the average weekly wage was $**293.91**.

On the date of accident, Petitioner was **26** years of age, ***single*** with **2** dependent children.

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

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

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

ORDER

Petitioner failed to prove she sustained an accident on July 15, 2014, or any other date, that arose out of and in the course of her employment with respondent.

Petitioner's claim is hereby denied and case is dismissed.

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

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

Christine Moy

Signature of Arbitrator

11/05/2015

Date

ICArbDec19(b)

NOV - 9 2015

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tina Spoonmore	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 14 WC 29766**
	)	
Illico, Inc., d/b/a Spring Valley Shell,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter was heard on September 30, 2015 pursuant to § 19b and § 8a of the Act. The parties agree that on July 15, 2014, The Petitioner and Respondent were operating under the Illinois Workers' compensation or Occupational Diseases Act, and their relationship was on of employee and employer. They agree that in the year pre-dating the accident petitioner earned $15,283.32 and her average weekly wage was $293.91.

At issue in this earing is as follows:

1. Whether the petitioner sustained accident injuries that arose out of and in the course of her employment;
2. Whether petitioner gave respondent notice of the accident within the time limits sated in the Act.
3. Whether petitioner's current condition of ill-being is causally connect to the claimed injury.
4. Whether respondent is liable for the unpaid medical bills totaling $42,666.30.
5. Whether petitioner is due TTD as claimed from July 16, 2014 to the date of hearing on September 30, 2015.

STATEMENT OF FACTS

Petitioner testified that she had a prior right knee injury from February, 2012 that was settled in July, 2013. She had been under the care of Dr. Shin and Dr. Perona for the previous right knee injury. Petitioner testified she had been discharged from care by Dr. Perona for about one year before this claimed work injury.

She began her job with respondent in May, 2014. This was petitioner's first job since she settled her previous workers' compensation case for the right knee injury. She was employed by respondent as a cashier. As such, she was required to stock shelves, clean coolers and washrooms.

On the night of July 15 2014 petitioner testified she was working alone on the 3 P.M. to midnight shift. At about 10:30 P. M. she bent down to restock the coolers and felt a pop. She

had a case of beer in her hand. After that she noticed it was hard to walk on the right knee as it was painful and swollen. She testified that that by the time she left at 12:15 A.M. at the end of her shift, the pain was unbearable. She testified she was unaware of the proper forms to be completed to report a work injury. Prior to July 15, 2014, she was not on any prescribed medication.

Petitioner testified that on the afternoon of July 16, 2014, she sought treatment for her right knee at St. Margaret's Hospital. She was prescribed pain meds, an ice pack and referred to an orthopedic surgeon by the emergency room doctor, Dr. Grivetti.

On July 23, 2014, petitioner returned to St. Margaret's Hospital, where she was seen by Dr. Bailey. She had not been able to get in to see Dr. Perona between July 16, 2014 and July 23, 2014. She was taking hydrocodone. The knee was very swollen and painful.

Petitioner testified she did not call off work and did not go into work on July 16, 2014. Petitioner testified that on July 23, 2014 she went back to the E R at St. Margaret's Hospital where she was seen by Dr. Baily and was prescribed anti-inflammatories, a knee brace and pain meds. She testified she texted a message to Trina advising she was injured at work. She testified she did not complete an accident report as she though she couldn't file a second case for her right knee.

Petitioner testified she saw Dr. Perona about a month after the accident. Her knee was swollen and she was unable to walk. She had an MRI. He did not prescribe meds, PT or surgery. She was not able to work. She did not like Dr. Perona as she said they were not on the same page. She therefore sought the care and treatment by a Dr. Patel. Her knee was getting worse. She was not able to work. She was on crutches as prescribed by Dr. Perona.

She was referred by Dr. Patel to Hinsdale Orthopaedics at the end of September, 2014. She came under the care of Dr. Puppala of Hinsdale Orthopaedics. Dr. Puppala ordered another MRI and X-ray. On January 23, 2015 Dr. Puppala ordered surgery. She now follows up about once a month with Dr. Puppala and Dr. Patel. She has physical therapy at St. Margaret's rehabilitation in Peru, Illinois, about three times a week. This started about three months ago.

She takes hydrocodone three times a day and an anti- inflammatory about one time per day. These meds were obtained through Medicaid card.

Petitioner testified she is very limited in that she can't take kids to the park or walk more than a half hour at a time. She can't bend or squat and her leg swells. She gets pain that shoots down her right leg. She does side to side stretches and quad strengthening exercise. She has not been released to return to work by any doctor. Petitioner testified Dr. Puppala estimated she will have a five month recovery after surgery. She testified her condition has not improved.

On cross-examination petitioner testified she had no short term memory loss. She admitted she had been under the care of Dr. Rhode from June through December, 2013. She also admitted Dr. Rhode had previously given her permanent restrictions with limited bending, squatting and lifting. She also admitted she had seen Dr. Perona on January 2, 2014 for her right knee and that Dr. Perona had performed surgery to her right knee on January 29, 2014. She further admitted to seeing Dr. Perona on May 1, 2014.

Petitioner admitted that on May 2, 2014, she completed respondent's questionnaire for job applicants agree she could perform the essential functions of the job which included carrying and stocking up to 50 pounds of various products and to stock shelves and coolers (RX.2)

Petitioner agreed she began working for respondent on May 7, 2014 and after training she was work evenings. Petitioner agreed she worked July 15, 2014 to July 16, 2014 Petitioner denied returning to work for respondent after July 16, 2014 even though the payroll records showed petitioner worked and was paid until July 22, 2014.

Petitioner could not recall exactly when she texted Katrina about the work accident; she thought it was within a week after the accident. Petitioner denied she sent the text message to Katrina identified as Respondent's Exhibit 3. She was not sure where the forms were kept to report claims.

Petitioner admitted she signed the Application for Adjustment of Claim on July 25, 2014 alleging a date of accident as July 22, 2014. Petitioner testified she did not look at the date and told her attorney she was unsure of the actual date of accident.

Petitioner admitted she completed the questionnaire for Hinsdale Orthopedics indicating the date of accident as June 18, 2014.

Petitioner admitted she had gone to Florida in January, 2015 and had surgery at the end of February, 2015. Petitioner had gone to Florida with her former boyfriend, his son and her daughter as her former boyfriend's mother had cancer. Petitioner denied having a phone of her own with text capabilities as she shared the phone with her former boyfriend, Carl Telford. She now has obtained an order of protection against the former boyfriend.

Petitioner admitted to pleading guilty to retail theft charges in December 2014 (RX. 13).

Katrina Bourey testified in behalf of respondent. She is the current storage manager for respondent and has been that for three years. She does the scheduling, makes the deposits and does the training. Part of Bourey's job was to train new employees. She goes through policies with the new employees on how to fill out accident reports; related to customers or employees. She also shows the new employees were the binder is kept for these reports. Bourey testified the binder was kept down by the cash register. She also has the employee initial after each category discussed in the training. She had done this with petitioner when petitioner had started.

Bourey testified petitioner was hired the first week in May, 2014. According to the schedule (RX.1) petitioner was scheduled and worked July 14,15,16,17, and 18. She was not scheduled to work July 19. Petitioner was scheduled to work and did work on July 20 and 21. Petitioner was to work on July 22, 2014 but was a no-call and no-show. Bourey did not notice any problems with petitioner's knee prior to July 15, 2014.

Bourey would often communicate with petitioner through texts. Bourey had stored petitioner's name and number on her phone. Bourey would off and on text message with petitioner. Bourey denied anyone else had access to her phone. Bourey denied receiving a text message from petitioner that she was hurt. Bourey denied receiving any notification or having any communication of any accident directly from petitioner. The first she knew of a claimed accident was when she received a letter from petitioner's attorney.

Bourey testified that Jamie Miranda was a former assistant manager who left respondent's employ under good terms. Bourey testified she had seen Miranda on the date of hearing and had lunch with her. After lunch, Miranda did not return to the court room.

On rebuttal, petitioner testified she did not receive training on reporting any accidents and was unaware of the location of the binder.

Respondent introduced the records of Dr. Blair Rhode (RX.6).

These records show petitioner was first seen by Dr. Rhode on January 9, 2013 due to right knee pain from an injury which occurred on February 10, 2012 while working for Best Western. The initial MRI was reported as normal, but she underwent arthroscopic surgery because she was not responding to conservative care. Six weeks post-operatively she again had pain and swelling. Physical Therapy was ordered.

She followed up with Dr. Rhode on February 15, 2013. An MRI was ordered and 90 Norco was prescribed. She was again seen by Dr. Rhode on March 1, 2013. She had not yet had the MRI. Another 90 Norco was prescribed.

On June 1, 2013 she was seen by Dr. Rhode. At that time the MRI was deferred due to petitioner's pregnancy. Oral medication was deferred to petitioner's obstetrician.

She was seen again on June 27, 2013 and then on June 28, 2013. On June 28, 2013 petitioner was cleared to take oral medication and 60 Norco was prescribed.

On August 24, 2013, petitioner had delivered her child and thus able to proceed with an MRI. She was prescribed 60 Norco for pain.

On October 5, 2013 she returned to Dr. Rhode. Her MRI was scheduled for October 8, 2013. She was prescribed 60 Norco tablets. On October 17, 2013 she returned post MRI. The MRI was reported as unremarkable. She was prescribed 60 Norco.

On November 14, 2013 petitioner obtained an injection by Dr. Rhode and prescribed 60 Norco. She was given permanent restrictions of no squatting, kneeling or crawling. She also had limited restrictions in climbing ladders or to bend or stoop.

On December 6, 2013 she followed up with Dr. Blair who could not provide any further treatment to her and referred her to pain management. He prescribed 60 Norco at that time.

On December 10, 2013, at the referral of Dr. Rhode, petitioner was seen by Dr. Ronald Kloc. He had nothing to offer her and suggested she se Dr. Perona. Dr. Kloc stated that under no circumstances is [petitioner] a candidate for any other pain medication therapy.

The records of St. Margaret Hospital show the following visits (RX. 15):

E R visit of September 6, 2013 chipped tooth had dental abscess/trauma. 24 Hydrocodone (Vicodin) and Amoxicillin were prescribed.

E R visit of November 2, 2013 pain in right knee has gotten progressively worse and tonight unbearable. The only thing that helps is hydrocodone (Norco) which was prescribed.

E R Visit of November 30, 2013 pain in right knee after shopping today and out of hydrocodone, which was prescribed.

E R visit of December 19, 2013 ER visit when she fell landing on her lower ribs. She felt as though her knees gave out. She was prescribed Naproxyn.

Pre-op Physical on January 21, 2014.

On March 2, 2014 a two-page report entitled "Ambulatory Prescriptions and Procedures" there was reported prescriptions of Norco on January 31, 2014, February 11, 2014 and February 19, 2014. There was also a cancelled prescription for Norco on February 4, 2014.

E R visit of March 3, 2014 petitioner twisted her left foot. She was diagnosed with a foot sprain and prescribed Naproxyn.

E R visit of March 23, 2014 due to altercation with boyfriend and possible suicide attempts.

E R visit of July 16, 2014 for right knee complaints at 13:26. History was: "Patient enters with a right knee injury. She sustained this at work last night. Patient squatted down to store something on the lower shelf. When she felt a pop and had immediate pain. Patient has had previous knee injury on the affected knee, requiring a repair per Dr. Perona. Patient is concerned about possible internal derangement." The diagnosis was knee sprain. She was prescribed Norco. She was given an excuse from work from July 16, 2014 through July 17, 2014.

E R visit of July 23, 2014 due to right knee pain for three years. The description of the accident give at that time was: "she was squatting at work dropping a beer case down on the ground she felt a pop 2 weeks ago she was evaluated in the emergency room because of the severity of the pain she is given anti-inflammatory and a few Norco she still in severe pain".

The records of Dr. Perona where introduced by respondent (RX.11). The history recited in Dr. Perona's records on January 2, 2014 was petitioner had right knee pain complaints for nine months. She indicated she injured the right knee when she tripped while getting out of an elevator two years before. She had surgery by Dr. Shin in 2011 which only provided one month relief; then the pain returned. She stated that the knee gives way, grinds, and catches, but does not lock. In her patient questionnaire, petitioner indicated she was taking hydrocodone every 5-6 hours and meloxicam daily. Dr. Perona recommended right knee arthroscopy with lateral retinacular release and medial reefing, only after reviewing the surgery pictures taken by Dr. Shin in 2011 (RX.11).

On January 29, 2014, petitioner underwent a right knee arthroscopy and mini open lateral retinacular release and medial reefing due to right knee patellofemoral maltracking. Petitioner returned to Dr. Perona on February 11, 2014 with complaints of pain and burning around the incision and the knee giving out. She has medial and lateral pain when flexing the knee. Additional Norco was prescribed (RX.11).

On March 11, 2014 she returned to Dr. Perona. A hand-written notation indicates petitioner had been prescribed 140 Norco since her surgery of January 29, 2014. She reportedly was doing okay with only some pain and soreness along the incision. She was to continue with the Zostrix cream Meloxicam and discontinue formal physical therapy (RX.11).

She contacted Dr. Perona's office requesting a letter stating that she is off work until her next visit of April 15, 2014 for child support reasons. This letter was completed on March 25, 2014. She returned to Dr. Perona on May 1, 2014. She reports doing a little better but unable to squat, kneel or drive long distances and the knee gives out a lot. She reported to have been to the ER twice since her previous visit due to pain. She was released with light duty restrictions and to return in three months (RX.11).

Petitioner returned to Dr. Perona on July 29, 2014 as follow for her right knee. Her history at that time was: "working 2 weeks ago-was stocking cooler, bent over, felt pop-Went to ER. X-rays-Norco. (almost gave out hurt later in day swelling) Went back to work for one week then went back to ER-severe pain & was told to wear immobilizer-not working now. Taking Mobic and Norco 4 per day. Feels grinding again." Dr. Perona ordered an MRI, physical therapy and referred petitioner to a pain clinic (RX.11).

Petitioner was first seen by Dr. Rajesh Patel of Pain & Spine Institute on August 1, 2014. She reported the pain started after an injury of July 22, 2014. Dr. Patel wrote: "The event which precipitated this pain was stocking a cooler at work Shell gas station, bent down felt a pop, finished shift but later that evening went to Spring Valley ER due to the pain. This occurred at work." Dr. Patel's diagnosis was osteoarthritis of knee and lower back pain. Dr. Patel ordered an MRI and prescribed 28 Norco (PX.8)

The MRI of August 5, 2014 only indicated that there was a T2-weighted signal intensity or edema in the fat lateral to the interior pole of the patella that may reflect impingement. These findings were similar to the October, 2013 MRI. Otherwise the MRI was unremarkable (PX.2).

Petitioner returned to Dr. Patel on September 5, 2014. He ordered continued PT and conservative care and renewed her prescription for Norco. She saw Dr. Patel on September 17, 2014. He continued with conservative care and prescribed 60 Norco. Petitioner was to take a maximum of two per day. On October 13, 2014, she returned to Dr. Patel who ordered an intra-Articular Join Injection, as well as a prescription for 60 Norco. On October 21, 2014 petitioner underwent the Intra-Articular Knee injection by Dr. Patel. She returned to Dr. Patel on November 10, 2014. He prescribed 60 Norco and ordered a drug screen. He initiated a referral to Dr. Puppala (PX.8).

She returned to Dr. Patel on December 9, 2014. She was now under the care of Dr. Puppala. Norco prescription was refilled. She returned to Dr. Patel on January 16, 2015. Her pain score was 8 out of 10. She advised Dr. Patel that Dr. Puppala had planned surgery. 30 Norco were prescribed. She again saw Dr. Patel on February 17, 2015. She reported that surgery was scheduled with Dr. Puppala for February 23, 2015. Dr. Patel refilled the Norco prescription with 75 pills due to the impending surgery.

Petitioner first saw orthopedic surgeon, Dr. Dr. Puppala, on November 17, 2014 as a referral by Dr. Patel. On the patient questionnaire, completed by petitioner for Dr. Puppala, petitioner listed the date of accident as June 18, 2014 when stocking a cooler. Dr. Puppala assessed the condition as chondromalacia of the patella on the right. When she returned to Dr. Puppala on December 16, 2014, he determined she had a fat pad impingement syndrome, patella maltracking and painful retained suture. Dr. Puppala recommended surgery. She returned on February 16, 2015 and asked to proceed with surgery. Dr. Puppala performed a right knee

arthroscopy for removal of a retained foreign body (suture) and fat pad impingement. In the operative report, Dr. Puppala noted the patellar tracking appeared quite good and he could not detect any pathologic patellar instability, so no release was performed (PX3).

On March 17, 2015 Dr. Puppala ordered physical therapy (PX.6).

On July 6, 2015 petitioner returned to Dr. Puppala. She was still in physical therapy. She was still complaining about a lot of pain and stiffness. She was to follow up in four weeks and still unable to work (PX.5)

CONCLUSIONS OF LAW

In support of whether an accident occurred which arose out of and in the course of Petitioner's employment with Respondent the Arbitrator makes the following conclusions of law:

The Arbitrator finds petitioner failed to prove she sustained injuries from an accident which arose out of and in the course of her employment with respondent. Petitioner claimed that she injured her right knee in an un-witnessed work accident. The Arbitrator found petitioner not to be credible.

Petitioner testified she had not had any treatment to her right knee since 2013. However, the medical records proved she had surgery to her right knee in January, 2014 and had last seen Dr. Perona for her right knee on May 1, 2014; six days before she began her employment with respondent.

The original Adjustment of Claim signed on July 25, 2014 indicated petitioner's date of accident was July 22, 2014 (RX.7). The 19 b-1 Petition dated October 2, 2014 listed the date of accident as July 22, 2014 (RX.9). She advised Dr. Patel on August 1, 2014 that her date of accident was July 22, 2014 (PX.8). However, the payroll records introduced with no objection indicated petitioner did not work on July 22, 2014 (RX.1).

The Request for Hearing listed the date of accident as July 15, 2014 (Arb. Ex.1). Petitioner testified that the accident occurred on July 15, 2014. The emergency room record from St. Margaret's Hospital from July 16, 2014 puts the date of accident at July 15, 2014.

The Amended Application listed the date of accident as July 14, 2014 (RX.16).

Petitioner completed a questionnaire for Dr. Puppala on November 17, 2014 listing the date of accident as June 18, 2014 (PX.3).

Petitioner testified that on July 15, 2014 she bent down to restock the coolers and felt a pop in her right knee. She had a case of beer in her hand. The ER report from St. Margaret Hospital from July 16, 2014 recites a history of: "Patient enters with a right knee injury. She sustained this at work last night. Patient squatted down to store something on the lower shelf when she felt a pop and had immediate pain. On July 23, 2014, the history in the emergency room records from St. Margaret Hospital was: "she was squatting at work dropping a beer case down on the ground she felt a pop 2 weeks ago." On July 29, 2014 the records from Dr. Perona indicate the injured had occurred two weeks prior while stocking a cooler; bent over and felt a

pop. When completing the questionnaire for Dr. Puppala, she stated she injured her knee when stocking a cooler on June 18, 2014.

She testified that she was not able to work after July 16, 2014 and yet the payroll records show she worked on July 17, 18, 20 and 21 (RX.1). Furthermore, she reported to Dr. Perona on July 29, 2014 that she had hurt her knee two weeks before at work, went to ER; had returned to work for a week, then returned to the ER and had not worked since (RX.11).

Petitioner admitted she had completed the job questionnaire for respondent agree she had the physical capability to perform the essential elements of the job including stocking coolers and shelves as well as being able to transport and stock up to 50 pounds (RX.2). Petitioner had agreed to this despite the fact that she had been given permanent restrictions by Dr. Rhode as late as November 14, 2013 which restricted her from performing the essential elements of the job (RX.6).

She contradicted herself as to why she did not complete the accident form. At first she testified she did not believe she could file another claim for her right knee as she had already claimed an injury to her right knee which was settled. She further testified she did not know where the forms were kept which is the reason she never completed an accident form for respondent. Petitioner's supervisor, Katrina Bourey, provided credible testimony on the training of petitioner as to completing accident forms and where the accident forms were kept.

Petitioner admitted to misdemeanor retail theft in December, 2014, which also goes to her credibility.

The evidence suggests petitioner consistently complained of pain in her right knee, without objective findings in order to obtains treatment and numerous prescriptions of hydrocodone by various doctors and hospital. Petitioner's drug-seeking propensities shows motive to pursue a claim in order to obtain the pain medication; thus goes to her credibility.

The Arbitrator also notes petitioner claims to have had a work accident shortly after respondent received notification of payroll withholding for child support; said withholding began on July 12, 2014 (RX.1). Petitioner had previously asked Dr. Perona to write a letter in March, 2014 regarding her disability for child support reasons (RX.11). Avoidance of child support payments would be another motivating factor that calls into question petitioner's credibility as to whether an accident actually occurred.

Finally, there is no evidence petitioner actually suffered any injury to her right knee in June or July, 2014. The MRI of August 5, 2014 only indicated that there was a T2-weighted signal intensity or edema in the fat lateral to the interior pole of the patella that may reflect impingement. These findings were similar to the October, 2013 MRI. Otherwise the MRI was unremarkable (PX.2).

As reported in his operative report of February 23, 2015, Dr. Puppala removed a suture which was there due to the previous procedure, as well as a fat pad. He found no instability and described the cartilage as pristine. There were no tears or degenerative changes. He found the patella tracking quite good and did not find any instability to warrant a medial release (RX.4).

For the foregoing reasons, the Arbitrator finds petitioner failed to prove she had an accident which arose out of and in the course of her employment with respondent and denies her claim.

As the Arbitrator has determined petitioner failed to prove an accident occurred which arose out of and in the course of her employment with respondent all other issues are moot.

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

BANDERAS, JOAQUIN Case# **14WC032465**

Employee/Petitioner

CERMAK PRODUCE NO 11 INC

Employer/Respondent

On 11/10/2015, 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 0.34% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1922 STEVEN B SALK & ASSOC
FRANK I GAUGHAN
150 N WACKER DR SUITE 2570
CHICAGO, IL 60606

2461 NYHAN BAMBRICK KINZIE & LOWRY
GARY WALLACE
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
19(b)

JOAQUIN BANDERAS,
Employee/Petitioner
v.

Case # **14 WC 32465**

CERMAK PRODUCE NO. 11, 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 **Milton Black**, Arbitrator of the Commission, in the city of **Chicago**, on **August 27, 2015 and August 28, 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 23, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$25,263.16**; the average weekly wage was **$485.83**.

On the date of accident, Petitioner was **48** years of age, ***single*** with **1** dependent child.

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

Respondent shall be given a credit of **$4,525.71** for TTD, $N/A for TPD, $N/A for maintenance, and **$2,500.00** for other benefits, for a total credit of **$7,025.71**.

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 **$323.89**/week for **5 4/7^{ths}** weeks, commencing **July 23, 2014** through **September 1, 2014**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of **$4,525.71** for TTD and **$2,500.00** for other benefits, for a total credit of **$7,025.71** that have been paid.

Petitioner's claims for any medical treatment after September 1, 2014, Petitioner's claims for any temporary total disability benefits after September 1, 2014, and Petitioner's claims for penalties and attorneys' fees are denied, because Petitioner's current condition of ill-being is not causally related to the 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 8, 2015

Date

ICArbDec19(b)

NOV 10 2015

FACTS

Petitioner suffered an accident arising out of and in the course of his employment with Respondent on July 23, 2014. Petitioner was cleaning a cooler. While moving containers of meat, he injured his lower back. Initial medical treatment was at St. Anthony Occupational Medicine for a lumbar strain (PX1, p6). An MRI dated August 5, 2014 indicated mild degenerative disc disease (PX1, p3). Petitioner was treated with medication, given work restrictions, and physical therapy was ordered (PX1, pp6-9).

Petitioner testified on direct examination that when he was discharged from St. Anthony Occupational Medicine on August 29, 2014, he was told he needed to see another doctor. On cross-examination, Petitioner admitted that he was told he needed to see another doctor for osteoarthritis and that his condition was no longer related to his work accident. The cross-examination version is corroborated by the August 29, 2014 St. Anthony Occupational Medicine chart note of (PX1, p22).

Petitioner testified that he next went to Marquis Medicos for further treatment. Those records indicate Petitioner received multiple chiropractic treatments as well as multiple physical therapy sessions from September 2, 2014 through January 14, 2015 (PX2). Petitioner testified that he was referred to Dr. Harsoor, a pain specialist, by the Marquis Medicos Group, for further pain management. Petitioner testified that he was referred to Dr. Erickson (PX6) for a surgical consult by Dr. Harsoor.

On October 16, 2014, Petitioner was evaluated by Dr. Gunnar Andersson, an orthopedic surgeon at Midwest Orthopedics. Dr. Andersson examined Petitioner and reviewed medical records. Dr. Andersson stated that there was an essentially normal MRI. Dr. Andersson concluded that all treatment through August 29, 2014 was reasonable and necessary. Dr. Andersson further concluded that treatment beyond August 29, 2014 was not related to the accident of July 23, 2014. Dr. Andersson further concluded that Petitioner had reached maximum medical improvement as of August 29, 2014 (RX1). August 29, 2014 was the Friday before Labor Day.

DISCUSSION

The Arbitrator finds that Petitioner's current condition of ill-being is not related to the accident of July 23, 2014. The Arbitrator specifically adopts the opinions of Dr. Gunnar Andersson and of Dr. Carl Gustas.

Therefore, the Arbitrator makes the following findings:

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

Petitioner's claims for any medical treatment after Labor Day, September 1, 2014 are denied.

Petitioner's claims for any temporary total disability benefits after September 1, 2014 are denied.

Petitioner's claims for penalties and attorneys' fees are denied.

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

BACKUS, RICHARD Case# **15WC023612**

Employee/Petitioner

RICHARD'S BUILDING SUPPLY

Employer/Respondent

On 11/10/2015, 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 0.34% 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

1109 GAROFALO SCHREIBER STORM
STEVEN SCARLATI JR
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

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)

RICHARD BACKUS
Employee/Petitioner

v.

RICHARD'S BUILDING SUPPLY
Employer/Respondent

Case # **15** WC **23612**

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 **09/24/2015**. 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, **03/30/2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**35,859.20**; the average weekly wage was $**689.60**.

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

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

Respondent shall be given a credit of $**-0-** for TTD, $**-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.

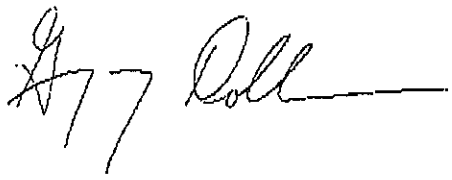
ORDER

Respondent shall pay reasonable and necessary medical services of $270.52, as provided in Section 8(a) of the Act. Respondent shall further authorize the surgical procedure as recommended Dr. Garst.

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

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

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



Signature of Arbitrator

11/6/15
Date

ICArbDec19(b)

NOV 10 2015

STATEMENT OF FACTS:

Richard Backus is a 58 year old warehouse truck driver who worked for Respondent for the last 6 years. Richards Building Supply is in the business of supplying roofing, siding, windows, doors, felt paper and other building supplies. Petitioner testified that as part of his job, he is required to help load trucks, drive them to job sites, and unload them at the job site.

Petitioner testified that he works with bundles of shingles on a regular basis. Depending what truck they are using, the process of handling this material is different. Petitioner indicated that if he is operating a boom truck, which he often times does, he would have to take a pallet of 48-56 bundles of shingles and break them down into pallet of 20 bundles of shingles so that the boom truck could lift them. Petitioner provided that this is done this way because the boom truck cannot lift a full pallet of shingles. He stated that breaking down these shingle pallets would be done manually by hand.

Petitioner testified that if loading a conveyor truck, the shingles can be loaded on the truck in full pallets. This could be done with a fork lift, however it was much more labor intensive on the unloading side. Items such as siding would have to be loaded onto the truck one box at a time. Petitioner stated he would have to pull this item off a fork lift or a rack, carry it to the truck and slide it into the truck using a forceful pushing motion. This was essentially the same process for doors, windows, felt paper and other items. Petitioner estimated that a bundle of shingles weighed 80 pounds and a box of siding weighed 90 pounds. When loading siding, they would have to stack these boxes and slide them in the trucks so they could be delivered. This involved pushing and pulling the product. The loading process would be the same for other items such as doors, windows, and felt paper. According to Petitioner's job description (PX 5), 35% of his job would be loading & unloading in the warehouse.

Petitioner testified that when delivering the products, the unloading process varied depending on what truck he was driving. If he was using a boom truck, he would have to physically slide a 400 pound set of forks on the truck so he could hook it up to the boom then maneuver it and slide it under a pallet so he could pick up a pallet with the boom. This required pushing and pulling the heavy set of forks. The boom would then place the pallet on the roof. When the process was complete, Petitioner would slide the forks back into place by pushing them and secure them for travel. The process is different for a conveyor truck.

Petitioner explained that the pallets delivered on the conveyor truck could be loaded by the fork lift, however; the unloading process was much more cumbersome. Each bundle of shingles would have to be lifted, carried to, and placed on the conveyor. This required Petitioner to handle every bundle on each pallet. Petitioner provided that although he often drove the boom truck, he also drove the conveyor truck. Petitioner stated he drove the conveyor truck three times during the week prior to the arbitration hearing.

Unloading the other materials such as siding, windows, doors and felt paper is all done by hand. Petitioner indicated that he would pull the boxes of siding, windows and doors off the truck then lift and carry them to their destination. Petitioner testified that none of the trucks had a lift gate on them. He further testified that there was never a load that he didn't have to physically lift or move something to deliver. According to his job description, Petitioner spent 15% of his time unloading in the warehouse, 20% of his time loading in the warehouse and 50% of his time delivering. Petitioner stated that included in this 50% time spent on delivery, he would unload his truck at the delivery site.

Petitioner testified that he began to notice his right arm began aching. At the end of the day he noticed loss of strength and had a "dead spots" in his elbow. At night, he experienced numbness and tingling in his hands and arms that woke him up. Petitioner provided that because he often times is handing products to somebody or working in close proximity with another individual, he was concerned that he might lose his grip and injury someone.

On November 6, 2014, Petitioner saw Dr. Mark Montefolka of UnityPoint Health with a history of bilateral wrist pain for the past couple of months. Petitioner rated his pain as high as 8/10 on the pain scale and reported no injury that he knew of. After performing an examination, Dr. Montefolka diagnosed bilateral carpal tunnel syndrome and ordered an EMG study. (PX 3) On November 17, 2014, Petitioner completed an "Employee Injury Report" claiming he had "pain in hands and wrist." (RX 2)

On November 20, 214, Petitioner saw Dr. Yibing Li for the prescribed EMG study. On the initial consultation form, the reason for visit lists pain in hands and wrists, lack of strength. The EMG indicated right cubital tunnel syndrome. Dr. Li recommended activity modification and an orthopaedic consult was ordered. (PX 2) Petitioner testified that he discussed the findings of the EMG with Dr. Li. At that time he learned that his symptoms may have emanated from his arm. Petitioner stated, "I didn't know it was my arm."

Petitioner returned to Dr. Montefolka on January 5, 2015. Dr. Montefolka noted Petitioner still had some pain shooting from the right elbow to his right fingers. The doctor provided the symptoms were intermittent. The doctor diagnosed cubital tunnel syndrome and noted Petitioner was awaiting approval for surgical intervention. (PX 3)

On March 20, 2015, Petitioner presented to Dr. Jeffrey Garst. At that time, he was diagnosed with right cubital tunnel syndrome. Dr. Garst stated in his note that clinically he believed Petitioner had cubital tunnel syndrome and the EMG study supports this diagnosis. His recommendation was for a right ulnar nerve transposition. This would be done on an outpatient basis under general anesthesia. Dr. Garst states in his note that Petitioner requested his opinion regarding causal connection. Dr. Garst provided, "He did describe his job for me. He is a truck driver, but he does a lot of delivery and quite a bit of lifting, pushing and pulling with his arms. He has been doing this for many years. I would think that his cubital tunnel syndrome was work related and I related that opinion to him." (PX 3) Petitioner testified that he told Dr. Garst about what he did at work with regards to delivering shingles, siding and building supplies. Petitioner testified that this was the first doctor to tell him his condition was caused by work.

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Lawrence Li on May 1, 2015. Dr. Li recorded that Petitioner provided a history that he began experiencing numbness and tingling in his right elbow and forearm that went to his fingers starting in September. His symptoms were worse during the work day. Dr. Li recorded that he reviewed Petitioner's job duties and that Petitioner provided that he spends about two or three hours a day driving and delivering roofing materials; he had been doing same for 30 years making about five (5) deliveries a day; and that he has to build pallets and he has to put shingles and other products onto a pallet so that the pallets can be lifted onto a truck. After performing an examination, reviewing the job description and reviewing Petitioner's medical records, Dr. Li diagnosed mild right cubital tunnel syndrome. He felt that Petitioner's subjective complaints and the diagnostic study (EMG/NCV) were consistent. Dr. Li opined that "...loading the roofing products onto a pallet for five deliveries a day is not causal or contributory to development of right cubital tunnel. He has significant COPD, which would affect his oxygenation and the micro circulation to all of his nerves and so the cubital tunnel syndrome is more likely related to his personal medical condition as opposed to his job duties." Dr. Li felt that six weeks of physical therapy would be appropriate and if same fails, surgery would be indicated. (RX 1)

Mr. Pat Turner testified on behalf of Respondent in this matter. Mr. Turner is the Branch-Manager who oversees the day-to-day operation of the location including the warehousemen and drivers. Mr. Turner testified that although it was not their primary duty, "as a general statement, all truck drivers do warehouse [work]." Mr. Turner stated that Petitioner averaged approximately three loads per day and that a survey showed that nine (9) out of ten (10) loads were prepared for Petitioner. He testified that Petitioner's main job was to operate the boom truck. Mr. Turner testified that it was not uncommon for the truck drivers to be involved in loading their own trucks for delivery. He indicated that Petitioner handled shingles on a daily basis, indicating he would handle a few bundles at a time. He also stated that Petitioner would handle more bundles on his own loads. Lastly, Mr. Turner agreed with Petitioner's job description (PX 5) which indicates Petitioner spent 15% of his time unloading in the warehouse, 20% of his time loading in the warehouse, and 50% of his time driving a truck which would include unloading at the job site.

Petitioner testified he has been symptomatic and had been having pain and tingling in his right hand with numbness. It was affecting his grip and dexterity. It would often wake him up at night. Petitioner testified he would wake up and his fingers would be cold and numb. Petitioner indicated he would like to have the surgery as prescribed by Dr. Garst.

In Support of the Arbitrator's decision regarding (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 as follows:

It is undisputed with regard to all of the testimony in this case that Petitioner handled shingles and building products on a daily basis. He has worked for Respondent for six years. His job description indicates that 15% of his time is spent unloading in the warehouse, 20% of his time is spent loading in the warehouse, and 50% of his time is spent on delivery where he would have to ultimately unload his truck at a job site. The testimony of Mr. Pat Turner that nine (9) out of ten (10) trucks are loaded for Petitioner is inconsistent with his testimony that it would not be uncommon for Petitioner to load his own truck and his testimony that the job description was accurate. According to the job description, Petitioner would spend 35% of his work day loading and unloading in the warehouse. This does not include the time spent unloading at a job site.

Dr. Garst describes Petitioner's job as a delivery driver who does a lot of lifting, pushing and pulling. Petitioner indicated that this was an accurate description and by all accounts in the record this description appears accurate. Dr. Li believed that Petitioner worked at Richard's Building Supply for 30 years felt that COPD likely was the cause of Petitioner's symptoms rather than making five deliveries a day, i.e., lifting 90 pound bundles of shingles frequently and carrying 80 pounds boxes of siding, as well as moving a variety of other heavy building supplies. The Arbitrator finds Petitioner's testimony credible and is persuaded by the opinion of Dr. Garst.

Relying on the credible testimony of Petitioner, Dr. Garst's persuasive opinion and the job description (PX 5), the Arbitrator finds that Petitioner has suffered an accident that arose out of and in the course of his employment with Respondent. The Arbitrator further finds that Petitioner's right cubital tunnel syndrome condition of ill-being is causally related to his employment.

In Support of the Arbitrator's decision regarding (J) Were 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 finds as follows:

Petitioner's Exhibit 4 is a bill from Dr. Garst for $270.52 for out-of-pocket medical expenses paid by Petitioner. Having found the issues of accident and causal connection in favor of Petitioner, the Arbitrator

awards this bill to be refunded in full to Petitioner. As for prospective medical care under section 8(a), the Arbitrator finds that the recommended right cubital tunnel release by Dr. Garst to be reasonable and necessary medical treatment and awards the same.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

☐ 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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ronald Hoegger,

Petitioner,

vs.

NO: 09 WC 2987

15IWCC0860

State of Illinois Youth Center,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission modifies the Arbitrator's Decision finding that a causal relationship existed only through May 4, 2009 and therefore Petitioner failed to prove he was entitled to temporary total disability benefits from June 15, 2011 through September 9, 2011 and vacates the TTD award of the Arbitrator. According to the medical records of OSF Medical Group's Dr. Richardson, Petitioner's neck strain resolved by May 4, 2009. Petitioner had been released to return to work full duty on April 2, 2009 and was discharged from care on May 4, 2009. Then there is almost a 15 month gap between May 4, 2009 and July 20, 2010 where Petitioner did not seek treatment and was working full time. On July 20, 2010, Petitioner reported radicular symptoms, which he did not have during his initial treatment through May 4, 2009. Petitioner testified to have had continuing symptoms during the 15 month period, yet the records from May 4, 2009 show he was symptom free.

Dr. Stroink could not opine whether or not the December 30, 2008 injury is related to the surgery she performed on June 15, 2011. Dr. Ghanayem opined causal connection. §12 Dr. Phillips opined that Petitioner sustained a cervical sprain/strain type muscular injury in 2008 and this would also be consistent with the mechanism of injury. He opined that there is no evidence to suggest an acute herniated disc suffered in that injury. §12 Dr. Phillips opined, "His symptoms resolved and I believe he had fully recovered and reached MMI by May of 2009 with regard to that injury." §12 Dr. Phillips opined that typically radiating pain would have manifested earlier after the December 30, 2008 accident if it was causally connected, usually within days of the accident if there was acute pathology that injured the nerve or caused some disc to compress the nerve. The Commission finds that §12 Dr. Phillips' opinions more accurately reflect the events of this case and gives greater weight to his opinions than those of Dr. Ghanayem.

The Commission modifies the medical expenses award by the Arbitrator and awards medical expenses only through May 4, 2009. The Commission finds that the following medical expenses are causally related to the December 30, 2008 accidental injury:
-Px17: Saint James Occupational Health Center: D/S 12-30-08 and 1-5-09: charges: $356.90. No payments or adjustments noted. Balance due: $356.90.
-Px18: OSF Medical Group, Dr. Richardson: D/S 1-6-09: charges: $323.00. Payments: $279.96. Adjustments: $43.04. Balance due: $0.
-Px19: OSF Medical Group, Dr. Richardson: D/S 2-3-09: charges: $101.00. Payments: $91.65. Adjustments: $9.35. Balance due: $0.
-Px21: OSF Medical Group, Dr. Richardson: D/S 3-12-09: charges: $101.00. Payments: $91.65. Adjustments: $9.35. Balance due: $0.
-Px22: OSF Medical Group, Dr. Richardson: D/S 4-2-09: charges: $101.00. No payments or adjustments noted. Balance due: $101.00.
-Px23: OSF Medical Group, Dr. Richardson: D/S 5-4-09: charges: $101.00. Payments: $91.65. Adjustments: $9.35. Balance due: $0.
-Px29: OSF Saint James Medical Center: D/S 1-30-09 cervical MRI: charges: $2,622.00. Payments: $1,992.72. Adjustments: $629.28. Balance due: $0.
-Px40: Central Illinois Radiology: D/S 1-30-09 cervical MRI reading: charges: $451.00. Payments: $440.37. Adjustments: $10.63. Balance due: $0.
-Px44: County West Physical Therapy; D/S 2-24-09 through 4-16-09: charges: $3,181.00. Payments: $1,066.02. Adjustments: $1,360.98. Balance due: $814.00.
-Px56: Prairie Emergency Physicians: D/S 12-30-08 ER: charges: $339.00. Payments: $111.91. Adjustment: $227.09. Balance due: $0.
-Px57: Provena Saint Joseph Medical Center: D/S 12-30-08 ER: charges: $2,011.61. Payments: $1,375.95. Adjustment: $635.68. Balance due: $0.
-Px58: Joliet Radiology: D/S 12-30-08 cervical x-ray reading: charges $95.00. Payments: $37.18. Adjustment: $57.82. Balance due: $0.
The total due of the above is $1,271.90 and the Commission awards this amount in medical expenses.

Regarding nature and extent of permanent disability, the Commission finds that Petitioner sustained a cervical sprain/strain that resolved and modifies the Arbitrator's award to 5% man as a whole. The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's award of TTD benefits from June 15, 2011 through September 9, 2011 is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $637.85 per week for a period of 25 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the permanent disability of the person as a whole to the extent of 5%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $1,271.90 for under §8(a) of the Act, subject to the Medical Fee Schedule under §8.2 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 injury.

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

DATED: NOV 2 3 2015
MB/maw
o9/24/15
43

Mario Basurto

Stephen J. Mathis

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HOEGGER, RONALD
Employee/Petitioner

Case# **09WC002987**

15IWCC0860

STATE OF ILLINOIS YOUTH CENTER
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:

0924 BLOCK KLUKAS & MANZELLA PC
BRYAN SHELL
19 W JEFFERSON ST SUITE 100
JOLIET, IL 60432

0000 ASSISTANT ATTORNEY GENERAL
COLIN KICKLIGHTER
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1350 CENTRAL MANAGEMENT SYSTEMS
WORKERS' COMP MGR
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 21 2015

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

15IWCC0860

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

Ronald Hoegger
Employee/Petitioner

v.

State of Illinois Youth Center
Employer/Respondent

Case # **09** WC **2987**

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 8, 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 **December 30, 2008**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$55,280.16**; the average weekly wage was **$1,063.08**.

On the date of accident, Petitioner was **40** years of age, ***married*** with **1** dependent child.

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 **$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 **as agreed by the parties** under Section 8(j) of the Act. *See* AX1.

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner has established a causal connection between his neck/cervical spine condition and his accident at work.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $708.72/week for 12 & 3/7th weeks, commencing June 15, 2011 through September 9, 2011, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from December 30, 2008 through December 8, 2014, and shall pay the remainder of the award, if any, in weekly payments.

Medical Benefits

Respondent shall pay reasonable and necessary medical services reflected in Petitioner's Exhibits 17-59 totaling $97,376.44 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 **as agreed by the parties** 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. *See* AX1.

Permanent Partial Disability: Person as a whole (neck/cervical spine)

Respondent shall pay Petitioner permanent partial disability benefits of $637.85/week for 100 weeks, because the injuries sustained caused the 20% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

January 13, 2015
Date

JAN 21 2015

15IWCC0860

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Ronald Hoegger
Employee/Petitioner

v.

State of Illinois Youth Center
Employer/Respondent

Case # **09** WC **2987**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues in dispute at this hearing include causal connection, Respondent's liability for certain unpaid medical bills, Petitioner's entitlement to a period of temporary total disability benefits commencing June 15, 2011 through September 9, 2011, 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 worked for Respondent for approximately 20 years and as a Youth Supervisor on the date of accident. Previously, he worked for the Livingston County Sheriff's Department for four years and then did factory work for six months before becoming employed with Respondent. Petitioner has an associate's degree in law enforcement.

As a Youth Supervisor, Petitioner testified that he ensured the safety and security of the youth inmates at IYC Joliet. He performed tasks such as taking inmates to school and making sure that they showered, etc. He testified that he worked in the observation unit also and that those inmates need one-on-one attention.

On December 30, 2014, Petitioner testified that a youth was attempting to hang himself. Petitioner explained that he had to enter the room with consent of the supervisor to prevent the youth from this act. As he attempted to help the youth, Petitioner testified that he was hit in the face and his neck snapped back. When the scene was secure, Petitioner reported the incident to his direct supervisor, Tracey Walker. Petitioner described the youth to be almost 18 years old and 6 feet tall weighing approximately 225 pounds. Petitioner testified that he felt stiffness in his neck almost immediately, even before his report was written.

Medical Treatment

Petitioner testified that another supervisor took him to St. Joe's Hospital, now known as Provena St. Joseph Medical Center. The medical records reflect that he gave a medical history consistent to the injury that occurred that he was punched in the left eye at work. Specifically, he reported being assaulted by an inmate and being injured during an altercation at work. PX2 at 15-18. He presented with a blunt trauma injury to the left orbit and increasing neck stiffness since the incident. *Id.* On examination, the emergency room physician noted moderate tenderness of the left infraorbital area, diminished range of motion, and Petitioner's report of stiffness with range of motion. *Id.* Petitioner underwent cervical and orbital x-rays, which were negative for fracture,

[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. Exhibits attached to depositions will be further denominated with "(Dep. Exh. _)."

and Petitioner was diagnosed with an eye contusion and neck pain. *Id.* Petitioner was released with orders to follow up with a primary care physician. *Id.*

Petitioner then went to Saint James Occupational Health Center on December 30, 2008 where he was examined by a Certified Physician's Assistant, Tom Moran ("P.A. Moran"). PX3. He reported that he was "struck in the eye by inmate – contusion [left] eye [and] whiplash[.]" PX3 at 3-6. Petitioner reported no previous injuries or illnesses and continuing complaints of a headache, neck stiffness, tightness in the neck, and pain under his left eye. *Id.* During the physical examination of the neck, Petitioner reported pain with motion and P.A. Moran noted palpable spasms. *Id.* Petitioner was diagnosed with whiplash/strain/spasms. *Id.* He was given orders to do home exercises, apply moist heat, and return in 7-10 days. *Id.* Petitioner also received a prescription for Naprosyn, Norflex and biofreeze. *Id.* He was also placed on work restrictions with no upward looking. *Id.*

The Saint James Occupational Health Center records of the following day, December 31, 2008, reflect that Petitioner returned to work, but called and spoke to P.A. Moran reporting continued neck stiffness and tightness in the back and that his neck hurt working in the jail. PX3 at 8. Petitioner reported no change in his ability to move about or in his alertness. *Id.* He was unable to leave the jail for a physical examination and he reported that he believed he needed a few days off to get better. *Id.* Mr. Moran "advised him that whiplash may take a few days to resolve and neck motion is needed to resolve spasm." *Id.*

Petitioner returned to see P.A. Moran on January 5, 2009. PX3 at 9-12. He reported that his eye was better, but his neck was tighter. *Id.* On examination, Petitioner has swelling about the left eye and cervical spasms. *Id.* P.A. Moran noted "guarding, spasm bilat trap." and that Petitioner was not moving his head/neck. *Id.* He diagnosed Petitioner with a resolved left eye contusion and whiplash. *Id.* He also imposed work restrictions with no overhead work. *Id.*

In a noted dated January 6, 2009, P.A. Moran noted that Petitioner was discharged to his physician of choice, Dr. [Travis] Richardson. PX3 at 13. Petitioner also saw Dr. Richardson on January 6, 2009. PX4A at 2-5.

Petitioner reported that he was involved in an altercation with an inmate on December 30, 2008 at which time he was hit on the left side of his head. *Id.* He reported that he "did sustain some bruising to the left side of his face and developed pain in the neck." *Id.* He also reported some bilateral neck pain from the base of his skull to the base of his neck, which he described as tight stiffness that worsened with any movement. *Id.* On examination, Dr. Richardson noted tenderness to palpation on bilateral paraspinal cervical muscles and bilateral trapezius muscles. *Id.* There was some acute spasm with pain, decreased range of motion, and increased pain with flexion, extension and lateral movement. *Id.* Dr. Richardson also noted a positive Spurling's sign with right posterior extension with some slight radiation of pain towards the right shoulder. *Id.* He diagnosed Petitioner with neck pain secondary to injury, continued the current medication regimen, and ordered an MRI. *Id.* Dr. Richardson placed Petitioner off work. *Id.*

Petitioner returned on January 7, 2009 and saw Dr. William Hough, also at Saint James Occupational Health Center. PX4A at 7-8. He reported a consistent mechanism of injury. *Id.* On examination, Dr. Hough noted limited range of motion in the neck. *Id.* Dr. Hough diagnosed Petitioner with an acute ligamentous strain and cervical somatic dysfunction. *Id.* He noted that Petitioner was under the care of the orthopedic specialist, Dr. Richardson, and indicated that he should continue to follow up with him. *Id.* Dr. Hough also placed Petitioner off work. *Id.*

Petitioner went to County West Physical Therapy for an initial evaluation and began treatment on February 24, 2009. PX7A at 3-4.

Petitioner underwent the recommended MRI on January 30, 2009. PX4A at 9-10. The interpreting radiologist noted multilevel degenerative changes most severe at C5-C6 where there was mild-to-moderate central canal stenosis with possible cord impingement. *Id.* The report specifically noted a mild disc bulge at C4-5 indenting the thecal sac and touching the cord and mild central canal stenosis, a right central disc protrusion at C5-C6 with bilateral uncinate process hypertrophy combined with bilateral facet arthrosis, right greater than left, mild-to-moderate central canal, and right lateral recess stenosis. *Id.* Petitioner also had a mild disc bulge at C6-C7. *Id.*

Petitioner returned to Dr. Richardson's office on February 3, 2009 and saw a Certified Nurse Practitioner, Amy Hepner ("N.P. Hepner"). PX4A at 11-12. She reviewed the MRI and diagnosed Petitioner with neck pain, degenerative disc disease at C5-6, with right central disc protrusion and spinal canal stenosis. *Id.* N.P. Hepner recommended a discogram of the C4-5 and C5-6 levels and ordered physical therapy. *Id.* Petitioner was released to light duty work. *Id.*

On March 12, 2009, Petitioner saw N.P. Hepner again reporting improvement with physical therapy. PX4A at 13-14. Petitioner continued to report pain in the base of his neck, however. *Id.* He declined the discogram evaluation at the time and requested physical therapy for a couple more weeks before undergoing the discogram. *Id.* He remained on light duty work. *Id.* Petitioner testified that he is afraid of needles and the discogram is supposed to be a painful procedure, so he declined it.

On April 2, 2009, Petitioner reported that physical therapy continued to improve his symptoms. PX4A at 15. He also reported occasional neck pain and pain with turning his head too fast. *Id.* On examination, N.P. Hepner noted a relatively normal exam. *Id.* She diagnosed neck pain, cervical degenerative disc disease and cervical spinal stenosis. *Id.* Petitioner was returned to work full duty. *Id.*

Petitioner was discharged from physical therapy at County West Physical Therapy on April 16, 2009. PX7A at 16. By May 4, 2009, Petitioner was released from care and was advised by N.P. Hepner to return for medical care if he had any return of symptoms. PX4A at 16.

After his release, Petitioner continued to work full duty and testified that he had no other injuries either at work or elsewhere.

On July 20, 2010, Petitioner returned to Dr. Richardson. He testified that he had a sharp pain shooting down his right arm and he was dropping items like keys and pens. The medical records reflect that on physical examination, Dr. Richardson noted positive pain with axial compression above the cervical spine, positive Spurling's maneuver in the right upper extremity, pain when he turned or leaned his head to the right, and mild sensory changes about the right lateral shoulder. PX4B at 14. Dr. Richardson diagnosed Petitioner with a herniated nucleus pulposus at C5-C6 in the right upper extremity, radicular symptomatology, degenerative disc disease, and cervical neck pain. *Id.* After noting his review of Petitioner's MRI and prior treatment history, he recommended epidural steroid injections. *Id.* He noted there were no significant changes since the Petitioner's presentation on January 6, 2009, and opined that Petitioner's pain was consistent with his C5-C6 herniation. *Id.*

On July 23, 2010, Petitioner was evaluated by a physician at OSF who noted his ongoing treatment with Dr. Richardson. PX4B at 15-17. He reported weight loss, fatigue, cervical neck pain and numbness down the arms. *Id.* He also reported stress at work and working heavy hours, including overtime such that he gets home and

sleeps and then returns to work. *Id.* He was diagnosed with cervical neck pain, fatigue, weight loss, and tobacco abuse. *Id.*

Petitioner then saw Dr. Richardson on August 31, 2010 reporting significant neck pain, numbness and tingling. PX4B at 18. Dr. Richardson noted that Petitioner's "physical examination is simply unchanged since the date of service of 07/20/2010." *Id.* He diagnosed Petitioner with C5-C6 right upper extremity radicular symptomatology and mild diskogenic disk changes at C5-C6. *Id.* He recommended continued conservative care including traction at OSF Millenium and noted that, if it failed, Petitioner would most likely be considered a surgical candidate. *Id.*

Petitioner went to OSF Millennium Pain Center on November 2, 2010. PX8. He completed an intake form and pain assessment noting an injury and symptoms including shooting pain and tingling in the neck and into the right arm. *Id.* After an examination and review of Petitioner's MRI, which he noted showed a herniated disc with foraminal and central stenosis, Dr. Amaresh Vydyanathan diagnosed Petitioner with a cervical herniated nucleus pulposus and radicular pain to the right arm. PX8 at 12-14. He recommended epidural steroid injection, which were to be performed under anesthesia due to phobia. *Id.*

Petitioner underwent the first epidural steroid injections on November 9, 2010. PX8 at 21. Petitioner reported on December 28, 2010 that he had 40% relief of pain for about five days. *Id.* Petitioner underwent a second injection on January 4, 2011. PX8 at 22-23. The final injection was done on March 8, 2011. PX8 at 23.

Petitioner was also prescribed an updated MRI by Mary Kennedy, FNP from OSF, which was performed on May 4, 2011. PX6 at 31; PX10 at 4. The prior MRI was compared. *Id.* The interpreting radiologist noted multilevel spondylosis most severe at C5-C6, moderate central canal narrowing at C5-C6 secondary to disc osteophyte complex, and degenerative thickening of the ligamentum flavum, which was slightly increased from January 30, 2009. *Id.*

Petitioner then began treatment with Dr. Ann Stroink on May 12, 2011 reporting neck pain that radiated into his right arm that began after he was struck by an inmate approximately one year earlier. PX11 at 4-5. Petitioner testified that, after his injury, his symptoms never completely resolved; they improved after physical therapy, but he had some stiffness and range of motion problems. The medical records reflect that Petitioner reported that the neck pain got better, but never completely went away and had gotten worse in the last few months. *Id.* Dr. Stroink reviewed both of Petitioner's MRI's. *Id.* She indicated that he had a herniated disc at the C5-6 level, which had become significantly worse. *Id.* After an examination, Dr. Stroink recommended a discectomy at C5-6. *Id.*

Petitioner underwent the recommended surgery on June 15, 2011. PX11 at 10-11. Pre and post-operatively, she diagnosed C6 radiculopathy secondary to spondylitic disc disease and soft disc herniation at C5-C6. *Id.* Dr. Stroink performed an anterior cervical discectomy and fusion at C5-6. *Id.*

Petitioner saw Dr. Stroink post-operatively on June 30, 2011. PX11 at 7. She noted excellent resolution of his right arm pain and placed him off work for three months because she did not want him to suffer further injury to his neck given his type of work with inmates. *Id.* She referred the Petitioner to Dr. Won Jhee, a physiatrist, for further work recommendations. *Id.*

Petitioner saw Dr. Jhee on August 2, 2011. PX13 at 3-5. He noted that noted that Petitioner was eager to return to work and recommended physical therapy. *Id.* He was released to return to work with no contact with

inmates effective August 7, 2011. *Id.* Petitioner returned on September 9, 2011, at which time Dr. Jhee recommended continuing physical therapy and restricted duty with no inmate contact. PX13 at 6.

Petitioner returned to County West Physical Therapy for an initial evaluation and began treatment on August 8, 2011. PX7B at 4. He was discharged from physical therapy on September 7, 2011. PX7B at 12.

Petitioner testified that between June 15, 2011 and September 9, 2011 he used his accumulated sick days. He testified that he was given light duty on September 9, 2011 and immediately started working.

Petitioner returned to Dr. Stroink one last time on September 22, 2011. PX11 at 8-9. She recommended a one year post-operative visit and continued light duty work for a maximum of 90 days. *Id.*

Petitioner's final doctor's visit was on October 14, 2011 with Dr. Jhee. PX13 at 7. He noted that Petitioner underwent ACDF surgery at C5-6 secondary to a disc herniation and cervical radiculopathy. *Id.* Petitioner reported that he rarely experienced neck pain, but that he still had pain and had difficulty looking upward for prolonged durations. *Id.* Dr. Jhee recommended continue full work without inmate contact for three more weeks, after which he could return to work full duty. *Id.*

Section 12 Examination & Deposition Testimony – Dr. Phillips

On November 8, 2011, Petitioner submitted to an independent medical evaluation with Dr. Frank Phillips at Respondent's request. RX1 (Dep. Exh. 2). After taking a history from Petitioner, examining him, and reviewing various treating medical records, Dr. Phillips rendered various opinions about Petitioner's cervical spine condition, medical treatment, and connection, if any, to Petitioner's accident at work. *Id.*

Dr. Phillips noted that Petitioner presented clinically with complaints of neck pain after 2008, but no indication of radicular symptoms. *Id.* He noted that Petitioner subsequently became symptom-free and began treating again approximately one year later. *Id.* Dr. Phillips opined that as a result of his accident at work, Petitioner sustained a cervical strain and that there was no evidence that Petitioner suffered a herniated disc in that accident. *Id.* He further opined that Petitioner's then-current cervical condition of ill-being was not causally related to his accident at work, that the medical treatment rendered to him (while appropriate) was not required as a result of his accident at work, and that Petitioner required no additional treatment as a result of his accident. *Id.* He placed Petitioner at maximum medical improvement by May of 2009 as it related to his accident. *Id.*

Respondent called Dr. Phillips as a witness and he gave testimony at an evidence deposition on June 10, 2014. RX1. Dr. Phillips is a board certified orthopedic surgeon. RX1 at 5-7. Dr. Phillips testified about Petitioner's cervical spine condition, medical treatment, and she rendered various opinions. *See generally* RX1.

Dr. Phillips testified about the medical records that he reviewed, and indicated that he did not review the MRI films from January 30, 2009, rather the radiologist's report. RX1 at 13-14. He did review the films from the May 4, 2011 MRI. RX1 at 15.

Dr. Phillips opined that Petitioner's cervical condition as reflected in the May 4, 2011 MRI was not causally connected to his accident at work in 2008. RX1 at 15. He explained that there was no acute pathology related to the accident in his review of the MRI. *Id.* With regard to the surgery, Dr. Phillips testified that it was appropriate for his cervical condition but not causally related to his accident at work because he did not have any radicular symptoms during the treatment after his accident until he was released to full duty. RX1 at 16-17,

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22. He explained that, typically, radiating pain would have manifested sometime earlier after the accident if it was causally related. *Id.*

On cross examination, Dr. Phillips indicated that Petitioner "seemed like a very motivated, legitimate patient from everything I can see in my note." RX1 at 28-29. He further testified that he "absolutely" did not see any evidence of malingering or symptom magnification. *Id.*

Deposition Testimony – Dr. Stroink

Petitioner called Dr. Stroink as a witness and she gave testimony at an evidence deposition on July 26, 2012. PX14. Dr. Stroink is a board certified neurosurgeon. PX14 at 5-6. Dr. Stroink testified about Petitioner's cervical spine condition, medical treatment, and she rendered various opinions. *See generally* PX14.

She was asked about the history reported to her by Petitioner about the onset of symptoms and injury at work. PX14 at 6-9, 11-13, 35-36. Dr. Stroink noted that her intake form referred to the Petitioner being struck in the head by an inmate while on duty. *Id.* She understood that occurred in 2010. *Id.*

Notwithstanding, Dr. Stroink compared the January 30, 2009 MRI and the May 4, 2011 MRI films, which she testified showed a C5-6 herniation that became significantly worse. PX14 at 15-17. She indicated that it had worsened by increasing in size. PX14 at 16-17. She also indicated that the natural process of the body in the far majority of cases was that such a herniated disc would heal and Petitioner's worsened. PX14 at 17. Dr. Stroink testified that she testified that Petitioner's disc herniation had worsened in her review of both MRI's and Petitioner's report that he was involved in an altercation, which she understood to have occurred in 2010. PX14 at 19-20. Assuming that Petitioner's date of accident was December 30, 2008, she testified that a disc herniation can result from an altercation as described. PX14 at 20-21. She later testified that a common cause for a herniated disc could be a whiplash injury caused by an inmate assault. PX14 at 48.

Dr. Stroink testified about a car accident that Petitioner sustained on April 25, 2012 and a follow up visit occurring with her on May 3, 2012. PX14 at 27. She testified that Petitioner's cervical spine films subsequent to that accident showed a very solid fusion and that he did not need to worry about it. *Id.*

Ultimately, Dr. Stroink testified that the medical treatment that Petitioner had received through her office and Dr. Jhee was medically necessary and reasonable to treat Petitioner's cervical cord compression and nerve root compression. PX14 at 31-32. She testified on direct and cross examination that she had no reason to believe that Petitioner had been dishonest with her, and that if she felt he had been she would have noted that in her chart. PX14 at 28, 40-41.

On cross examination, Dr. Stroink testified that she did not believe that osteoarthritis lead to an increased risk of developing a herniated disc. PX14 at 40. On re-direct examination, Dr. Stroink testified that given the January 30, 2009 MRI, if a patient did not have a neurological deficit at the time or calcitrant pain, she would not have recommended surgery and rather waited to see how the patient fared over time. PX14 at 49.

Petitioner's Independent Medical Evaluation & Deposition Testimony – Dr. Ghanayem

On October 4, 2012, Petitioner saw Dr. Ghanayem for an independent medical evaluation at his attorney's request. PX16. After reviewing Petitioner's treating medical records, taking a history from him, and examining Petitioner, Dr. Ghanayem rendered various opinions relating to Petitioner's cervical spine condition. *Id.*

Specifically, he noted that Petitioner had cervical disc disease in the way of an osteophyte at C5-6 and he opined that Petitioner sustained or aggravated his cervical disc disease/disc herniation due to the work injury as described. *Id.*; PX15 at 8. Dr. Ghanayem indicated that the "mechanism of injury, temporal sequencing, and the evolution of his symptoms seems to make sense for a positive causal connection." *Id.*

Petitioner called Dr. Ghanayem as a witness and he gave testimony at an evidence deposition on November 13, 2013. PX15. Dr. Ghanayem is a board certified orthopedic surgeon. PX15 at 4-5. Dr. Ghanayem testified about Petitioner's cervical spine condition, medical treatment, and he rendered various opinions. *See generally* PX15.

Specifically, Dr. Ghanayem testified that Petitioner's osteophyte at C5-6 pre-dated his injury at work, but that the herniation could be new on top of the osteophyte. PX15 at 8-9. He reviewed both of Petitioner's MRI's and testified that Petitioner had fundamental narrowing, nerve root compression from a disc, and an osteophyte at C5-6. PX15 at 11-12.

Ultimately, he opined that Petitioner's accident aggravated the osteophyte in terms of compression and symptoms, and that the disc herniation at C5-6 may or may not have been new, but reiterated from his report that the "mechanism of injury, temporal sequencing, and the evolution of his symptoms seems to make sense for a positive causal connection." PX15 at 13-14. He opined that the disc herniation may have been a new problem caused by the accident, however. PX15 at 14. He further opined that the surgery Petitioner had was appropriate for Petitioner's condition and that all of his medical treatment had been reasonable and necessary. PX15 at 12, 14.

On cross examination, Dr. Ghanayem explained that patients' symptoms wax and wane and that Petitioner may not have been consistently symptomatic after his injury. PX15 at 16-18.

Additional Information

Petitioner testified that he is currently a supply supervisor at the Pontiac Correctional Center. He drives forklifts, performs inventory, prepares the commissary, and still has some inmate contact.

Regarding his current condition, Petitioner testified that he has difficulty looking up to see where the pallets go or turning around. He also currently takes ibuprofen 3-4 times per week usually in the morning.

He also explained that he used to make his own fishing lures, which required him to look down and he can no longer do. He also testified that he can no longer play guitar because he has to look down or go on amusement park rides with his grandkids.

15IWCC0860

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 hearing as follows:

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:

The Arbitrator finds that Petitioner's claimed current condition of ill-being in the cervical spine is causally related to the injury sustained at work on December 30, 2008. In so concluding, the Arbitrator relies on the credible testimony of Petitioner which is corroborated by contemporaneous medical records as well as the opinions of Petitioner's treating physidian, Dr. Stroink, and Petitioner's independent medical examiner, Dr. Ghanayem.

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 neck when he sought medical attention on the date of accident. He continued to report such symptoms until he was released to full duty on May 4, 2009 to medical staff at the Saint James Occupational Health Center, Dr. Richardson, Dr. Hough, and various physician's assistants and nurse practitioners. Petitioner's testimony at the hearing was consistent with these medical records.

Petitioner then returned to full duty work and did not have medical treatment until approximately one year later when he saw Dr. Richardson on July 20, 2010. Petitioner reported radiating symptoms at this time and Dr. Richardson noted positive pain with axial compression above the cervical spine and a positive Spurling's maneuver in the right upper extremity. Petitioner then saw Dr. Stroink and he underwent his one-level fusion surgery to address the disc herniation at C5-6, nerve root compression and narrowing noted in the May 4, 2011 MRI. Petitioner's testimony was also consistent with these medical records.

The physicians opining on causal connection in this case based their opinions on the medical records available to them, Petitioner's history as reported to each, presentation clinically at the time of their examinations, and the results of the May 4, 2011 MRI compared to the one taken January 30, 2009. Dr. Stroink, Petitioner's treating orthopedic surgeon, understood the same mechanism of injury reported by Petitioner to all physicians, but that the accident occurred in 2010 and not at the end of 2008. Notwithstanding, she agreed that the reported mechanism of injury could cause Petitioner's symptoms. Dr. Ghanayem, Petitioner's own independent medical examiner, had the benefit of the more accurate information. He understood that correct accident date, the same

mechanism of injury as reported to all physicians, and was able to review both MRI films as did Dr. Stroink. Dr. Phillips, Respondent's Section 12 examiner, did not have the benefit of reviewing the actual MRI films from January 30, 2009. Nonetheless, he acknowledged on cross examination that Petitioner exhibited no signs of malingering, symptom magnification or other ulterior motives.

Thus, given the totality of the medical evidence, Petitioner's credible testimony, and the information available to each of the examining physicians, the Arbitrator finds that the opinions of Dr. Stroink and Dr. Ghanayem are more persuasive than those of Dr. Phillips in this case. Based on all of the foregoing, the Arbitrator finds that Petitioner's condition of ill-being with respect to his cervical spine is causally related the work accident he sustained on December 30, 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. 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 cervical spine condition is causally related to his accident at work relying on Petitioner's credible testimony as well as the opinions of his treating physician, Dr. Stroink, and those of his own independent medical examiner, Dr. Ghanayem. The medical bills submitted into evidence are for the reasonable and necessary medical treatment rendered to Petitioner to address his cervical spine 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.

In support of the Arbitrator's decision relating to Issue (K), 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 he is entitled to temporary total disability benefits for the disputed period beginning June 15, 2011 through September 9, 2011.

"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 his treating physicians as it related to his cervical spine 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 (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 sustained a cervical spine injury requiring conservative care ultimately followed by a one-level anterior cervical discectomy and fusion at C5-C6 with some continued symptoms after a full duty release to work, lifestyle changes and a job change—the Arbitrator finds that Petitioner has established permanent partial disability to the extent of 20% loss of use of the man as a whole pursuant to Section 8(d)2 for his neck/cervical spine injury.

STATE OF ILLINOIS	)	☒ Affirm and adopt	☐ 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

Ruth Lindley,

Petitioner,

15IWCC0850

vs.

NO: 09 WC 21086

Southeastern Special Education,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 10, 2013 is hereby affirmed and adopted.

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

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: NOV 2 0 2015
KWL/vf
O-9/21/15
42

Kevin W. Lamborn

Michael J. Brennan

DISSENT

I respectfully dissent from the majority decision and would award Petitioner mileage for her expenses incurred as part of her vocational rehabilitation. Section 8(a) (second paragraph) of the Illinois Workers' Compensation Act ("Act") states: The employer shall also pay for...vocational rehabilitation of the employee, including all maintenance costs and expenses incidental thereto." Further, Section 8(a) (sixth paragraph) of the Act also states: "Maintenance shall include costs and expenses incidental to the vocational rehabilitation program."

Indeed, it is certainly appropriate to consider mileage driven in Petitioner's personal vehicle as a 'cost and expense incidental' to her vocational rehabilitation program. The quoted provisions of §8(a) of the Act should include the entitlement of mileage reimbursement to Petitioner, even if the mileage is not an extraordinary amount.

The Petitioner had to spend money (a 'cost') for the gasoline (an 'expense') utilized in her car to drive to potential employers and a community college for training at the direction of her vocational rehabilitation counselors. She drove in excess of 1,300 miles for her job search and for computer training. Some of Petitioner's job search trips were over forty miles long one-way, which is a significant distance.

In addition, the Petitioner was furnished Mileage Reimbursement Request Forms by Respondent. Interestingly, Respondent issued two checks to Petitioner for her mileage incurred as part of her vocational rehabilitation program.

This Petitioner's situation is not akin to the mileage incurred due to medical treatment because a Petitioner generally has more flexibility with his ability to choose a medical provider. Because vocational rehabilitation is employer-directed, the mileage that the Petitioner in this case incurred was substantially out of her control. Accordingly, mileage expenses should have been awarded.

Thomas J. Tyrrell

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

15IWCC0850

LINDLEY, RUTH
Employee/Petitioner

Case# **09WC021086**

SOUTHEASTERN SPECIAL EDUCATION
Employer/Respondent

On 5/10/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0258 HELLER HOLMES & ASSOC
FRED JOHNSON
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MATTOON, IL 61938

2904 HENNESSY & ROACH PC
STEPHEN J KLYCZEK
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

15IWCC0850

Ruth Lindley
Employee/Petitioner

v.

Southeastern Special Education
Employer/Respondent

Case # **09** WC **21086**

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 **Joshua Luskin**, Arbitrator of the Commission, in the city of **Mount Vernon**, on **March 6, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0850

FINDINGS

On the date of accident, **11-29-2006**, 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 $**46,488.00**; the average weekly wage was $**894.00**.

On the date of accident, Petitioner was **51** 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 $**N/A** for TTD, $**N/A** for TPD, $**N/A** for maintenance, and $**280.07 in benefits paid and $109.15 in benefits tendered but not yet received** for other benefits.

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

ORDER

For reasons set forth in the attached decision, the mileage benefits requested, as well as penalties and fees based upon same, are denied.

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

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

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

Signature of Arbitrator

May 1, 2013
Date

ICArbDec19(b)

MAY 10 2013

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RUTH LINDLEY,	)	15IWCC0850
Petitioner,	)	
vs.	)	No. 09 WC 21086
SOUTHEASTERN SPECIAL EDUCATION,	)	
Respondent.	)	

ADDENDUM TO ARBITRATION DECISION

This matter was originally tried pursuant to Section 19(b) of the Act before Arbitrator Nalefski on March 18, 2010. The Arbitrator's award was entered April 5, 2010 and was not appealed. This decision was introduced as Arbitrator's Exhibit III as the controlling law of the case. See, e.g., *Help at Home vs. Illinois Workers' Compensation Commission*, 405 Ill.App.3d 1150 (4th Dist. 2010).

This matter was again heard pursuant to Section 19(b) of the Act.

STATEMENT OF FACTS

Briefly, this matter involves a teacher who was injured while she worked with autistic students. She subsequently had arthroscopic right knee surgery on December 26, 2006, and a right knee total arthroplasty on July 12, 2007. She has been released with work restrictions not consistent with her usual occupation and has since pursued vocational rehabilitation, which has been authorized by the respondent. The petitioner remains in that process at this juncture. The issues presented at this time are whether the respondent is liable for mileage expenses incurred during the vocational process and whether the respondent's non-payment of such expenses warrants imposition of penalties and fees. The parties agreed that the respondent has paid maintenance benefits at the TTD rate at the appropriate times and the claimant continues to receive same.

The mileage submission from the claimant is PX3. It is a six-page document which demonstrates the following:

Page 1 indicates eight trips to various employer facilities from May 22, 2012 through October 29, 2012. The mileage to each of these varied from less than one mile to 41.92 miles. The total mileage represented comes to 462.74 miles. This sheet was delivered to the respondent on or about December 6, 2012.

Page 2 indicates fourteen trips to Olney Central College from August 16, 2012 through December 6, 2012 (one trip per week) for a computer class that was part of the

vocational process. This was a trip of 18.96 miles one way, for a total of 530.88 miles. This sheet was also delivered to the respondent on or about December 6, 2012.

Page 3 indicates a single trip to the Department of Employment Security on December 13, a distance of 23.73 miles one way. This sheet was delivered to the respondent on or about December 13, 2012.

Page 4 indicates two trips, one on December 31 for a job interview 46.09 miles away, and a trip on January 4, 2013 which involved two stops. The total mileage submitted on this sheet comes to 185.54 miles.

Page 5 indicates a single trip to a potential employer on February 4, 2013, a distance of 23.49 miles one way. This sheet was delivered to the respondent on or about February 4, 2013.

Page 6 indicates a multi-stop trip to three potential employers which took place on February 14, 2013. The total mileage for this trip was 52.28 miles, with the longest leg of that trip being 24.46 miles.

In summary, the petitioner submits 1,325.88 miles incurred over the course of approximately nine months. See generally PX3.

OPINION AND ORDER

Vocational rehabilitation and retraining is contemplated as one of the benefits available to claimants under Section 8(a) of the Act, specifically the "treatment, instruction and training" of a claimant not able to return to his or her usual employment. In theory, only the process of training (i.e., page 2 of PX3) would be included in this language, rather than the job search in its entirety; however, a claimant's job search has been interpreted to be part and parcel of the rehabilitation process. See *Roper Contracting v. Industrial Commission*, 349 Ill.App.3d 500 (5th Dist. 2004). The Arbitrator also notes that incidental expenses have apparently been paid in this case, such as the tuition and books for the computer course. The question turns to the issue of mileage as an incidental expense within the limits of Section 8(a), and whether mileage incurred during the course of vocational rehabilitation is subject to a different standard than mileage incurred for medical treatment.

Mileage expenses for medical care and mileage expenses for vocational costs have not been specifically distinguished in the statutory language of Section 8(a), and this Arbitrator has not found such a distinction having been made in the case law. Being disinclined to conclude such a distinction should be made, analysis turns to awards of mileage within the general confines of Section 8(a).

Mileage expenses under section 8(a) of the Act may be awarded pursuant to a reasonableness standard, as discussed at length in *General Tire & Rubber Co. v. Industrial Commission*, 221 Ill.App.3d 641 (1991). There, the Appellate Court held the respondent liable for long distance mileage of approximately 100 miles to and from the petitioner's treating physician. However, the Commission has repeatedly held that "the holding in General Tire & Rubber Co. is the exception to the rule and that local mileage

is not normally deemed to be reasonable and necessary..." *Kosinski v. Mobil Chemical Co.*, 99 IIC 794.

Applying the *General Tire & Rubber Co.* standard to this matter, it is first notable that the overall scope of the mileage in this case is not particularly impressive, only about 1,326 miles over almost a year's time. Further, no individual trip was especially onerous. The driving faced by the claimant is well within the usual driving burden expected by the general public[1]. For example, the repeated trips for the computer course (PX3 p.2) involved trips of 18.96 miles each way, but the Commission has pointed out a petitioner who sought medical care 18 miles from her home remained "in the general area where she lives" and disallowed such expenses. *Frey v. Aldi, Inc.*, 09 IWCC 0061.

The mileage incurred herein is neither unduly burdensome in its overall character nor overly substantial in any particular trip, and is generally localized to the claimant's home community. In light of case precedent that mileage is to be awarded only in unusual or excessive circumstances, mileage expenses are not found to be appropriate in this matter and are denied in their entirety.

Regarding the request for penalties and attorney's fees, these are denied in light of the above findings. However, it should further be noted that the imposition of penalties is a question to be considered in terms of reasonableness. See, e.g., *Avon Products, Inc. v. Industrial Commission*, 82 Ill.2d 297 (1980); *Smith v. Industrial Commission*, 170 Ill.App.3d 626 (3rd Dist. 1988). Given case precedent on this issue, penalties and fees would not be merited even if mileage benefits were apposite.

[1] The Arbitrator does not wish to indicate a rigid cutoff for when driving becomes overly burdensome, but does observe the U.S. Department of Transportation Federal Highway Administration has found the average American to drive 13,476 miles annually. http://www.fhwa.dot.gov/ohim/onh00/bar8.htm

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

WILLIAM "RANDY" BUNN,

Petitioner,

15IWCC0520

vs.

NO: 09 WC 049372

GILSTER-MARY LEE CORP.,

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, medical expenses, jurisdiction, notice, temporary disability and permanent disability and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below on the issue of accident and subsequently awards benefits under the Act.

Arbitrator Lindsay found there to be evidence to support Petitioner's claim of sustaining an accident while working for Respondent on August 13, 2009, but found both that the Commission lacked jurisdiction to hear his claim and that the Petitioner's claim was time-barred from proceeding due to his failure to provide timely notice to Respondent. The Commission finds otherwise and reverses the arbitrator on both counts.

The threshold issue in the Decision of the Arbitrator was jurisdiction. Arbitrator Lindsay found the Commission had no jurisdiction to adjudicate Petitioner's claim. She found that there was no nexus between Petitioner's claim and the State of Illinois, as required by the Act. Petitioner, a resident of the State of Missouri, was injured in McBride, Missouri, while working for Respondent, an Illinois entity. Arbitrator Lindsay recognized elements of Respondent's hiring process involved Petitioner undertaking certain acts in Illinois but found those acts insufficient to confer jurisdiction to the Commission. Of most significance to Arbitrator Lindsay were the final actions taken in the formation of the employment contract between Petitioner and Respondent. By the arbitrator's view, the Petitioner's hire occurred within the State of Missouri. As explained below, the Commission finds the final elements of Petitioner's contract formation occurred in Illinois and, resultantly, confers jurisdiction to the Commission.

There is agreement between the parties that the hiring process began in Illinois. Petitioner testified that he submitted his application for employment to Respondent's headquarters in Chester, Illinois. Richard Welker, Respondent's Traffic Manager and the Respondent's employee responsible for human resource matters, acknowledged that applications are received there and the receipt of the same begins the hiring process. Mr. Welker indicated that applications are reviewed and background investigations are conducted in Chester, Illinois. Those applicants Respondent feels merit an interview are then interviewed in Chester, Illinois.

During the interview, a discussion is had about Respondent and the benefits it offers to its employees. A successful interview results in the applicant being sent to a Chester, Illinois, hospital to undergo drug screening and a physical examination. Following this process, the applicant is then brought to Respondent's Perryville, Missouri, facility where the applicant's driver's license and eligibility for employment as well as Respondent's operational policies are reviewed. Mr. Welker testified the hiring process is not completed until the meeting in Perryville, Missouri. Petitioner's testimony corroborated Mr. Welker's testimony except as to where the post-drug screening and physical examination meeting occurred. Petitioner testified this meeting occurred in the basement of Respondent's headquarters in Chester, Illinois.

The Commission is not satisfied with Mr. Welker's explanation of the hiring process. The Commission questions the claimed changing of venue from Respondent's headquarters in Chester, Illinois, to its facility in Perryville, Missouri. The Commission's questions this as no explanation was offered as to why the second meeting would take place in Perryville, Missouri, if the only actions taken there were for Respondent to review Petitioner's driver's license and his eligibility to work and to review Respondent's operational policies.

Lost upon the Commission is why Respondent would initially interview Petitioner in Chester, Illinois, and have Petitioner undergo drug screening and a physical examination in Chester, Illinois, only to have a subsequent meeting in Perryville, Missouri. What was not lost upon the Commission is Mr. Welker's admission that he could not say to a certainty that the as-testified-to hiring procedures were followed in this situation. The combination of the unexplained changing of venues from Chester, Illinois, to Perryville, Missouri, and Mr. Welker's uncertainty as to whether the process he described actually occurred as described leads the Commission to find Petitioner's testimony concerning the hiring process to be credible. The Commission, therefore, finds the actions taken to finalize the employment contract between Respondent and Petitioner occurred in Respondent's headquarters in Chester, Illinois. Accordingly, the Commission finds there is jurisdiction for it to consider Petitioner's claim under the Act.

Arbitrator Lindsay adopted Petitioner's claim of having sustained a compensable injury on August 13, 2009, noting the opinions of both Dr. deGrange and Dr. Riew were that Petitioner did sustain a work-related injury as the result of removing the fifth wheel pin to disconnect the trailer from his semi-tractor. The Commission was presented with no evidence that would cause it to disturb Arbitrator Lindsay's finding with respect to accident. Arbitrator Lindsay, notwithstanding her finding a lack of jurisdiction to adjudicate Petitioner's claim, nevertheless found Petitioner failed to give timely notice of his injury to Respondent and, as a result, not be entitled to benefits under the Act. The Commission finds Petitioner provided notice within the statutory timeframe to do so.

Petitioner described experiencing a sensation akin to a shock on August 13, 2009, when he pulled the fifth wheel pin. He continued to decouple the trailer from his semi-tractor and proceeded to go home. Two days later, on August 15, 2009, the back of his left hand, his left arm and left thumb became cold. He subsequently experienced tingling in his left arm as well. Petitioner was seen by his primary care physician, Dr. Womack, on September 14, 2009. Petitioner claims it was only then that he became aware that the problems he presented to Dr. Womack for were the result of the incident he experienced on

15IWCC0520

August 13, 2009. Petitioner testified to having notified Respondent of the accident on September 21, 2009, the Monday after he was seen by Dr. Womack. Respondent countered this testimony with a recorded statement Petitioner made that indicated he first informed Respondent of his accident on October 19, 2009. Petitioner did not dispute the accuracy of the recorded statement.

The Commission acknowledges Petitioner's proffered testimony of providing notice of his injury to Respondent following his September 14, 2009, visit was convincingly rebutted by the aforementioned recorded statement. The Commission, however, does not find this to be fatal as to the issue of Petitioner's notice of an accident to Respondent. It simply clarifies the date on which the Commission finds notice was received by Respondent from September 21, 2009, to October 19, 2009. The revised date is still within the timeframe, as set forth in Section 6(c) of the Act, requiring Petitioner to inform Respondent of his injury. Petitioner became aware of the connection of his then-current condition of ill-being and his August 13, 2009, injury on September 14, 2009, and reported this to Respondent on October 19, 2009. Under this circumstance, the Commission is satisfied the Petitioner provided Respondent notice of his accidental injury that comports with the Act.

The Decision of the Arbitrator, having found against Petitioner on the issues of jurisdiction and notice, did not address the remaining contested issues, deeming them to be moot. Having found otherwise, the Commission now addresses those issues.

The Commission finds Petitioner's complaints of ill-being to be causally related to his August 13, 2009, accident. Petitioner, in 2005, had a history of symptomatic cervical spinal stenosis and of treating this condition with a number of physicians in 2005. The absence of treatment records for the same between 2005 until August 13, 2009, implies the symptomatic nature of Petitioner's condition had resolved to a degree that made treatment unnecessary. The Commission finds only a 50-pound lifting restriction continued beyond Petitioner's treatment in 2005.

On August 13, 2009, Petitioner sustained an accident while removing the fifth wheel pin, an accident that caused his cervical spinal stenosis to become symptomatic once more. The treatment that ensued included a decompression with a laminectomy of C3, laminoplasties of C4-7, and left-sided foraminotomies from C4-7, all occurring on November 23, 2009. Later, he underwent an anterior cervical discectomy and fusion a C5-6 and C6-7, that being on January 3, 2011. Petitioner's treating physician, Dr. Daniel Riew, lends credence to this claim, by the finding of the causal relationship between Petitioner's August 13, 2009, accident and his need for two surgical interventions to his cervical spine. He noted Petitioner had continued to work following the 2005 diagnosis and did so without any problems with ambulation or complaints of numbness or cold affecting his arms and hands. Those problems emerged, per Dr. Riew, only after Petitioner's August 13, 2009, accident. The Commission notes, despite the multiple surgical interventions, Petitioner testified to experiencing continued pain, numbness in his hands and arms, and numbness and tingling in his legs with generalized weakness. The Commission finds Petitioner's August 13, 2009, accident to have resulted in the two surgeries, as well as his continuing complaints.

In treating the injuries to his cervical spine, Petitioner undertook medical treatment at Washington University Orthopedic, Barnes Jewish Hospital, the Brain and Neurospine Clinic of Missouri and Therapy Solutions and incurred medical bills as a result. Respondent contested these charges only on the issue of liability. The Commission finds these bills were reasonably and necessarily incurred to treat Petitioner's injuries and are the responsibility of Respondent.

Petitioner, over the course of treatment for his injuries, was medically precluded from working for a total of eighteen (18) weeks, from October 19, 2009, through January 5, 2010, and again from January 3, 2011, through February 20, 2011. This period of disability was as a result of Petitioner's two

surgeries to his cervical spine. The Commission awards TTD benefits accordingly.

The Commission notes Petitioner made a successful return to his career as truck driver and returned to his unrelated baseline lifting restriction of 50 pounds. It also notes, however, Petitioner's residual symptoms include pain in his left hand, generalized weakness, occasional loss of balance and dizziness. For these lingering after effects, the Commission finds Petitioner sustained a 25% loss of the person as a whole stemming from his August 13, 2009, accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $875.30 per week for a period of 18 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 $787.77 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 loss of 25% use of the person as a whole

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $ 66,237.66 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.

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: JUL 8 - 2015
KWL/mav
O: 5/11/15
42

Thomas J. Tyrrell

Michael J. Brennan

DISSENT

I respectfully dissent from the decision of the majority. Arbitrator Lindsay's findings are thorough, well reasoned and grounded in the law. This decision is correct and should be affirmed

Kevin W. Lamborn

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

Maria Garcia,
Petitioner,
vs.

NO: 10WC 15246

Columbia Sussex,
Respondent,

15IWCC0855

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,whether Petitioner exceeded the choices of medical providers and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 4, 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 $5,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 2 3 2015
o111215
DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GARCIA, MARIA
Employee/Petitioner

Case# 10WC015246

15IWCC0855

COLUMBIA SUSSEX
Employer/Respondent

On 12/4/2014, 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:

0147 CULLEN HASKINS NICHOLSON ET AL
JOSE M RIVERO
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

0766 HENNESSY & ROACH PC
PETER J PUCHALSKI
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

15IWCC0855

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

MARIA GARCIA
Employee/Petitioner

v.

COLUMBIA SUSSEX
Employer/Respondent

Case # **10** WC **15246**

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 **Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **October 20, 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. [x] Other

15IWCC0855

FINDINGS

On the date of accident, **March 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.

In the year preceding the injury, Petitioner earned **$24,596.00**; the average weekly wage was **$473.00**.

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.

Respondent shall be given a credit of **$784.95** for TTD, **$N/A** for TPD, **$N/A** for maintenance, and **$N/A** for other benefits, for a total credit of **$784.95**.

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 $315.33 for 2 2/7 weeks, pursuant to Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $283.80/week for 8.35 weeks, because the injury sustained caused 5% loss of use of the left foot/ankle, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $283.80/week for 10.75 weeks, because the injury sustained caused 5% loss of use of the left leg/knee, as provided in Section 8(e) of the Act.

Respondent has no liability for the medical bill from Dr. Howard Freedberg, in the amount of $5,902.00. Respondent is not liable for the bill from Nuestra Clinica de Chicago in the amount of $31,544.81, 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.

FINDINGS OF FACT

The disputed issues in this matter are: 1) causal connection; 2) medical bills; and 3) the nature and extent of petitioner's injuries. *See,* AX1.

On March 6, 2010, Petitioner was 43 years old and worked for Columbia Sussex/Wyndham Hotel, as a mini-bar attendant. Petitioner had worked in this capacity for approximately three years. Petitioner testified that her general job duties included checking the mini-fridges located in hotel rooms and replacing any items that may be missing.

The parties stipulated that on March 6, 2010 Petitioner suffered a work accident. Petitioner testified that she was injured when she tripped over a pile of linens, spraining her left ankle.

Petitioner first presented for treatment at the emergency room of Little Company of Mary Hospital. The following history of injury was recorded, "states her left foot 'twisted inward.' No apparent injury noted, no deformity." X-rays of the left ankle were completed and read to be normal. On examination, minimal swelling was noted. Petitioner was diagnosed with a left ankle sprain. Petitioner did not have any complaints involving the left knee. The records indicate that Petitioner was able to ambulate "with steady, independent gait." PX1.

Petitioner returned to Little Company of Mary two days later on March 8, 2010, presenting with complaints of pain in the left ankle and left knee. Petitioner's prior medical history was noted as significant for a left knee replacement surgery. Petitioner was diagnosed with a left knee sprain and was recommended to complete an orthopedic evaluation.

An initial evaluation was completed on March 10, 2010 and Petitioner presented with left ankle and left knee complaints. . Chiropractor Kuk recommended physical therapy. PX2.

Petitioner performed therapy with this provider from March 11, 2010 through April 27, 2010. The daily progress notes document twenty-three (23) visits and Kuk released Petitioner to return to work on a full duty basis effective March 23, 2010. The last visit was April 30, 2010 and Kuk referenced an 80% improvement in Petitioner's ankle pain. Petitioner was discharged from care and no additional therapy was ordered. PX2.

The Petitioner completed diagnostic studies while treating with Rehab Dynamix/ Chiropractor Kuk. On April 16, 2010, a left ankle MRI was completed which demonstrated post-traumatic, soft tissue bruising with no obvious osseous abnormalities. A left knee MRI, also completed on April 16, 2010, was read to demonstrate no obvious abnormalities.

On April 21, 2010, Petitioner presented for a Section 12 examination, which was performed by Dr. Michael Stover. Dr. Stover completed a physical examination, reviewed Petitioner's diagnostic studies and diagnosed a grade II left ankle sprain and a left knee lateral ligamentous strain. Dr. Stover recommended four to six (4–6) weeks of formal physical therapy and opined that Petitioner would then reach maximum medical improvement ("MMI"). Dr. Stover opined that Petitioner was capable of performing full duty work. RX1.

Petitioner testified that following this independent medical examination ("IME"), she performed physical therapy from May 3, 2010 through July 12, 2010 at ATI Physical Therapy. She further testified that she was then seen by another orthopedic surgeon, Dr. Johnny Lin. Dr. Lin examined Petitioner on July 13, 2010 and administered a corticosteroid injection, recommending additional physical therapy. Dr. Lin opined that Petitioner could continue performing full duty work and estimated that MMI would be achieved within six to eight (6-8) weeks. PX3.

The records from Dr. Lin include Petitioner's discharge summary from ATI Physical Therapy, which confirms that Petitioner participated in physical therapy from May 3, 2010 through July 15, 2010, for a total of 27 therapy sessions. The summary also indicates that Petitioner called ATI Physical Therapy on July 19, 2010, cancelling all remaining appointments.

Petitioner then sought treatment with a second chiropractor, Joe Santiago, at Nuestra Clinica de Chicago. An initial evaluation with Chiropractor Santiago was completed on July 21, 2010, who diagnosed ankle and knee pain and recommended therapy with his clinic. The records from this provider confirm that Petitioner received chiropractic treatment/therapy with Nuestra Clinica de Chicago from July 23, 2010 through August 10, 2011. The billing documents and treatment records confirm that Petitioner completed one hundred fifteen (115) therapy sessions with this provider. PX4.

The Daily Soap Notes from this provider indicate that Petitioner's sessions typically included the following modalities: chiropractic manipulation, interferential therapy and hot/cold packs. Despite having completed one hundred fifteen (115) therapy sessions, the final notes from August 10, 2011 confirm that Dr. Santiago was recommending further therapy.

While treating with Chiropractor Santiago, Petitioner was referred for an orthopedic evaluation with Dr. Howard Freedberg. An initial evaluation with Dr. Freedberg took place on August 12, 2010. In this treatment note, Dr. Freedberg discussed Petitioner's prior medical treatment. The history indicates that Petitioner was previously seen by Dr. Lin and that Petitioner was referred to Dr. Lin by her physical therapy provider, ATI. The recorded history also indicates that Petitioner was referred to Chiropractor Santiago/Nuestra Clinica de Chicago by her attorney. This is inconsistent with Petitioner's trial testimony who denied, under cross-examination, that she was referred to Dr. Santiago by her attorney. PX5.

Dr. Freedberg's physical examination documented full range of motion of the left ankle, no effusion, and no sensory or motor deficits. Dr. Freedberg diagnosed a left ankle LCL sprain and ligamentous laxity in the left knee. Dr. Freedberg recommended a double upright brace and additional treatment with Dr. Santiago. Petitioner was not placed under any restrictions and was found to be capable of full duty work.
Dr. Freedberg offered the same diagnosis, treatment recommendations and work capacity opinion when Petitioner returned for evaluation on September 16, 2010, October 21, 2010 and December 16, 2010 and February 15, 2011. PX5.

Petitioner was seen on April 14, 2011 and Dr. Freedberg noted the following, "We explained to the patient that her ankle pain should be resolved by now, since her ankle sprain was over 1 year ago." Dr. Freedberg offered the same comment when Petitioner was seen June 16, 2011 and August 18, 2011.

On November 29, 2011, Dr. Freedberg placed Petitioner at MMI and instructed Petitioner to return on an as needed basis.

Dr. Stover completed an addendum report on February 13, 2013. Dr. Stover reviewed Petitioner's treatment records from Dr. Freedberg and Nuestra Clinica de Chicago. Upon review of those records, Dr. Stover maintained his opinion that Petitioner suffered a left ankle sprain and lateral ligamentous strain of the left knee. Dr. Stover opined that Petitioner required four to six (4-6) weeks of physical therapy for her injuries and that her treatment through July 2010 was warranted; Dr. Stover found no evidence to warrant additional treatment after July 2010. Specifically, Dr. Stover opined that Petitioner's one hundred fifteen (115) therapy/chiropractic sessions with Nuestra Clinica de Chicago between August 2010 and August 2011 were not reasonable or necessary. Finally, Dr. Stover opined that there was not any significant change in impairment of the extremity in regards to motion and strength. RX2.

Petitioner returned for one additional visit with Dr. Freedberg on April 11, 2013, 1 ½ years after her November 2011 visit. At the time of this visit, Dr. Freedberg reviewed the report prepared by Dr. Stover. Dr. Freedberg disagreed with the opinions offered by Dr. Stover regarding the reasonableness and necessity of Petitioner's chiropractic treatment with Nuestra Clinica de Chicago. The refuting opinion from Dr. Freedberg cites one factor, Petitioner's work capacity: "He [Dr. Stover] denies the necessity of treatment and I again disagree as I believe it helped her get back to full duty which she is doing now." PX5.

On November 13, 2012, Dr. Clarence Fossier, an orthopaedic surgeon, prepared a retroactive utilization review report. In the report, Dr. Fossier provided his Illinois license number, Q361041172. The report addressed Petitioner's treatment with Nuestra Clinica de Chicago. Dr. Fossier did not certify Petitioner's treatment from July 2, 2010 through August 10, 2011 as medically necessary and

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appropriate. Dr. Fossier found that per ODG guidelines no more than 12 therapy sessions (overall) would have been appropriate. RX3.

The parties stipulated that Petitioner was temporarily and totally disabled from March 10, 2010 through March 25, 2010 and that Petitioner was paid TTD benefits of $784.95. Petitioner testified that she returned to her employment position as a minibar attendant effective March 26, 2010, less than three weeks after the subject occurrence. Petitioner testified that she returned to her position on a full duty and full time basis.

CONCLUSIONS OF LAW

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

A decision by the Commission cannot be based upon speculation or conjecture. *Deere and Company v Industrial Commission*, 47 Ill.2d 144, 265 N.E. 2d 129 (1970). A petitioner seeking an award before the Commission must prove by a preponderance of credible evidence each element of the claim. *Illinois Institute of Technology v. Industrial Commission*, 68 Ill.2d 236, 369 N.E.2d 853 (1977). Where a petitioner fails to prove by a preponderance of the evidence that there exists a casual connection between work and the alleged condition of ill-being, compensation is to be denied. Id. The facts of each case must be closely analyzed to be fair to the employee, the employer, and to the employer's workers' compensation carrier. *Three "D" Discount Store v Industrial Commission*, 198 Ill.App. 3d 43, 556 N.E.2d 261, 144 Ill.Dec. 794 (4th Dist. 1989).

The burden is on the Petitioner seeking an award to prove by a preponderance of credible evidence all the elements of his claim, including the requirement that the injury complained of arose out of and in the course of his or her employment. *Martin vs. Industrial Commission*, 91 Ill.2d 288, 63 Ill.Dec. 1, 437 N.E.2d 650 (1982). The mere existence of testimony does not require its acceptance. *Smith v Industrial Commission*, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require that an award be entered or affirmed whenever a claimant testified to an injury no matter how much his testimony might be contradicted by the evidence, or how evident it might be that his story is a fabricated afterthought. *U.S. Steel v Industrial Commission*, 8 Ill.2d 407, 134 N.E. 2d 307 (1956).

It is not enough that the petitioner is working when an injury is realized. The petitioner must show that the injury was due to some cause connected with the employment. *Board of Trustees of the University of Illinois v. Industrial Commission*, 44 Ill.2d 207, 214, 254 N.E.2d 522 (1969); see also *Hansel & Gretel Day Care Center v Industrial Commission*, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991).

The Illinois Supreme Court has held that a claimant's testimony standing alone may be accepted for the purposes of determining whether an accident occurred. However, that testimony must be proved credible. *Caterpillar Tractor vs. Industrial Commission*, 83 Ill.2d 213, 413 N.E.2d 740 (1980). In addition, a claimant's testimony must be considered with all the facts and circumstances that might not justify an award. *Neal vs. Industrial Commission*, 141 Ill.App.3d 289, 490 N.E.2d 124 (1986). Uncorroborated testimony will support an award for benefits only if consideration of all facts and circumstances support the decision. *See generally, Gallentine v. Industrial Commission*, 147 Ill.Dec 353, 559 N.E.2d 526, 201 Ill.App.3d 880 (2nd Dist. 1990), *see* also *Seiber v Industrial Commission*, 82 Ill.2d 87, 411 N.E.2d 249 (1980), *Caterpillar v Industrial Commission*, 73 Ill.2d 311, 383 N.E.2d 220 (1978). It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence, and assign weight to the witness' testimony. *O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253, 403 N.E.2d 221, 223 (1980); *Hosteny v Workers' Compensation Commission*, 397 Ill.App. 3d 665, 674 (2009).

The Arbitrator first notes that the parties have stipulated that Petitioner suffered a work-related accident which caused injuries to the left ankle and left knee; the causation dispute is based on timeframe and Respondent is denying and disputing that any condition after July 2010 was causally related to the subject occurrence.

Dr. Stover examined Petitioner pursuant to Section 12 of the Act, on April 21, 2010 and diagnosed a left ankle sprain and left knee lateral ligamentous strain. Dr. Stover opined that for the left ankle injury, Petitioner would reach MMI within six (6) weeks, at the completion of a physical therapy program. Dr. Stover opined that Petitioner did not require any further treatment for the left knee. In an addendum report of February 13, 2013, Dr. Stover reviewed subsequent treatment records and opined that Petitioner reached a plateau and maximum medical improvement by July 12, 2010.

The Arbitrator finds the opinions of Dr. Stover to be most persuasive than those of Chiropractor Santiago and Dr. Freedberg; and further finds that Petitioner reached MMI by July 12, 2010. The Arbitrator finds further support in the records from Chiropractor Kuk, who examined Petitioner on April 30, 2010 and stated that Petitioner reported an 80% improvement in her pain symptoms. Petitioner was discharged from care and no additional therapy was ordered.

Based on the foregoing, the Arbitrator finds that Petitioner suffered a left ankle sprain and left knee strain as the result of her accidental injuries of March 6, 2010. Petitioner reached MMI for those injuries by July 12, 2010 and any symptoms, conditions and treatment after that date were unrelated to the subject occurrence.

J. Has Respondent paid all appropriate charges for all reasonable and necessary medical services? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

Petitioner is seeking payment of two outstanding medical bills from Dr. Howard Freedberg ($5,902.00) and from Nuestra Clinica de Chicago ($31,544.81). In denying these bills, the Arbitrator places emphasis of the opinions of Dr. Stover and Chiropractor Kuk, as well as the utilization review completed by Dr. Fossier.

Dr. Stover opined that Petitioner had reached MMI by July 12, 2010. When Petitioner was examined on April 21, 2010, Dr. Stover opined that Petitioner required and additional four to six (4-6) weeks of physical therapy for her left ankle and no treatment or therapy for the left knee. Petitioner subsequently completed twenty-seven (27) therapy sessions with ATI physical therapy from May 3, 2010 through July 15, 2010. In an addendum report dated February 13, 2013, Dr. Stover opined that the 115 chiropractic sessions Petitioner completed with Dr. Santiago were not reasonable or necessary. In his office note of April 11, 2013, Dr. Freedberg disagreed with Dr. Stover and opined that Petitioner's treatment was reasonable and necessary as it helped her return to full duty work. The Arbitrator places no weight on this opinion as Petitioner had returned to full duty work on March 26,

2013, over four months prior to ever seeking treatment with either Nuestra Clinica de Chicago or Dr. Freedberg.
Chiropractor Kuk last examined Petitioner on April 30, 2010, documented an 80% improvement in pain symptoms and did not recommend any additional therapy.

Dr. Fossier, who completed a retroactive utilization review on November 13, 2012, likewise found that the chiropractic treatment/therapy with Dr. Santiago was not reasonable and necessary. Dr. Fossier cited ODG guidelines, which recommend between nine to twelve (9-12) therapy visits.

The Arbitrator notes that prior to completing treatment with Nuestra Clinica de Chicago/Dr. Santiago, Petitioner already completed twenty-three (23) therapy sessions with Dr. Kuk/Rehab Dynamix and twenty-seven (27) therapy sessions with ATI physical therapy. In addition to those 50 therapy sessions, Petitioner is seeking an award of one hundred fifteen (115) chiropractic/therapy sessions with Dr. Santiago. During this period, Petitioner was performing full duty work, which involved prolonged standing, frequent squatting and pushing a heavy cart. The Arbitrator finds Petitioner's treatment with Nuestra Clinica de Chicago unreasonable, unnecessary and clearly excessive and notes that the entire bill consists or hot/cold packs, EMS, CMT (extra-spinal), with therapeutic exercise starting on September 24, 2010. The Arbitrator notes that there is no itemization of the exercises so there can be no determination as to its efficacy. On this basis, the request for payment of its medical bill, is denied.

The bill from Dr. Freedberg is for orthopaedic treatment from August 2010 through April 2013. The Arbitrator notes that the final office visit is more than three years after Petitioner suffered a left ankle sprain. During this timeframe, Dr. Freedberg only recommended chiropractic treatment with Dr. Santiago and a knee brace. During this period, Petitioner was performing full duty work, which involved prolonged standing, frequent squatting and pushing a heavy cart. The office notes from Dr. Freedberg indicate that he felt that the Petitioner's condition should have improved as he stated that "We explained to the patient that her ankle pain should be resolved by now, since her ankle sprain was over 1 year ago." The Arbitrator finds most of Petitioner's treatment with Dr. Freedberg to be unreasonable, unnecessary and excessive and denies Petitioner's request for payment of his bill

At issue is whether either ATI physical therapy or Dr. Lin would constitute a second choice of medical provider. The Arbitrator finds that Dr. Kuk/Rehab Dynamix would constitute Petitioner's first choice of medical provider and that there is no apparent dispute to this finding. Petitioner testified that she was referred to Dr. Lin by respondent's nurse case manager and that neither provider should constitute an independent choice. This testimony, however, is not supported by Petitioner's treatment records.

Petitioner presented for an orthopaedic evaluation with Dr. Freedberg on August 12, 2010 and a comprehensive prior treatment history was recorded. The history indicates that Petitioner was

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previously seen by Dr. Lin and that Petitioner was referred to Dr. Lin by her physical therapy provider, ATI. Dr. Lin did complete an orthopaedic evaluation on July 13, 2010, which included a corticosteroid injection to the left ankle. The Arbitrator finds that Dr. Lin was referred as a treater and therefore does not constitute a second choice of medical provider.

Accordingly, Dr. Santiago/Nuestra Clinica de Chicago would represent Petitioner's second choice of medical provider, as would Dr. Freedberg who was within a chain of referral. The Arbitrator denies Petitioner's request for medical bills from Dr. Freedberg and Nuestra Clinica de Chicago on the basis that these services were unreasonable and unnecessary.

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

The Arbitrator finds that Petitioner suffered sprain/strain injuries to the left ankle and left knee as the result of her accidental injuries of March 6, 2010. X-ray imaging, completed on March 6, 2010 and on several subsequent occasions, confirmed that Petitioner did not suffer from any fracture, dislocation or bony abnormality involving the left ankle. Petitioner's MRI of April 16, 2010 documented soft tissue bruising with no obvious osseous abnormalities. Dr. Freedberg diagnosed Petitioner with a left ankle LCL sprain. Dr. Stover diagnosed a grade II left ankle sprain. Petitioner's treatment was conservative in nature, involving physical therapy, chiropractic treatment and a single corticosteroid injection.

In addition, all left knee x-rays were negative for fracture or dislocation and Petitioner's MRI of April 16, 2010, did not identify any obvious abnormality or internal derangement. Dr. Freedberg diagnosed left knee ligament laxity. Dr. Stover diagnosed a lateral ligamentous strain. Petitioner's treatment was conservative and involved physical therapy and chiropractic treatment.

The Arbitrator places emphasis of the fact that Petitioner returned to work on a full duty basis in less than three (3) weeks and was capable of completing her work activities, which included prolonged standing, frequent squatting and pushing a heavy cart. She testified that wearing a brace and receiving physical therapy, strengthened her leg.

Based on the foregoing, the Arbitrator finds that Petitioner has suffered accidental injuries that caused 5% loss of use of the left foot/ankle and 5% loss of use of the left leg/knee.

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ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
10WC15246
SIGNATURE PAGE

Signature of Arbitrator

December 3, 2014
Date of Decision

DEC 4 - 2014

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

Joseph Agresto,
Petitioner,
vs.

NO: 10WC 23983

City of Chicago,
Respondent,

15IWCC0857

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, prospective medical, penalties, fees, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 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.

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: NOV 2 3 2015
o111215
DLG/mw
045

David L. Gore

Mario Basurto

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

AGRESTO, JOSEPH
Employee/Petitioner

Case# 10WC023983

15IWCC0857

CITY OF CHICAGO
Employer/Respondent

On 5/5/2015, 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 0.07% 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:

0391 HEALY SCANLON LAW FIRM
JACK CANNON
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
JOSEPH A ZWICK
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

15IWCC0857

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 Agresto
Employee/Petitioner

v.

City of Chicago

Case # **10** WC **23983**

Consolidated cases: **D/N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **March 26, 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 _____

FINDINGS 15IWCC0857

On **6/9/2010**, 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.

With respect to causation, the Arbitrator finds, based on the "law of the case," that the accident resulted in lumbar disc herniations at two levels. For the reasons set forth in the attached decision, the Arbitrator further finds, in reliance on Respondent's examiner, Dr. Goldberg, that the accident did not result in left-sided neural compression or spondylolisthesis.

In the year preceding the injury, Petitioner earned $**40,346.80**; the average weekly wage was $**775.90**.

On the date of accident, Petitioner was **52** 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 $**80,219.79** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $**80,219.79.**.

ORDER

Temporary Total Disability: Based on the prior unappealed 19(b) decision and the "law of the case," the Arbitrator finds that Petitioner was temporarily totally disabled from June 10, 2010 through September 1, 2010. PX 5. The Arbitrator finds that Petitioner was also temporarily totally disabled during the following three intervals: 1) September 2, 2010 through November 28, 2010; 2) December 2, 2010 through April 4, 2011; and 3) December 28, 2011 through January 8, 2013. These three intervals total 84 1/7 weeks. Based on the stipulated average weekly wage, the Arbitrator awards temporary total disability benefits at the rate of $517.27 per week. The basis of the award is more fully explained in the attached decision. The Arbitrator adopts Dr. Goldberg's opinion that Petitioner reached maximum medical improvement on January 8, 2013.

Permanent Partial Disability: Respondent shall pay Petitioner permanent partial disability benefits of $465.54 per week for 125 weeks, because the injury sustained caused 25% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Medical: For the reasons set forth in the attached decision, the Arbitrator awards the following medical expenses, subject to the fee schedule and the parties' stipulation: 1) United Rehab Providers, $3,910.00; 2) Advanced Orthopedics (Dr. Stamelos), charges for care rendered from December 1, 2010 through January 8, 2013; 3) Northwestern Neurosurgical Associates (Dr. Yapor), $140.00; and 4) Advanced Lab Services, $1,232.00. The Arbitrator declines to award the $10,232.49 bill from Central Medical Specialists.

Penalties: Petitioner's claim for penalties and 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.

Molly C Mason
Signature of Arbitrator

5/5/15
Date

MAY 5 - 2015

Joseph Agresto v. City of Chicago
10 WC 23983

15IWCC0857

Procedural History

Petitioner originally worked as a garage attendant for Respondent's police department. On June 23, 2010, he filed an Application for Adjustment of Claim alleging a back injury of June 9, 2010. As of June 9, 2010, Petitioner was subject to restrictions, which Respondent was accommodating, due to a previous work-related back injury in 2005 that required surgery in 2006.

On September 1, 2010, former Arbitrator (now Commissioner) DeVriendt conducted a 19(b) hearing in the instant case. On September 30, 2010, he issued a decision (PX 5) finding that Petitioner established a compensable accident of June 9, 2010 when a wheel on his work chair broke, causing him to jerk backward, with the chair dropping several inches. Arbitrator DeVriendt noted that Petitioner was subject to light duty prior to and at the time of this accident due to the previous back surgery of January 31, 2006, which involved the L4-L5 level. He also noted that a lumbar spine MRI performed on June 16, 2010 showed a "broad based central disc herniation at L3-L4 and a new or recurrent disc herniation at the prior level of L4-L5." He went on to find Petitioner's "current condition of ill-being" to be causally related to the June 9, 2010 accident. He awarded two medical bills and 11 6/7 weeks of temporary total disability benefits. He declined to award penalties and fees, citing the prior back injury and surgery, and reserved the issue of prospective care "for further determination if necessary."

Neither party filed a review.

Arbitrator's Findings of Fact

Summary of Testimony – Hearing of March 26, 2015

A second hearing took place on March 26, 2015, with Respondent disputing causation, among other issues, and Petitioner seeking a permanent total disability award as well as other benefits. Arb Exh 1.

James Boyd, a vocational rehabilitation counselor, testified on behalf of Petitioner at the March 26, 2015 hearing. Respondent stipulated to Boyd's qualifications.

Boyd testified he initially met with Petitioner on November 4, 2014 in order to conduct a vocational evaluation and determine Petitioner's skills level. In connection with his evaluation, he reviewed Dr. Goldberg's Section 12 examination report, deposition testimony given by Drs. Goldberg, Yapor and Stamelos and records concerning Petitioner's cervical and lumbar spine treatment.

Boyd testified it was his understanding Petitioner had sustained several injuries over time. Petitioner initially injured his back in 2005 and underwent lumbar spine surgery thereafter. Petitioner resumed working for Respondent on a light duty basis following this surgery, injured his back again on June 9, 2010 and underwent a second spine surgery in October 2011. It was Boyd's understanding that Petitioner attempted to resume working for Respondent following this second surgery but was unable to.

Boyd testified that Petitioner was on various medications as of the November 4, 2014 meeting. Those medications included Norco, a topical cream, anti-inflammatories and anti-anxiety medication. Petitioner indicated he was experiencing constant back and leg pain and occasionally used a cane. Petitioner told him he routinely experienced three or four particularly bad days each month. Such a day could be triggered by something as innocuous as sneezing. On those bad days, he would sleep on the floor due to his pain level. Petitioner also indicated he was unable to bend, twist or stoop and that he had difficulty with certain routine activities such as putting socks on. He could lift a gallon of milk but could not carry it. Petitioner also indicated that bad weather conditions caused his symptoms to increase.

Boyd testified he understood that Dr. Stamelos viewed Petitioner as "100% disabled" while Dr. Goldberg viewed him as capable of sedentary duty so long as he could get up and change positions each hour.

Boyd testified that, as of the meeting, Petitioner was 57 years old and married. Petitioner did not have any children. He had attended one year of high school and subsequently obtained his GED. He had never served in the military. He had performed a "collection of jobs" before being hired by Respondent in 2000. He initially worked as a garage attendant, loading tires and towing/delivering vehicles. Following his 2005 accident and subsequent surgery, he returned to Respondent in a light duty capacity at a different location. Before the 2005 accident, he had worked at the police station at Western and Belmont. After the accident, Respondent transferred him to an office at 52nd and Wentworth, where he made "beat tags," answered telephones and delivered vehicles. Boyd testified it was his understanding that Petitioner attempted to resume working following the June 9, 2010 accident but experienced increased pain and anxiety attacks.

Boyd testified that Petitioner was off work as of the November 4, 2014 meeting. The meeting lasted three hours. Petitioner's overall appearance was "messy." He was cooperative but "very distracted."

Boyd testified that, during his forty years as a vocational rehabilitation counselor, he has interviewed literally thousands of individuals and has observed various behaviors that he perceives as manifestations of pain. During the November 4, 2014 meeting, he observed that Petitioner frequently changed position, interrupted testing and experienced difficulty moving his upper extremities during dexterity-related tests. He also observed a tremor in Petitioner's right hand and right upper extremity.

Boyd testified he administered a battery of tests to Petitioner during the November 4, 2014 meeting. Those tests included the WRAT test, which measures reading comprehension. Petitioner scored at the seventh grade level. That level is considered "functional." The fact that Petitioner had previously obtained a GED would typically prompt suspicion of a higher reading level. The tests also included the math component of the Woodcock Johnson test. Petitioner performed at a 4.9 grade level on this test. Petitioner had "difficulty with simple math." He could not solve problems involving fractions or decimals. On the Beta IQ test, Petitioner scored an 85, which is the low average range. A score of 85 is in the sixteenth percentile for Petitioner's age. Boyd testified he also administered the Minnesota clerical examination to Petitioner. This examination involves checking company names and number-related data. Petitioner worked "very slowly" on this test and ultimately scored only in the first percentile on all of the sub-tests. His overall error rate was 10% and his name-related error rate was 20%. The results were indicative of difficulty paying attention to accuracy and detail. Boyd testified he also administered a dexterity test to determine the extent of Petitioner's eye-hand coordination. Petitioner did not do well on this test. Petitioner was "heavy-handed." He exhibited a tendency to "drag" pieces in order to minimize hand and arm movement. He scored only in the first percentile on both right hand and bilateral hand testing.

Boyd testified that the results of such testing are "possibly subjective." Vocational testing does not have any built-in factors to determine effort. Boyd testified he believes he is able to detect sub-maximal effort. Petitioner did not exhibit sub-maximal effort.

Boyd testified he would disagree that the testing he administered was worthless. Each test he gave Petitioner has validity co-efficients. There is no way to determine an individual's skills other than to conduct testing. In the past, Petitioner presumably had a higher level of manual dexterity, since he used to be a drummer. Boyd testified that the EMG he reviewed would explain the lack of dexterity he observed in Petitioner.

Boyd opined that, based on the evaluation, the test results and Petitioner's lack of transferable skills, Petitioner is not capable of competitive employment and is not a suitable candidate for vocational rehabilitation.

Boyd testified he requested but did not receive a formal description of Petitioner's job. He looked at the DOT [Dictionary of Occupational Titles] but was not able to find a job similar to Petitioner's.

Under cross-examination, Boyd testified that, in terms of documents, he reviewed only the deposition testimony, Dr. Goldberg's report and records from MercyWorks, Dr. Yapor and Dr. Stamelos. He understands that, when Petitioner returned to work in 2006, he retained the title "garage attendant" but performed different tasks than he had previously performed, namely making "beat tags," signing vehicles in and out, checking data on a computer, making sure vehicles were washed and putting keys on key rings. He assumes that, when Petitioner resumed working later on, for a three-month period, he again performed these tasks. "Beat tags" are placards that identify a police officer's assigned territory. Such tags typically have

numbers and letters on them but it is not clear whether Petitioner was required to write numbers or letters on the tags. He agrees that vocational rehabilitation is only as successful as motivation allows. He has performed other vocational evaluations for Petitioner's attorney's firm. He has performed between ten and twenty-five such evaluations during the last twenty years. He did not produce the raw data underlying Petitioner's test results when he responded to Respondent's subpoena. The code of ethics by which he is bound allows release of such data only to an individual who is qualified to interpret it. He did not request a job description from anyone other than Petitioner.

On redirect, Boyd testified he has performed three or four other vocational evaluations for Petitioner's counsel, Jack Cannon. He also performs such evaluations for respondents. His practice is divided 50/50 between claimants and respondents.

Kurt Peterson testified on behalf of Respondent. Peterson testified he has worked for Respondent's fleet management division for almost four years. He is the deputy of communications for Respondent's human resources department. He previously worked as an administrator for North Park University.

Peterson testified he met with Petitioner on March 1, 2013. The meeting took place at his office at 30 North LaSalle Street. Petitioner was originally scheduled to meet with Paul Plantz but Plantz called in sick that day so he met with Petitioner instead. No one else was present during the meeting. The purpose of the meeting was to explore whether Petitioner could return to work within the sedentary duty restrictions imposed by Respondent's examiner, Dr. Goldberg. He told Petitioner he had sedentary duty available at the same garage where Petitioner had worked in the past. Petitioner told him he needed money and wanted to return to work. Petitioner completed all of the paperwork that was required in order for him to return to work but Petitioner did not turn in this paperwork. Petitioner told him he needed to check something with his doctor and was going to see the doctor the next day.

Peterson identified RX 1 as a letter Respondent sent to Petitioner referencing Dr. Goldberg's opinions and directing Petitioner to attend a meeting with Paul Plantz on March 1, 2013 concerning returning to work within the restrictions set by Dr. Goldberg. The letter advises Petitioner that his workers' compensation benefits might be suspended if he fails to attend the meeting. It also advises him he can apply for a leave of absence in the event "other medical reasons" prevent him from being able to return to work.

Under cross-examination, Peterson identified an E-mail he received from Respondent's counsel the previous day. In the E-mail, Respondent's counsel listed questions he planned to ask during the hearing.

Peterson testified he independently recalls meeting with Petitioner. He reviewed his notes in preparation for the hearing. He did not bring his notes to the hearing. With reference to the E-mail, he placed check marks next to the questions he was ready answer. In preparation for the hearing, he talked with Plantz. He verified that Plantz was out sick on the

day of the meeting. Plantz also refreshed his recollection as to the purpose of the meeting. During the meeting, Petitioner gave him a dated copy of his doctor's restrictions and told him he would be seeing the doctor the following day.

Peterson testified he has looked at Dr. Goldberg's report and restrictions on many occasions. He could not recall exactly when he last looked at it.

Peterson testified he is not aware of Petitioner having returned to work in March 2013 but he knows Petitioner showed up at work unannounced on two occasions. On those occasions, Petitioner did not have the necessary paperwork. Petitioner's managers called him when Petitioner showed up at work because the necessary paperwork had not been completed. The paperwork is not in Respondent's computer system. Before Petitioner could return to work, he would have had to go to Respondent's finance department to clear any existing debt and then go to the human resources department in order to be fingerprinted. If Petitioner had had debt, he would have been required to either clear it or set up a payment plan. Petitioner also would have been required to complete a child support affidavit and a background consent form. Respondent's policy is that any employee who is off work for more than one year is required to complete new paperwork.

Peterson testified he does not know whether Petitioner turned in the paperwork to a Respondent clerk or teller. He did not check with any clerk or teller to see if this occurred. He sent Petitioner a letter concerning the paperwork but does not have this letter with him. Petitioner returned to work for one day, on June 5, 2013. Prior to that, Petitioner was on a leave of absence, which ended on June 4, 2013. [See RX 6, a letter dated May 3, 2013, directing Petitioner to complete and return an application for a leave of absence by May 17, 2013.] After Petitioner showed up at work on June 5, 2013, Szysko and Chapulis contacted Toney, who instructed them to send Petitioner home. Chapulis is Respondent's garage manager. Petitioner called in sick the next day, June 6, 2013. [On June 20, 2013, Kevin Murphy, a labor relations supervisor for Respondent, sent Petitioner a letter referencing his one day of work on June 5, 2013 and directing Petitioner to supply both documentation supporting his absence since June 6, 2013 and various forms so as to permit payment for the hours he worked on June 5, 2013. RX 7.]

On redirect, Peterson testified that the E-mail he received from Respondent's counsel directed him to always tell the truth when testifying.

Under re-cross, Peterson acknowledged he has testified before.

Julie Bose also testified on behalf of Respondent. Bose testified she has worked as a vocational rehabilitation counselor for thirty-one years. She is certified. [Petitioner's counsel stipulated to her qualifications.]

Bose testified she prepared a report in connection with this case, after reviewing Jim Boyd's notes and records from Drs. Stamelos and Goldberg. It is her understanding that

Petitioner had upper extremity problems as well as problems with both his cervical and lumbar spine. She also understands that Dr. Goldberg viewed Petitioner as capable of sedentary duty while Dr. Stamelos felt Petitioner was permanently and totally disabled.

Bose identified RX 2 as her report of March 20, 2015. The subpoenaed materials she reviewed did not include the raw data from the testing Boyd conducted, in accordance with the standard of conduct that governs vocational rehabilitation counselors. The testing had no external validity measurements and it is thus not possible to determine from the test results whether Petitioner put forth full effort. The tests have validity co-efficients built into them but those relate to similar tests, not to effort put forth by the person being tested.

Bose opined that Petitioner's test scores are inconsistent with an individual who obtained a GED, performed semi-skilled work and played the drums for a living. Petitioner's test scores were well below average. In fact, the Minnesota test scores were in the first percentile. A person who obtained a GED, performed semi-skilled work and is a musician should have done better on these tests.

Bose opined that she agrees with Dr. Goldberg that Petitioner could perform his previous clerical position. Petitioner has an advantage in that many employers do not accept individuals who lack a GED. She has never met with Petitioner. Her opinions are based solely on what she reviewed.

Under cross-examination, Bose testified she did not ask Respondent whether she could meet with Petitioner. Respondent retained her on February 11, 2015. In her report, she did not render an opinion concerning Petitioner's transferable skills. She reviewed Dr. Goldberg's report of December 28, 2011. Page 5 of this report contains a reference to Dr. Sheth's note of August 5, 2011. She has never seen Dr. Sheth's notes. She is familiar with MercyWorks. MercyWorks is a treatment facility utilized by Respondent.

Bose testified she has some criticism of Boyd's testing. The testing could have been more thorough and there was no built-in validity factor. She believes the testing should not be given much weight, given the other factors bearing on the issue of employability. She does not know where or when Petitioner obtained his GED. If Petitioner obtained his GED last week, it should be no different than if he had obtained it thirty years ago. She recommends a functional capacity evaluation but she is not a physician. She did not read Dr. Goldberg's deposition and thus does not know that the doctor testified a functional capacity evaluation would be a waste of time. She disagrees with the doctor on this point.

On redirect, Bose testified that vocational rehabilitation counselors use functional capacity evaluations to determine employability.

Under re-cross, Bose testified she would follow a doctor's recommendation concerning a functional capacity evaluation if the doctor felt it would be unsafe for the individual to undergo such an evaluation. The term "sedentary duty" has a working definition for her. With

respect to Dr. Goldberg, she knows of no restrictions the doctor imposed other than the restriction relating to changes of position.

Petitioner was the last witness to testify. He testified that, following the prior 19(b) hearing, he resumed treatment at MercyWorks and also returned to Dr. Yapor, the surgeon who operated on his back in 2006. Dr. Yapor recommended he undergo a lumbar spine fusion but he declined because he was afraid of having more back surgery. On December 2, 2010, Dr. Stamelos took him off work and recommended therapy and injections. He underwent an injection but it did provide any relief. He underwent therapy thereafter.

Petitioner testified he returned to work in April 2011. He was given a light duty position but at a different location. Before the accident of June 9, 2010, he performed light duty in an office, putting keys on rings and performing filing. He also drove cars to a car wash. The light duty position he began performing in April 2011 required him to make "beat tags," answer a telephone, drive a paddy wagon to body shops and do filing. He worked from 7 AM to 3:30 PM five days per week. The job was at a Respondent facility at 52nd and Wentworth. Because he lives on the far northwest side of Chicago, he had to leave home at 5:15 or 5:30 AM each workday. It took him 40 to 60 minutes to get to work. By the time he arrived each morning, he was experiencing numbness in his legs and low back pain. He had to walk around for a while before punching in. His trip home took even longer. It averaged between 75 and 90 minutes, depending on traffic. When he arrived home, he had difficulty getting out of his car due to low back and left leg pain. Sometimes his neighbor had to help him get out of the car.

Petitioner testified that, as of 2011, he regularly took prescription pain medication (Norco and Hydrocodone) as well as muscle relaxants and Ranitidine for stomach problems associated with the medication. He used an exercise ball at home twice daily to stretch out his back.

Petitioner testified he stopped working on June 8, 2011 due to "massive" back pain. Because Dr. Stamelos imposed driving-related restrictions, since driving was aggravating his back, he investigated public transportation options. He determined that, in order to get to work each day, he would have to walk two blocks to the Addison bus, take that bus east to the Kennedy Expressway, transfer to the Blue Line subway, transfer to the Red Line subway and then walk three and a half blocks. He did not believe he would be capable of making this trip each day. There was no guarantee he would obtain a seat and ice and snow would be a factor in the winter.

Petitioner testified he continued seeing Dr. Stamelos thereafter. He continued receiving temporary total disability benefits until 2013. He saw Dr. Goldberg when Respondent directed him to do so. In 2013, Respondent began sending him letters about returning to work. He met with Peterson concerning returning to work. Peterson gave him directions as to what he would need to do in order to resume working and he followed those directions. Specifically, he went to Room 100 at City Hall, where he submitted to fingerprinting and completed paperwork.

Petitioner recalled attempting to return to work on June 5, 2013. His brother drove him to work that day. He reported to an individual named "Cade," who told him he would need to see another individual named "Chapulis." When Chapulis arrived, he told Petitioner he knew nothing about Petitioner returning to work. Chapulis made a telephone call and told Petitioner no work was available. Chapulis did not send Petitioner home, however. Instead, he directed Petitioner to take a safety-related test on a computer. Petitioner testified he took this test and it lasted about three hours. Petitioner testified he then performed a "made up" job having to do with numbers. He clocked out at the end of the day.

Petitioner testified he continued seeing Dr. Stamelos thereafter. The therapy that he underwent at the doctor's direction helped to an extent in that it got him to a state where he was able to move more easily. Dr. Stamelos views the fusion that Dr. Yapor previously recommended as an option but he (Petitioner) is "very afraid" to undergo more back surgery. The back surgery he underwent in 2006 did not help him much and he has a cousin who underwent a fusion and ended up in a wheelchair. He also tends to experience a bad reaction to general anesthesia. Nevertheless, he did undergo a cervical spine fusion and a carpal tunnel release during this same time period.

Petitioner testified he experiences constant low back pain. On some days, this pain is tolerable and he able to get around, so long as he takes his medication. About three days per month, his pain is unbearable and he has to lie on the floor because he "can't move."

Petitioner testified he obtained his GED in 1976. He paid a fee to a private company in order to get the GED.

Petitioner recalled seeing Dr. Sheth at MercyWorks in 2011. [See further below for a discussion of Petitioner's offer of proof as to a conversation he had with Dr. Sheth.]

Petitioner testified he is a musician. He has played the drums since he was five years old. He played the drums once in 2015. On March 14, 2015, he sat in for two 45-minute sets in a friend's band. He earned $500 for this. His friend asked him to play because a band member was unavailable. He took a Norco beforehand. He did not sit in a conventional chair while playing the two sets. Instead, he was in a semi-standing position, braced against a bicycle type of seat. He was able to move his feet. The next day, however, he could not move. In 2014, he played the drums in one set on one occasion and two sets on another occasion. He also sang at his great niece's wedding. Due to his financial difficulties, he is selling off the drums he has collected over the years. He is on the verge of losing his house and getting a divorce.

Under cross-examination, Petitioner testified he never reported for work after June 5, 2013. He called in to work on June 6, 2013 and said he was unable to come in. He played the drums on one or two occasions in 2012. He could not recall playing drums in 2013. He used to fish at his father's house in Wisconsin but has not done so since his father's death on March 9, 2009. The house in Wisconsin has been sold. In 2013, he and one of his attorneys, Matthew Gannon, attended a meeting. At that meeting, he was told that Respondent was making a job

available to him and that it would be the same job he had performed in 2011. When he performed light duty in 2011, he did whatever desk work he was told to do but never performed much data entry because he is "not good with computers" or matching numbers. Back in 2010, he worked at the facility on Wentworth but in a different room. He never attempted to use public transportation to get to the Wentworth facility. When he called in to work on June 6, 2013, he spoke with "Cade," the garage attendant boss. He has played with a band called "Stepping Out." Sometimes the members of this band would ask him to sit in for a member who was unavailable. He has not reported to work since June 5, 2013 because he feels he cannot perform his job. When he and his attorney met with Respondent representatives, he was wearing a neck brace and a wrist brace and indicated he felt he had no use of his left arm.

On redirect, Petitioner testified he was afraid of undergoing the cervical fusion but proceeded because he was told he was at risk of damaging his left arm if he did not go ahead with the surgery. He does not want to undergo a lumbar fusion because he is afraid he will end up paralyzed.

After the Arbitrator admitted RX 6 and 7 (letters Kevin Murphy sent to Petitioner on May 3, 2013 and June 20, 2013) into evidence, Petitioner was recalled. He testified that, when he underwent the mandatory fingerprinting at Respondent's direction, he was not told anything about when he should report to work. It was his understanding he would receive a call telling him when and where to go but he never did receive such a call.

Under additional cross-examination, Petitioner testified that, from that point on, he simply waited to get a call.

Summary of Medical Treatment and Medical Testimony

[The Arbitrator summarizes the pre-19(b) treatment so as to place that treatment in context.]

Petitioner saw Dr. Sheth at MercyWorks on June 9, 2010, the day of the accident. Dr. Sheth noted that Petitioner reported jerking and injuring his back when a chair he was sitting on broke. He also noted that Petitioner complained of 7/10 lower back pain, pain radiating down his left leg and tingling in his left foot.

Dr. Sheth recorded a history of an earlier work-related back injury in November 2005 which required surgery in 2006. He noted Petitioner had been performing sedentary work prior to the June 9, 2010 chair incident.

On examination, Dr. Sheth noted a moderately restricted range of motion in the lumbar spine, a healed scar from the prior lumbar surgery and a complaint of pain with left-sided straight leg raising. He took Petitioner off work and prescribed Ibuprofen and Flexeril. PX 1, p. 20.

Petitioner returned to Dr. Sheth on June 16, 2010 and reported no improvement. The doctor recommended a lumbar spine MRI and physical therapy. He instructed Petitioner to remain off work. PX 1, p. 21.

Petitioner underwent the MRI the same day. The MRI showed a broad-based central disc herniation at L3-L4 and a right central disc herniation at L4-L5. The radiologist noted no foraminal compromise at either level. PX 8.

Petitioner started attending therapy at Bryn Mawr Physical Therapy on June 18, 2010. PX 1, p. 21.

On July 1, 2010, Dr. Sheth noted that Petitioner was still complaining of low back and left leg pain. He also noted that Petitioner planned to see Dr. Yapor, a physician of his own selection. He kept Petitioner off work. PX 1, p. 22.

On July 20, 2010, Petitioner returned to Dr. Yapor, the neurosurgeon who had operated on his back in 2006. The doctor noted he had not seen Petitioner for four years. He also noted that Petitioner reported doing well until a work accident a couple of weeks earlier, when the wheels broke off his work chair, causing him to fall to the ground. He noted that Petitioner complained of left gluteal pain extending slightly down the posterior thigh along with numbness and tingling in the sole of his left foot. He indicated that Petitioner denied any right-sided complaints.

On examination, Dr. Yapor noted a limited range of lumbar spine motion, secondary to muscle spasms, and an "old decreased reflex in the Achilles on the right lower extremity only," but no neurological deficit or focal weakness.

Dr. Yapor interpreted the recent MRI as showing "minimal disc disease in the lower three lumbar discs" and no obvious stenosis at any level.

Dr. Yapor recommended physical therapy. Petitioner indicated he had been attending therapy but had stopped due to lack of authorization. Dr. Yapor wrote out a therapy prescription and instructed Petitioner to return to him in one month. PX 8, p. 7.

On August 11, 2010, Dr. Yapor wrote a note indicating that Petitioner should be excused from jury duty because he is "unable to sit for a prolonged period" due to a herniated lumbar disc. PX 8, p. 6.

The 19(b) hearing proceeded on September 1, 2010. The Arbitrator issued his decision on September 30, 2010. [See page 1 of the decision for a summary of this decision.] On October 21, 2010, the Arbitrator issued a Corrected Decision changing the temporary total disability rate.

Petitioner returned to MercyWorks on October 25, 2010 and again saw Dr. Sheth. The doctor noted that Petitioner complained of increased low back pain secondary to driving 80 minutes to the clinic. He described Petitioner's gait as antalgic and indicated Petitioner reported being unable to sit or lie down. He instructed Petitioner to go to an Emergency Room and follow up with Dr. Yapor thereafter. He kept Petitioner off work. PX 1, p. 23.

No Emergency Room records are in evidence.

On November 9, 2010, Petitioner saw Dr. Sheth again and reported improvement. He denied any radicular complaints. Dr. Sheth described Petitioner's gait as normal. He kept Petitioner off work and instructed him to follow up with Dr. Yapor. PX 1, p. 23.

On November 23, 2010, Dr. Yapor noted that Petitioner had been discharged from therapy. He indicated that Petitioner reported feeling "fine" most of the time but experienced significantly increased symptoms with prolonged sitting or standing.

Dr. Yapor recommended a discogram and a "possible stabilization procedure to eliminate these flare-ups." After noting that Petitioner was not interested in pursuing these options, he recommended that Petitioner return to full duty. He indicated Petitioner could contact him in the future if he changed his mind and elected to undergo a specific intervention. PX 8, p. 5. He completed a "patient status form" releasing Petitioner to "full duty with no restrictions" on November 29, 2010. RX 4.

On December 1, 2010, Petitioner saw Dr. Patel at MercyWorks and reported he had declined surgery. Dr. Patel noted Dr. Yapor's full duty release. He also noted that Petitioner was requesting a second opinion with Dr. Stamelos. He released Petitioner to full duty. PX 1, p. 23.

Petitioner saw Dr. Stamelos, an orthopedic surgeon, on December 1, 2010. The doctor's note of that date sets forth a history of the 2005 laminectomy, June 9, 2010 work injury and subsequent care. He described Petitioner's most recent interaction with Dr. Yapor as follows: "Dr. Yapor wanted fusion but [Petitioner] refused and was sent back to work regular duty by Dr. Yapor, apparently not believing that he is that disabled." He noted that Petitioner complained of significant activity-related back pain. He described Petitioner as stating he was unable to perform light duty and "want[ing] to go to physical therapy and get off of work." He indicated he believed this was a "good plan."

Dr. Stamelos indicated he reviewed the lumbar spine MRI.

Dr. Stamelos described Petitioner's gait as altered. On examination, he noted positive straight leg raising and a positive Kaufman knee sign.

Dr. Stamelos administered an injection, took Petitioner off work and prescribed therapy and medication. He directed Petitioner to return in four weeks. PX 2, p. 53.

Petitioner began a course of physical therapy at United Rehab Providers on December 2, 2010. The therapy records reflect that Petitioner initially rated his back pain during activity at 8/10, with that rating dropping to 6/10 by February 10, 2011. PX 3, pp. 12, 39.

Petitioner returned to Dr. Stamelos on January 3, 2011, with the doctor noting persistent work-related back pain along with "right shoulder pain that is non-related to work." He diagnosed a rotator cuff tear and cervical strain as well as various back conditions, including spondylolysis and spondylolisthesis. He prescribed EMG/NCV testing and medication (Mobic, Soma, Norco, Restoril and trans dermal compounds) and found Petitioner to be "100% disabled for work at this time." PX 2, p. 45.

Petitioner underwent the recommended EMG/NCV testing on January 7, 2011. Dr. Patel, a neurologist, performed this testing. He recorded a history of the previous back injury, the 2005 back surgery and the June 9, 2010 back injury. He noted a complaint of pain radiating down both legs, worse on the left. On examination, he noted 5/5 strength in both legs and negative straight leg raising. He described the results of the EMG/NCV as "essentially normal." PX 2, pp. 34-35.

Petitioner returned to Dr. Stamelos on January 24, 2011 and complained of pain in his right hand and right shoulder as well as his lower back. Petitioner reported injuring his right hand when he fainted during his mother's funeral. The doctor recommended a right hand X-ray. He continued to keep Petitioner off work. PX 2, pp. 42, 44.

Petitioner did not see Dr. Stamelos again until April 20, 2011, with the doctor recording the following complaints:

> "The patient complains of neck pain radiating to the left arm and hand is numb and painful. The patient also complains of low back pain. The patient was last seen in the office on January 24, 2011."

The doctor prescribed physical therapy for the lumbar spine along with Vicodin, Ultram and Flexeril. He released Petitioner to light duty, restricting various activities, "especially driving excessively." PX 2, pp. 29-32.

As noted earlier, Petitioner testified he resumed light duty for Respondent in April 2011 and continued performing light duty thereafter until June 8, 2011. He worked five days a week during this interval. His duties included making "beat tags," answering telephones, driving a paddy wagon to body shops and doing filing. He testified he stopped working on June 8, 2011 due to "massive" back pain.

Petitioner returned to Dr. Stamelos on May 18, 2011. The doctor noted complaints of pain in the neck, low back and right shoulder. He also noted Petitioner was trying to obtain

approval for cervical spine therapy. He completed a form releasing Petitioner to light duty with no lifting/pushing/pulling over 5 pounds, no overhead work and no excessive walking or standing. On the form, he wrote: "can't drive, can't sit, can't stand – may work with restrictions only when he can – may need to be on disability." PX 2, pp. 23-25. He prescribed additional therapy. PX 2, p. 26.

Petitioner saw Dr. Stamelos again on June 8, 2011, with the doctor noting complaints of anxiety, depression and back pain. The doctor described the low back pain as work-related and the cervical "problem" as "not related to back." He took Petitioner off work. On an accompanying form, he indicated that Petitioner "needs spinal fusion" and "needs to be on disability." PX 2, pp. 21-22.

On July 8, 2011, Petitioner saw Dr. Espinosa, a neurosurgeon affiliated with Neurological Surgery & Spine Surgery. Dr. Espinosa wrote to Dr. Leon-Jauregui the same day, acknowledging the referral. [Dr. Leon-Juaregui's records are not in evidence.] In his letter, he set forth a history of the chair-related work accident. He noted that Petitioner reported initially developing low back pain after that accident and, a month later, developing severe neck and left arm pain, aggravated by activity. He described Petitioner as having a prior history of similar problems. He noted that Petitioner previously performed a desk job at a Respondent garage but was no longer working due to the accident. He described Petitioner's past medical history as significant for high cholesterol, hypertension, anxiety, depression and a back surgery approximately seven years earlier.

Dr. Espinosa described Petitioner's gait as antalgic. On examination, he noted a "severe reduction of motion in both the cervical and lumbar spine and weakness of the intrinsic muscles in the left hand," along with absent left biceps and left brachioradialis reflexes.

Dr. Espinosa indicated he reviewed a cervical spine MRI. He interpreted the MRI as showing a shallow protrusion of no clinical significance at C4-C5, a left paracentral disc protrusion deforming the spinal cord at C5-C6 and a right paracentral disc protrusion deforming the right anterior surface of the spinal cord at C6-C7. He strongly recommended surgical decompression at both C5-C6 and C6-C7. He noted that Petitioner wanted to delay this surgery until October. He also noted that Petitioner did not want to undergo the surgery because he had an engagement to sing at a wedding and was concerned that the surgery would impair his singing ability. He indicated Petitioner planned to call him when he was ready to schedule the surgery.

On August 5, 2011, Petitioner returned to MercyWorks and saw Dr. Sheth. The doctor noted that Petitioner reported injuring his right shoulder at home three days earlier. He also noted that, according to Petitioner, Dr. Stamelos had advised he could not perform work conditioning at this time. He stated: "[Petitioner] will be off work permanently and MMI from lower back pain." He found Petitioner to be at maximum medical improvement and discharged him from care.

As part of an offer of proof, Petitioner testified that, when he saw Dr. Sheth on August 5, 2011, the doctor told him he was totally disabled from work. The Arbitrator addresses this offer of proof in the "conclusions of law" section below.

On lumbar spine examination, Dr. Sheth noted diffuse tenderness, a moderately restricted range of motion with severe pain and no neurovascular deficit. He diagnosed chronic low back pain and left leg radiculopathy.

On September 28, 2011, Dr. Stamelos described Petitioner as having "condition of spinal fusion" and "going to have a procedure on October 3, 2011." [It appears he was under the impression Petitioner was going to undergo a lumbar rather than cervical fusion on October 3rd.] He found Petitioner to be "100% disabled." PX 2, p. 11.

Dr. Espinosa performed a microdiscectomy and instrumented fusion at C5-C6 and C6-C7 on October 3, 2011. In his operative report, he noted that Petitioner delayed undergoing the surgery because he "had some singing engagements for weddings" over the summer.

Following the surgery, Petitioner returned to Dr. Espinosa on October 14, 2011. The doctor noted that Petitioner reported experiencing high levels of pain immediately after the operation but was now managing his pain with Norco. He also noted that Petitioner reported using a cervical collar only in the car. He did not indicate whether Petitioner was "in the car" as a driver or passenger.

Dr. Espinosa recommended that Petitioner continue wearing the cervical collar while in the car. He recommended that Petitioner undergo plain cervical X-rays prior to his next visit.

At Respondent's request, Petitioner underwent a Section 12 examination by Dr. Goldberg on December 28, 2011. The doctor's report of that date sets forth a history of both the 2005 and 2010 back injuries. The doctor noted that Petitioner underwent a discectomy by Dr. Yapor in early 2006 and subsequently returned to work with a 15-pound lifting restriction. The doctor also noted that Petitioner denied undergoing any back-related care from late 2006 until the June 9, 2010 accident. He noted that Petitioner had recently undergone cervical spine surgery but "did not injure his neck at work."

Dr. Goldberg indicated he reviewed lumbar spine MRI reports (but not films) dated August 2, 2005, April 25, 2006 and June 16, 2010. He also indicated he reviewed records from Dr. Yapor, various physicians from MercyWorks, Dr. Patel and Dr. Stamelos.

Dr. Goldberg described Petitioner's gait as antalgic. On examination, he noted negative straight leg raising, intact sensation and a well-healed but tender incision at L4-L5.

Dr. Goldberg addressed causation and work status as follows:

"I do believe [Petitioner] sustained an injury to the lumbar

> spine from the work-related accident of 6/9/10. [Petitioner] did have surgery in 2006, i.e., discectomy at L4-L5, but had no treatment from the end of 2006 until the new work-related accident. [Petitioner] states he did have some dull low back pain but it became severe after the new accident of 6/9/2010. Regarding the diagnosis, it appears that he does have a herniation at L3-4 and a herniation to the right at L4-L5. I do not have the films to confirm this. At the present time, I do believe that his symptoms are due to the work-related accident. I do feel he is capable of sedentary work and [should] be allowed to change position every 1 hour. Regarding the need for a fusion, I cannot comment upon it without reviewing the MRI. At this time, I feel [Petitioner] can return to sedentary work as discussed above. I would not recommend a functional capacity evaluation. The reason for this is that even after his initial surgery he was placed back to sedentary work."

Dr. Goldberg Dep Exh 2.

In February 2012, Petitioner underwent a left carpal tunnel release. It appears Dr. Espinosa performed this surgery. On March 2, 2012, Dr. Espinosa checked the incision and noted that Petitioner described improvement of both his carpal tunnel and neck symptoms. He noted that Petitioner had not yet started cervical spine therapy due to the intervening carpal tunnel surgery. He described Petitioner's gait as a "little slow but otherwise normal." On examination, he noted decreased sensation over the first and second digits of the left hand. He recommended that Petitioner return in two weeks.

On March 14, 2012, Dr. Espinosa noted that Petitioner had undergone a cervical spine CT scan which showed the fusion to be solid at both operated levels. He cleared Petitioner to begin therapy for both his neck and his left hand.

Dr. Goldberg issued an addendum on April 18, 2012, after reviewing the lumbar spine MRI scan dated June 16, 2010 and additional records. He indicated the MRI showed a defect on the right at L4-L5 from the 2006 surgery but "no evidence of any herniation at any level" and "no left-sided nerve compression." He found it likely that Petitioner aggravated a mild degenerative disc at L4-L5. He did not recommend surgery. He felt that Petitioner could return to work at a sedentary position and did not require any additional treatment other than anti-inflammatory medication "should he be symptomatic." Dr. Goldberg Dep Exh 2.

On April 25, 2012, Petitioner returned to Dr. Espinosa and reported some improvement secondary to therapy. The doctor's sensory examination was normal. He recommended that Petitioner continue attending therapy.

At the next visit, on June 8, 2012, Dr. Espinosa noted that Petitioner was about to finish therapy for his neck and hand and that his "main complaint today was that of low back pain." He described Petitioner's gait as slow due to this pain. He noted that Petitioner might be developing a left ulnar neuropathy. He recommended that Petitioner undergo four more weeks of neck and hand therapy, followed by a repeat cervical spine CT scan. RX 5.

Petitioner returned to Dr. Stamelos on July 11, 2012, with the doctor noting a history of the June 9, 2010 accident and "chronic low back pain." The doctor found Petitioner to be at maximum medical improvement but prescribed physical therapy. He also prescribed Norco and other medication. He described Petitioner as "100% disabled for any kind of work." PX 2, p. 145.

On July 19, 2012, Dr. Espinosa noted that Petitioner had improved overall but was still experiencing neck stiffness with rotation, intermittent numbness in the hand and some numbness and tingling in the fourth and fifth fingers of his left hand. He released Petitioner from care subject to a home exercise program, noting that Petitioner could return to him if his ulnar neuropathy worsened. RX 5.

Petitioner returned to Dr. Stamelos on August 8, 2012. The doctor noted that Petitioner was attending therapy, had lost ten pounds and reported improvement. The doctor prescribed additional therapy and again found Petitioner to be 100% disabled. PX 2, p. 141-143.

At Respondent's request, Dr. Goldberg re-examined Petitioner on August 17, 2012. In his report of that date, Dr. Goldberg noted the intervening two-level cervical fusion and left carpal tunnel release and indicated Petitioner was now complaining of left ulnar nerve problems. He also noted that Petitioner had undergone additional therapy for his back from January through June 2012 and that Dr. Stamelos was keeping Petitioner off work.

On re-examination, Dr. Goldberg noted that Petitioner was wearing an external bone stimulator for his cervical spine. On lumbar spine range of motion testing, he noted that Petitioner voluntarily limited forward flexion to 10 degrees, that straight leg raising was negative and that sensation was "diminished diffusely L4 to S1 bilaterally, whereas it was intact in the upper extremities C5 to T1." On upper extremity examination, he noted a positive Tinel's at the left cubital tunnel.

Dr. Goldberg opined that it was Petitioner's cervical condition that was now "limiting him most." With reference to the lumbar spine, he found Petitioner currently capable of working subject to a 10-pound lifting restriction but recommended Petitioner undergo a functional capacity evaluation once he had finished his cervical spine care. He indicated that this evaluation could help determine whether it was the cervical or lumbar spine that was limiting Petitioner's ability to return to work. Dr. Goldberg Dep Exh 3.

On August 29, 2012, Dr. Stamelos completed a disability form indicating a diagnosis of "work-related discogenic back pain syndrome" and stating Petitioner might need surgery. PX 2, p. 140.

On October 8, 2012, Dr. Stamelos indicated Petitioner sold a car because the car was "too low" but was now able to drive a "classic car." The doctor prescribed Norco and Restoril and indicated Petitioner was starting therapy again. PX 2, p. 124.

On November 5, 2012, Dr. Stamelos indicated Petitioner was "apparently in some kind of dispute" and was "having behavior modification." He prescribed Norco and again found Petitioner to be 100% disabled. PX 2, p. 112-113.

Dr. Goldberg issued an addendum on January 8, 2013, after reviewing additional records from Drs. Stamelos and Espinosa, Dr. Goldberg addressed causation and work status as follows:

> "Please note that none of Dr. Stamelos' notes offer physical examination of the spine. After reviewing the additional records, I do feel the patient is capable of sedentary work. I disagree that he is 100% disabled. It appears that the patient has been working as a musician at least during the time of his rehabilitation for his lumbar condition. Additionally, the patient's job for the City after his original injury and discectomy in 2006 by Dr. Yapor appeared to be sedentary in nature. I feel the patient can return to work at a sedentary position. He is at MMI for his lumbar spine."

Goldberg Dep Exh 3.

On February 4, 2013, Dr. Stamelos noted that Petitioner was seeing him "for some medications and work status," commenting: "apparently, we are his documenter and supporter of his being off of work." He indicated that Petitioner "is never going to go back [to work] since he feels that he cannot drive or sit and he does not want to have surgery," noting that Petitioner did in fact undergo cervical surgery. He also noted that Hydrocodone had been "flagged" on Petitioner's recent urine drug screening. He again found Petitioner to be 100% disabled. PX 2, pp. 99-100.

On May 14, 2013, Dr. Stamelos completed a disability form stating: "pt claims inability to work or travel – cannot return to his work – discogenic back pain." PX 2, p. 70.

On June 11, 2013, Dr. Stamelos noted Petitioner had recently tried to return to work for one day and was complaining of increased back pain. The doctor noted that Petitioner "refused surgery." He refilled Petitioner's medication and again found Petitioner to be 100% disabled. PX 2, pp. 250-251.

On July 9, 2013, Dr. Stamelos noted that Petitioner had lost weight and was "moving better" but still had "low back pain syndrome." He also noted Petitioner was undergoing therapy. He again found Petitioner to be 100% disabled. PX 2, pp. 239-240.

Dr. Stamelos continued to find Petitioner to be 100% disabled on August 6, September 3 and October 1, 2013. PX 2, pp. 214-215, 217-218 and 228-229.

Dr. Stamelos testified by way of evidence deposition on October 18, 2013. Dr. Stamelos testified he is board certified in orthopedic surgery. He attended medical school in Athens, Greece and did two residencies in orthopedic surgery in Chicago thereafter. Stamelos Dep Exh 1. He devotes half of his practice to spine conditions and the other half to trauma. He has performed about 5,000 spine surgeries. PX 7 at 5.

Dr. Stamelos testified he is able to independently recall Petitioner. PX 7 at 6. He first saw Petitioner on December 1, 2010. Petitioner brought a June 16, 2010 MRI with him. That MRI showed disc herniations at L3-L4 and L4-L5. PX 7 at 7. Petitioner complained of low back pain and indicated he "had to be medicated almost all of the time." PX 7 at 8. He had difficulty "doing anything sitting." Petitioner was "definitely a slave to his back pain." PX 7 at 8.

Dr. Stamelos testified that Petitioner provided a history of the June 2010 chair incident. He examined Petitioner's lower back on December 1, 2010 and noted positive straight leg raising. He diagnosed discogenic severe back pain. He testified the chair incident of June 2010 was a competent cause of this pain. PX 7 at 9. He recommended a course of conservative care because that was "best for a man of his age and weight." PX 7 at 9. He indicated he would discuss surgery if Petitioner failed to improve with conservative treatment. He took Petitioner off work and prescribed both Ultram, a non-narcotic, and Norco, a narcotic, for pain. PX 7 at 10-11.

Dr. Stamelos testified that, when he next saw Petitioner on December 17, 2010, he recommended that Petitioner avoid excessive sitting or driving. There was "apparently something" and "some kind of instability" that was putting pressure on Petitioner's nerves when he sat. PX 7 at 11. Sitting causes a "microshift" of the spine which, in turn, can cause impingement or entrapment of the nerve roots. PX 7 at 12. Petitioner had "right sciatica" which caused him to feel as if he might fall. PX 7 at 11-12.

Dr. Stamelos acknowledged that Petitioner's EMG was negative but he opined that EMGs are "not valid" for 40% of the patients who undergo them. PX 7 at 13. Simply because the EMG was normal does not mean Petitioner did not have a problem. PX 7 at 14.

Dr. Stamelos testified that Petitioner developed a neck problem in 2011. In his opinion, this problem is not related to the work accident. He did not treat Petitioner for the neck problem. PX 7 at 14-15. As of the April 2011 visit, Petitioner weighed 240 pounds, was 53 years old and had sciatica and low back pain. Dr. Stamelos opined that Petitioner has spondylolisthesis. This is a "shift of the spine," or a sliding of one vertebrae over the other. It

can cause a person to experience pain when sitting. PX 7 at 15. He views Petitioner's spondylolisthesis as pre-existing the June 2010 accident but Petitioner was capable of sitting and working before the accident. PX 7 at 16. In April 2011, he prescribed Vicodin, an opiate, for Petitioner. Vicodin is a drug you give for serious pain. He would typically instruct a patient on Vicodin to avoid driving but Petitioner never drove. Petitioner's wife did the driving. The sitting position was too much for Petitioner. PX 7 at 17. In April of 2011, he issued a note releasing Petitioner to restricted work. He instructed Petitioner to avoid excessive sitting, driving, twisting, bending forward and lifting. He indicated Petitioner should be excused for a day if he was in severe pain. PX 7 at 17-18.

Dr. Stamelos testified that, on June 8, 2011, Petitioner was experiencing chronic pain as well as a form of depression, due to his mother's death. The depression had nothing to do with the work injury. PX 7 at 20. He recommended that Petitioner undergo a lumbar fusion. He told Petitioner, "you got to return to work" and Petitioner replied, "I can't." He then told Petitioner he "should be disabled because of the seriousness of his condition." PX 7 at 22-23. He initially tried to get Petitioner back to work but Petitioner "had all these restrictions that didn't gel with his work." PX 7 at 23. After a while, he realized it was "futile" for Petitioner to continue with physical therapy. He believes Petitioner "needed to have a job where there would be a cot next to his desk and he'd have to lie down for a couple of hours if he couldn't handle the pain." PX 7 at 23. He watched Petitioner in his waiting room and Petitioner "was not comfortable in the sitting position." PX 7 at 23. After a while, he "gave up" on the idea of getting Petitioner back to work. PX 7 at 24. The fact that Petitioner was phobic about undergoing a lumbar fusion meant he probably could not work again. PX 7 at 24. When Petitioner last came to his office, on October 1, 2013, his condition had not changed. He still could not sit comfortably and was "heavily medicated." PX 7 at 25. On that date, he opined that Petitioner is "100% disabled for any work" and that his condition is "permanent and severe." PX 7 at 25. He does not expect Petitioner to improve. A fusion is the only thing that might help Petitioner, assuming it is successful. PX 7 at 25.

Dr. Stamelos opined that Petitioner could perform sedentary work "only if he didn't have to travel" and could take breaks each hour in order to lie down if he was in pain. PX 7 at 26.

Dr. Stamelos testified he billed a total of $13,705. He received a payment of $5,713.45 and there were adjustments totaling $2,494.55 so there is a balance of $5,497. PX 7 at 27. His charges are in the 50th percentile and "very reasonable." PX 7 at 27. He only treated Petitioner's low back, not his neck. PX 7 at 27.

Under cross-examination, Dr. Stamelos testified that, when he referenced a "dispute" in his initial treatment note, he meant to indicate that Petitioner was trying to work but could not do so. PX 7 at 30. He is aware that Petitioner saw doctors before seeing him but he has not reviewed any of those records. He respects Dr. Yapor. Dr. Yapor is "very qualified" to render an opinion concerning Petitioner's work status. When Dr. Yapor released Petitioner to full duty, he "might have misunderstood" or "did not know enough about the patient." Over time, he

(Dr. Stamelos) realized that Petitioner is legitimate. PX 7 at 33. Petitioner was "resistant" to the idea of returning to work. He (Dr. Stamelos) argued with Petitioner about this "every time" Petitioner came in. However, one of Petitioner's therapists told him that Petitioner was "in bad shape." No nurse case manager ever contacted him in this case and no one ever told him a job was available for Petitioner. The therapist told him Petitioner could not sit or bend or twist. PX 7 at 37. On July 6, 2011, he diagnosed Petitioner with failed back syndrome, meaning "multiple surgeries without improvement." PX 7 at 39. If Petitioner opted not to undergo a lumbar fusion, he guesses Petitioner would be at maximum medical improvement. He told Petitioner to go to a pain center but Petitioner "refused to go." PX 7 at 40. Petitioner wanted to continue to treat with him. He was supplying Petitioner with prescriptions for medication and therapy. PX 7 at 40. As of July 6, 2011, he would have allowed Petitioner to try to return to work but "there was no work for [Petitioner] to go back to." PX 7 at 41. Petitioner's inability to sit was objective. He has spondylolisthesis. PX 7 at 41. He went by the objective findings he made on examination. He knew nothing about Petitioner's personal life. If, as of that same time, Petitioner told another physician he wanted to put off cervical spine surgery so he could sing at weddings, that would be "very" inconsistent with what Petitioner was telling him. PX 7 at 42.

On redirect, Dr. Stamelos acknowledged there are typographical errors in his notes. He sends his notes out to a dictation service. PX 7 at 44. If you thought Petitioner was malingering, you could order a functional capacity evaluation but, if you believe Petitioner, there is no reason to perform such an evaluation. PX 7 at 45. He did not believe Petitioner was malingering and there was no job offer on the table so there was no purpose in Petitioner undergoing a functional capacity evaluation. PX 7 at 45. Petitioner's herniated discs have never been addressed. PX 7 at 46.

Under re-cross, Dr. Stamelos reiterated he has not seen Dr. Yapor's records. He does not know whether the doctor used the term "full duty" to mean that Petitioner should resume his regular restricted job. PX 7 at 47.

On further redirect, Dr. Stamelos testified he does not know whether Dr. Yapor had a description of Petitioner's job. Dr. Yapor "might have been just saying return to work, period." PX 7 at 48.

Dr. Goldberg testified by way of evidence deposition on June 9, 2014. He obtained board certification in orthopedic surgery in 1992 and was recertified in 2002 and 2012. RX 3 at 4-5.

Dr. Goldberg testified he examined Petitioner twice. At the first examination, in December 2011, Petitioner was "forthright" in that he indicated he underwent a discectomy and was subject to work restrictions before the June 9, 2010 accident. RX 3 at 9.

Dr. Goldberg testified he had access to Petitioner's 2010 MRI report, but not the films, when he first examined Petitioner. At that time, he felt Petitioner might have herniations at L3-L4 and L4-L5, based solely on the report. RX 3 at 9. He also felt Petitioner injured his lumbar

spine in the accident and was capable of sedentary work, so long as he could change positions hourly. Absent the films, he could not comment on the need for a fusion. RX 3 at 10. He reviewed the films in April 2012 (RX 3 at 14) and saw "no herniated disc at any level." He disagrees with Dr. Stamelos' diagnosis of multiple disc herniations. RX 3 at 14. He noted only a right L4-L5 hemilaminotomy defect, attributable to the prior surgery, with some minimal stenosis on the right, and no evidence of nerve compression on the left. He did not feel that Petitioner had a surgical lesion. The MRI did not explain Petitioner's left-sided complaints. He felt Petitioner could perform sedentary work, which he was already performing. RX 3 at 11-12. As of December 2011, Petitioner could have resumed a job that involved driving vehicles from one location to another, sitting at a computer, logging vehicles in and out, and writing vehicle assignments on a blackboard. RX 3 at 12. Petitioner's MRI showed no evidence of disc herniations or a spondylolisthesis at any lumbar spine level. RX 3 at 14. Petitioner does not require back surgery.

Dr. Goldberg testified he re-examined Petitioner on August 17, 2012 and issued an addendum on January 8, 2013. In the addendum, he again opined that Petitioner was not 100% disabled, did not exhibit any evidence of a spondylolisthesis, did not require surgery, could resume his sedentary job and did not require a functional capacity evaluation. RX 3 at 16-18. The need for work restrictions arose from the 2006 accident. RX 3 at 17-18.

Under cross-examination, Dr. Goldberg reiterated that, initially, he believed Petitioner had disc herniations at L3-L4 and L4-L5. He did not make any mention of symptom magnification in his initial report. If he had found inconsistencies, he would have noted them. RX 3 at 19. Petitioner appeared to be telling the truth. When he first examined Petitioner, he felt Petitioner was capable of sedentary duty and should also be allowed to change position every hour. RX 3 at 20. All along, he has felt that Petitioner was symptomatic in his lumbar spine. RX 3 at 20. Since he has not seen Petitioner for some time, he cannot say whether Petitioner should currently be avoiding repetitive bending or twisting. RX 3 at 21. When he initially recommended sedentary duty, that recommendation went to Petitioner's lifting capacity. He is not critical of the medications that have been prescribed for Petitioner, although he ultimately opined that Petitioner should just take an anti-inflammatory if he was still symptomatic. RX 3 at 22. He did not opine that medication was being mis-prescribed for Petitioner. He did not recommend that Petitioner be weaned off of his current medication. RX 3 at 22-23. As of April 2012, when he issued his addendum, he no longer felt Petitioner needed to be able to change positions hourly because he had reviewed the MRI and saw no disc herniations. A patient who has no disc herniations can still experience radiculitis. RX 3 at 24. Petitioner subjectively reported left-sided radicular symptoms. RX 3 at 24. He has no reason to doubt this reporting but the MRI showed no nerve compression. RX 3 at 25. If Petitioner is indeed experiencing radicular symptoms, it would be wise for him to get up and move about on an hourly basis. RX 3 at 25. In his August 17, 2012 and January 2013 reports, he found Petitioner capable of returning to work subject to a 10-pound lifting restriction. RX 3 at 25. He does not currently recommend a functional capacity evaluation. Petitioner is at the sedentary duty level and also has non-work-related cervical spine problems which he did not want to "convolute" with other body parts. RX 3 at 26. After he reviewed the MRI, he felt Petitioner

was capable of sitting in one place for more than two hours. RX 3 at 26. He would not place any limitations on Petitioner's sitting. He believes the June 9, 2010 accident resulted in aggravation of some mild disc degeneration at the L4-L5 level. RX 3 at 27. He believes Petitioner is at maximum medical improvement from a lumbar spine perspective. RX 3 at 28. He has not seen Petitioner for over a year but, as of the last examination, he felt Petitioner might have residual symptoms. RX 3 at 28. He would not impose any restrictions on Petitioner's walking, standing, climbing, bending or twisting. Such activities could, hypothetically, increase Petitioner's symptoms. Petitioner could address these symptoms by taking an anti-inflammatory. RX 3 at 29. He would not recommend Norco due to the risk of addiction but he saw no evidence of addiction in Petitioner. RX 3 at 29.

Petitioner continued seeing Dr. Stamelos throughout 2014. On August 19, 2014, the doctor noted that Petitioner "continues to come on a regular basis for secondary gain and documentation of his illness of back pain that he experienced at work when a chair broke, which is interesting satire on workers' compensation." PX 2, p. 287. On September 16, 2014, the doctor noted complaints relative to the right hand and neck as well as the lower back. He continued to find Petitioner disabled but commented: "I think the patient is using me to be his doctor of records so that he can go through these actions of proving his disability and stopping his return to work or not being able to return to work." PX 2, p. 288. On October 14, 2014, the doctor opined that the prescribed medication was providing a "diminishing return," noting that it rendered Petitioner "not able to function independently." He again found Petitioner 100% disabled. PX 2, pp. 291-292. On December 9, 2014, he described Petitioner as "desperate" because "he needs some doctor to write the status and agree with his, I believe, exaggerated work disability status." He also stated that there was something "very, very wrong" with Petitioner's back. On January 6, 2015, he described Petitioner as "bolting" into his practice and "dependent" on the prescribed medications. On February 3, 2015, he injected Petitioner's right shoulder, prescribed Norco and described Petitioner as "truly disabled." On March 3, 2015, a few weeks before the hearing, he described Petitioner's back as unchanged and his hands as "completely numb." He again found Petitioner "100% disabled for any kind of work." PX 2, pp. 325, 329.

Arbitrator's Credibility Assessment

Petitioner's credibility is a "mixed bag," so to speak. On the one hand, Respondent did not offer any surveillance and its examiner, Dr. Goldberg, did not note any symptom magnification. On the other, however, the longtime treating physician, Dr. Stamelos, admitted at his deposition that it would have been "very inconsistent" for Petitioner to have deferred cervical spine surgery in 2011 so as to be able to work as a drummer/singer, based on the level of back pain Petitioner was then reporting. Dr. Stamelos ultimately described Petitioner as continuing to see him "for secondary gain." In his treatment note of September 16, 2014, Dr. Stamelos went so far as to say he felt Petitioner was "using" him so as to be able to stay off work.

The Arbitrator also notes some inconsistencies between Petitioner's testimony and his medical records. Petitioner testified he stopped performing his accommodated job with Respondent on June 8, 2011 due to "massive" back pain that was being aggravated by his commute to work. Dr. Stamelos' early 2011 notes, however, show that Petitioner was complaining of significant neck, shoulder and arm pain as well as back pain. On April 20, 2011, Dr. Stamelos noted a primary complaint of neck pain radiating to the left arm and hand and a secondary complaint of low back pain. It was on April 20, 2011 that Dr. Stamelos first prescribed Vicodin. PX 2, pp. 27-30. At the next visit, on May 18, 2011, Dr. Stamelos noted that Petitioner complained of pain in his neck and right shoulder, as well as his back, and was "unable to function." PX 2, pp. 23-24.

Dr. Espinosa's initial note of July 8, 2011 mentions low back pain but also reflects significant complaints relative to the neck and left arm. The Arbitrator also notes that, while neither Petitioner nor any doctor had previously attributed the neck/arm complaints to the work accident, on July 8, 2011, Dr. Espinosa indicated that Petitioner reported "snapping" his neck as well as his back in that accident. The only logical conclusion to be drawn is that Petitioner misrepresented the mechanics of the accident to Dr. Espinosa.

Respondent's vocational expert, Julie Bose, opined that Petitioner's test scores were suspiciously low. Petitioner's expert, Jim Boyd, did not note sub-maximal effort but, with respect to Petitioner's reading achievement score, conceded that one would expect a better result.

Arbitrator's Conclusions of Law

Did Petitioner establish causal connection?

With respect to causation, Respondent argues that Petitioner failed to establish that the June 9, 2010 accident brought about a lasting change in his already disabling lumbar spine condition. Petitioner, citing the "law of the case" doctrine, maintains that the issue of causation was resolved for all subsequent proceedings by virtue of Respondent's failure to review the 19(b) decision issued on September 30, 2010.

Under the "law of the case" doctrine, the unreversed decision of a question of law or fact made during the course of litigation settles that question for all subsequent stages of the suit. Weyer v. IWCC, 387 Ill.App.3d 297, 307 (1st Dist. 2008). The Appellate Court has held that the principles underlying the doctrine should be applied to matters resolved in proceedings before the Commission. Irizarry v. Industrial Commission, 337 Ill.App.3d 598 (2003).

The Arbitrator notes that the 19(b) decision was issued very early on, before back surgery came under discussion and before Petitioner began treating for neck and upper extremity problems. The decision covered a period of temporary total disability of less than three months. The Arbitrator who issued the 19(b) decision described the June 2010 MRI as showing two disc herniations and found causation as to Petitioner's then current condition of

ill-being. The hearing of March 26, 2015 involved different legal and factual issues, including the issue of whether Petitioner's lumbar spine condition rendered him permanently and totally disabled. In the Arbitrator's view, the "law of the case" doctrine prevents Respondent from denying the existence of the disc herniations but does not bar Respondent from arguing, via Dr. Goldberg, that Petitioner has no left-sided nerve compression or evidence of a spondylolisthesis, that Petitioner does not require additional back treatment (other than anti-inflammatories) and that Petitioner can resume his former sedentary job.

In resolving the issue of causation, the Arbitrator has weighed Petitioner's testimony concerning his subjective complaints against the opinions rendered by the treating physicians and Dr. Goldberg.

Dr. Yapor, the original treater of Petitioner's selection, released Petitioner to "full duty with no restrictions" on November 29, 2010, after determining that Petitioner was not interested in pursuing a discogram and possible surgery. The Arbitrator views the doctor's full duty release as inconsistent with his treatment recommendations and his August 11, 2010 note referencing a disc herniation and indicating Petitioner "is unable to sit for a prolonged period of time."

Although it is clear that the second Petitioner-selected treater, Dr. Stamelos, ultimately lost patience with Petitioner, and began to question his motivation, he remained of the opinion that Petitioner is totally disabled and could work only if he could avoid driving and be afforded various accommodations, including multiple rest breaks. Dr. Stamelos based this opinion on his diagnosis of spondylolisthesis and his overall impression of Petitioner.

Respondent's examiner, Dr. Goldberg, disagreed with Dr. Stamelos. Based on his review of the June 2010 MRI film, he found no evidence of a left neural compression or a spondylolisthesis at any lumbar spine level. He conceded that the June 9, 2010 accident aggravated an underlying degenerative condition but ultimately opined that Petitioner requires only lifting-related restrictions and could resume his former light duty job with Respondent.

Dr. Goldberg recommended that Petitioner avoid taking Norco but saw no evidence of addiction. On February 4, 2013, Dr. Stamelos noted that Hydrocodone had been "flagged" on a recent urine toxicology screening. On September 16, 2014 (almost a year after his deposition), Dr. Stamelos indicated that Petitioner requested Hydrocodone, Soma and Mobic, commenting: "I am not sure if he is addicted." At the next visit, on October 14, 2014, Dr. Stamelos indicated he would continue to fill Petitioner's prescriptions despite his belief "that there is diminishing return." He also indicated that the "large amount of medication" Petitioner was taking rendered Petitioner "unable to function independently." Throughout this time, he continued to find Petitioner to be completely disabled.

The Arbitrator has considered all of the foregoing as well as the timeline of Petitioner's complaints. That timeline shows quite clearly that Petitioner's overall function began to decline in the early part of 2011 when he started experiencing neck and arm complaints in addition to

low back pain. No physician has linked those neck and arm complaints to the June 9, 2010 accident.

Of all of the medical opinions, the Arbitrator finds Dr. Goldberg's most persuasive. Dr. Goldberg is adamant that Petitioner does not have any left-sided neural compression. His reading of the June 2010 MRI is consistent with that of the radiologist to the extent that neither noted any left-sided pathology or foraminal narrowing. Dr. Goldberg is also adamant that Petitioner has no evidence of a spondylolisthesis at any spinal level. It is the diagnosis of a spondylolisthesis that prompted Dr. Stamelos to recommend Petitioner limit his driving. In the Arbitrator's view, Dr. Goldberg's criticism of Dr. Stamelos is well-taken. Following Petitioner's initial visit, Dr. Stamelos saw Petitioner on multiple occasions but did not record any examination findings in any note other than the notes of December 3, 2012 and April 9, 2013. The doctor's treatment notes, while never a model of clarity, devolved over time into rants. At various points, he betrayed a lack of understanding of Petitioner's situation. In the fall of 2011, he appeared to be under the impression Petitioner was going to undergo a lumbar fusion when in fact Petitioner was scheduled for cervical spine surgery. He testified that Petitioner has "right sciatica" when Petitioner's complaints have been left-sided.

The Arbitrator clarifies that she would reach the same result even if she accepted Petitioner's offer of proof, i.e., that on August 5, 2011, Dr. Sheth of MercyWorks told Petitioner he was totally disabled from work. The Arbitrator would be obligated to place that comment in context. The MercyWorks records reflect that, as of June 9, 2011, Dr. Sheth was aware of Petitioner's concurrent neck problem and possible need for neck surgery. The records also strongly suggest that, once Petitioner began seeing physicians of his own selection, i.e., Drs. Yapor and Stamelos, Dr. Sheth's role changed to that of monitor rather than "hands-on" treater. Finally, the record contains no information concerning Dr. Sheth's qualifications.

Is Petitioner entitled to temporary total disability benefits?

In his 19(b) decision, Arbitrator DeVriendt found that Petitioner was temporarily totally disabled from June 10, 2010 through the 19(b) hearing of September 1, 2010. PX 5. As indicated previously, neither party opted to review the 19(b) decision.

At the hearing held on March 26, 2015, Petitioner claimed two intervals of temporary total disability (June 10, 2010 through April 4, 2011 and June 9, 2011 through March 26, 2015) while Respondent stipulated Petitioner was disabled from June 10, 2010 through November 23, 2010. The parties also stipulated that, to date, Respondent has paid $80,219.79 in temporary total disability benefits. Arb Exh 1.

The Arbitrator, having elected to rely on Dr. Goldberg, adopts the doctor's opinion that Petitioner reached maximum medical improvement on January 8, 2013.

In accordance with the "law of the case," the Arbitrator finds that Petitioner was temporarily totally disabled from June 10, 2010 through September 1, 2010. The Arbitrator

surmises that the stipulated TTD payment of $80,219.79 includes the benefits awarded in the 19(b) hearing.

The Arbitrator further finds that Petitioner was temporarily totally disabled during the following three intervals: 1) from September 2, 2010 (the day after the 19(b) hearing) through November 28, 2010 (based on Dr. Yapor's work status note releasing Petitioner to full duty as of November 29, 2010 and the subsequent MercyWorks records); 2) from December 2, 2010 (the day after Dr. Stamelos took Petitioner off work) through April 4, 2011 (based on Petitioner's claim, Arb Exh 1) and from December 28, 2011 (the date of Dr. Goldberg's initial Section 12 examination) through January 8, 2013 (the date on which Dr. Goldberg found Petitioner to be at maximum medical improvement and about one month before Dr. Stamelos began questioning Petitioner's credibility and his role in Petitioner's care).

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner seeks an award of the following medical bills/balances:

United Rehab Providers Physical therapy, 12/2/10 – 2/10/11	$	3,910.00
Central Medical Specialists Physical therapy, 12/27/11 – 3/28/13	$	10,232.49
Advanced Orthopaedic Associates (Dr. Stamelos) 12/13/10 – 1/6/15	$	10,027.00
Northwestern Neurosurgical Associates (Dr. Yapor)	$	140.00 (balance brought forward on 7/2/10)
Advanced Lab Services 2/4/13 – 9/25/13, drug screenings (Dr. Stamelos)	$	1,232.00

PX 6. At the hearing, the parties stipulated that, should the Arbitrator find Respondent liable for any and all of these bills, Respondent would receive credit for any payments made toward the bills and would make payments directly to the providers.

The Arbitrator awards the balance from United Rehab Providers, subject to the fee schedule and the parties' stipulation. The Arbitrator finds it reasonable for Dr. Stamelos to have prescribed a course of conservative care when Petitioner first consulted him in December 2010.

The Arbitrator declines to award the bill from Central Medical Specialists. This bill relates to additional therapy (106 visits) prescribed by Dr. O'Keefe in 2011, 2012 and 2013. The

therapy records are in evidence but Dr. O'Keefe's office notes are not. The therapy records (PX 4) document virtually no improvement. Petitioner did not testify to seeing Dr. O'Keefe.

The Arbitrator turns to Dr. Yapor's $140.00 balance, noting that the doctor treated Petitioner before and after the June 9, 2010 accident. The bill in evidence does not link the balance to any particular date of service. The Arbitrator awards this balance, assuming the underlying services relate to treatment rendered after the June 9, 2010 accident and subject to the fee schedule and the parties' stipulation.

With respect to Dr. Stamelos' bill, the Arbitrator awards the doctor's charges through January 8, 2013, based on the Arbitrator's reliance on Dr. Goldberg and his finding of maximum medical improvement and subject to the fee schedule and the parties' stipulation.

The Arbitrator awards the Advanced Lab Series bill, subject to the fee schedule and the parties' stipulation, even though this bill relates to drug screenings performed after January 8, 2013. The Arbitrator, while generally not persuaded by Dr. Stamelos, agrees with the doctor that Petitioner needs drug monitoring.

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

In the Arbitrator's view, Petitioner's argument that he is permanently and totally disabled rests, to some degree, on his argument that he is unable to tolerate the commute to an accommodated position at Respondent's facility on the south side of Chicago. At the hearing, Petitioner spent a great deal of time describing the commute and its effects. He conceded that, absent the commute, he can function, albeit with limitations, much of the time and experiences only two or three "bad" days per month. He deals with his symptoms by resting and taking medication. Dr. Stamelos has continued to prescribe this medication despite his opinion that Petitioner might well be addicted and that the medication is rendering Petitioner "incapable of functioning independently."

Having considered all of the evidence, the Arbitrator finds that the undisputed work accident of June 9, 2010 did not ultimately decrease Petitioner's already reduced work capacity or render him permanently and totally disabled but did aggravate his pre-existing lumbar spine condition, bringing about the need for conservative treatment. The Arbitrator again relies primarily on Respondent's examiner, Dr. Goldberg, in making these findings. Dr. Goldberg conceded the accident rendered Petitioner symptomatic and in need of medication, i.e., anti-inflammatories. The Arbitrator awards permanent partial disability equivalent to 25% loss of use of the person as a whole, equivalent to 125 weeks, under Section 8(d)2 of the Act.

Is Respondent liable for penalties and fees?

On June 16, 2014, Petitioner filed a Section 19(b) petition along with a petition for penalties and fees. PX 11.

The Arbitrator, having elected to rely on Respondent's examiner and noting that Respondent paid over $80,000 in temporary total disability benefits prior to trial, declines to award penalties and fees in this case.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Brian Korando,

Petitioner,

15IWCC0854

vs.

NO: 10 WC 31266

State of Illinois - Department of Transportation

Respondent.

DECISION AND OPINION PURSUANT TO §19(H) AND §8(A) OF THE ACT

This claim comes before the Commission on a petition for review under §19(h) and §8(a) of the Act, filed by Petitioner on March 31, 2015. No question has been raised concerning the timeliness of the petition. Commissioner Luskin conducted a hearing in this matter on May 29, 2015 and a record was made. The issue on review is whether Petitioner is entitled to an additional award of medical benefits to obtain further treatment for his left upper extremity. Petitioner, a former highway maintainer for Respondent, sustained repetitive trauma injuries to both wrists and the left elbow manifesting on July 12, 2010. At arbitration, permanency was the only issue in dispute and a decision was filed on April 18, 2012. Petitioner sought review of the arbitrator's award, and on May 2, 2013 the Commission found that Petitioner was entitled to increased permanent partial disability benefits representing 15% loss of each hand and 20% loss of the left arm. Petitioner subsequently brought the instant petition for review under §19(h) and §8(a). After considering all of the evidence and being advised of the facts and law, the Commission denies the petition for the following reasons.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner worked for Respondent for over twenty-six years and retired in December of 2011. He testified that he worked in highway maintenance until he sustained a back injury in 2007. After he returned to work in July of 2008, he spent the remainder of his employment working light duty in a sedentary office position. As a highway maintainer, he used hand tools and power tools such as chain saws, jackhammers, and a hydraulic tamp. Petitioner filed an

15IWCC0854

Application for Adjustment of Claim on August 16, 2010 and alleged that his work as a highway maintainer caused repetitive trauma injuries to both hands and wrists and the left elbow. The date of accident, July 12, 2010, corresponds with the date of Petitioner's nerve conduction study. Dr. Brown performed a left cubital tunnel release with submuscular transposition and a left open carpal tunnel release on December 2, 2010. Dr. Brown performed a right carpal tunnel release on April 20, 2011. Dr. Brown released Petitioner to return to work without restrictions on June 13, 2011. At that time, Petitioner denied any numbness or tingling and thereafter he did not return to Dr. Brown. Petitioner testified at arbitration on October 17, 2011 that the surgeries performed by Dr. Brown were helpful in relieving his symptoms, although he claimed that he still experienced some left elbow numbness. (RX5)

At the §19(h) and §8(a) hearing on May 29, 2015, Petitioner testified that in July of 2012 he filed a workers' compensation claim for repetitive trauma injuries to his *right* elbow. He alleged a date of accident of June 19, 2012 and the claim was assigned the case number 12 WC 22984. (RX3) On October 25, 2012, Dr. Sudekum examined Petitioner at the request of Respondent and provided an opinion with respect to Petitioner's right elbow condition. (PX8) On June 26, 2013, Petitioner began treating with Dr. Paletta for right elbow complaints. Dr. Paletta has not made any diagnosis or recommended any treatment for Petitioner's left upper extremity. (PX5)

Petitioner argues that his petition for benefits under §19(h) and §8(a) should be granted because Petitioner is in need of further evaluation and treatment of the left elbow. Petitioner relies on peripheral statements contained in Dr. Sudekum's §12 report and deposition in 12 WC 22984, the right elbow case. Dr. Sudekum noted that Petitioner was experiencing cramping and muscle spasms of the left hand which may be indicative of a distal ulnar neuropathy at the Guyon's canal, or persistent or recurrent ulnar nerve compression in the left medial elbow region. Dr. Sudekum recommended continued evaluation and observation of the left upper extremity symptoms and added "If his intrinsic muscle spasms persist then I would consider a revision left ulnar tunnel release and distal ulnar nerve decompression at Guyon's canal." Dr. Sudekum added that it was possible that Petitioner was suffering from an undiagnosed systemic or central nervous system condition that could be contributing to his neuropathic symptomatology. Dr. Sudekum recommended Petitioner follow up with his primary care provider to rule out a systemic neurologic disease or Parkinson's disease. (PX8)

On May 26, 2015, Respondent took Dr. Sudekum's deposition in 12 WC 22984. Although the focus of Dr. Sudekum's report and testimony was the right elbow claim, Petitioner's attorney briefly questioned Dr. Sudekum with respect to Petitioner's left upper extremity. Dr. Sudekum testified that on examination he noted abnormal symptoms of *bilateral* tremor and spasms in Petitioner's upper extremities, and he highly recommended that Petitioner be examined by a neurologist. Dr. Sudekum also noted Petitioner's personal risk factors for idiopathic neuropathy – his age, obesity, hypothyroidism, and hypertension. On cross-examination, Dr. Sudekum disagreed that he diagnosed recurrent left carpal tunnel syndrome. He testified that he believed Petitioner may have a differential diagnosis, not simply recurrence of the prior condition. (PX8)

As previously stated, Petitioner never returned to Dr. Brown after he was released from

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care, and there are no recommendations from any treating physician for Petitioner's left elbow. We further note that at the §19(h) and §8(a) hearing, Petitioner did not testify with respect to any particular left upper extremity symptoms or subjective destabilization of his permanent condition. After considering all of the evidence, the Commission denies Petitioner's petition under §19(h) and §8(a) because we find that Petitioner has failed to support its allegation of a material increase in disability or its request for medical benefits at this time. An employer's liability under §8(a) is continuous so long as medical services obtained are in fact required to relieve the injured employee from the effects of the injury. The Commission previously determined that Petitioner's bilateral carpal tunnel syndrome and left cubital tunnel syndrome were causally related to his employment, and Petitioner is entitled to seek additional benefits medically necessary to treat those conditions. However any additional award from the Commission at this time would be pure speculation.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's petition under §19(h) and §8(a) 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: NOV 2 0 2015
RWW/plv
o-10/21/15
46

Ruth W. White

Joshua D. Luskin

Charles J. DeVriendt

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

DONNA JONES,

Petitioner,

vs. NO: 10 WC 38807

STATE OF ILLINOIS / PINCKNEYVILLE CORRECTIONAL CENTER,

15IWCC0848

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary total disability (TTD) and permanency, 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 vacates the permanency awarded by the Arbitrator, and finds that the Petitioner sustained the loss of use of 10% of the left hand and 10% of the right hand, pursuant to Section 8(e) of the Act.

The records of chiropractor Dr. Melvin note Petitioner has a longstanding history of neck pain and right arm symptoms. On March 14, 2007, Dr. Melvin noted a history of right neck and shoulder pain, including radiculopathy into the right arm. The report from a third cervical epidural on March 27, 2007 noted Petitioner had resolution of her arm pain with the second injection, but the neck pain was ongoing. On April 12, 2007, Dr. Melvin reported an ongoing and progressive four year history of neck pain and upper trapezius pain with radiation. On that date, Petitioner reported the injection had not provided improvement to the right arm, and it still felt numb. (Rx12).

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The Petitioner's Notice of Injury reported numbness to the hands and arms. (Rx3).

Petitioner first sought treatment with Dr. Brown on September 29, 2010, reporting a two to three year history of progressive pain, numbness and tingling in the hands, as well as a history of neck pain. He noted negative Tinel's sign over the median nerves at the wrists, and positive Tinel's sign over the ulnar nerves at the elbows. Direct ulnar nerve compression and elbow flexion testing were normal, while direct median nerve compression and Phalen's testing at the wrists were positive. His diagnosis was symptoms and findings consistent with bilateral carpal tunnel syndrome, and a possible component of cubital tunnel. He prescribed splinting for the wrists, advised her to keep her elbows extended when sleeping, and to take non-steroidal anti-inflammatories. (Px3).

An intake form completed by Petitioner for Dr. Brown notes symptoms of "mostly right arm, shoulder, hand; some in left hand". She also noted: "total numbness at times; pain in R arm – hand, numb after a few minutes of use – writing, stirring, any use after a few minutes." Petitioner also noted a history of bulging cervical discs and neck treatment. (Px3).

Dr. Phillips performed the EMG/NCV testing on September 29, 2010. He noted a three year history of gradually progressive right greater than left hand and arm pain with intermittent global hand numbness. There was neck pain, but it didn't radiate. (Px4). Dr. Brown's addendum noted findings consistent with severe right and moderate left carpal tunnel syndrome, and mild bilateral cubital tunnel syndrome. He recommended bilateral carpal tunnel releases, and conservative treatment for the elbows. (Px3).

Dr. Brown performed right carpal tunnel release surgery on November 5, 2010, and left carpal tunnel release surgery on November 19, 2010. (Px3). Petitioner had a single follow up visit with Dr. Brown on December 14, 2010. She reported the numbness and tingling had resolved. She did report some ongoing palm soreness and some weakness. She was advised to perform a home exercise program, was released to light duty, and as of January 3, 2011 to unrestricted duty. (Px3). Dr. Brown testified on November 15, 2013 that he had not seen Petitioner since December 14, 2010. (Px9).

The Petitioner testified to some continued soreness around the surgical site and numbness that "comes and goes". She stated that her hands are tired when she uses them for long shifts, and that her grip strength is still lacking, as she can't do what she used to do. She takes Tylenol occasionally. (Tr. 34-37).

The Commission finds that the Petitioner did not sustain any appreciable permanent disability to the arms. While there are complaints of generalized right arm numbness, it appears that any arm complaints were inconsistent. Additionally, there is evidence that Petitioner's right arm symptoms include unrelated radicular issues. EMG/NCV testing indicated mild cubital tunnel findings bilaterally. Clinically, however, there was no treatment offered or performed with regard to the arms or elbows, other than Petitioner being advised to sleep with her elbows extended. In our view, the Petitioner has failed to prove entitlement to a permanency award with regard to the arms.

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The Commission agrees that the Petitioner had bilateral carpal tunnel syndrome. She underwent bilateral releases, and has continued to work full duty since her release. The evidence indicates the Petitioner has good function, she has not sought treatment since December, 2010, and there has been no diminution in her earning capacity. Based on this evidence, we find that the Petitioner has sustained the loss of use of 10% of each hand.

The Request for Hearing form (Arbitrator's Exhibit 1) indicates the parties agree that all TTD and medical expenses were paid at the time of hearing.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision is modified with regard to permanency benefits, as noted above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $719.30 per week for a period of 8-3/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act; the parties have stipulated that Respondent has paid all temporary total disability owed, and is entitled to credit for same.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $647.37 per week for a period of 41 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of use of 10% of the left hand and 10% of the right hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the reasonable and necessary medical expenses as outlined in Petitioner's Exhibit 1, as provided in §8(a) of the Act. Pursuant to §8(j) of the Act, Respondent is entitled to credit for all amounts paid through its group carrier, and shall hold Petitioner harmless for any claims for reimbursement from any relevant health insurance provider.

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: NOV 2 0 2015
TJT: pvc
O 09/21/15
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JONES, DONNA
Employee/Petitioner

Case# **10WC038807**

SOI/PINCKNEYVILLE CORR CTR
Employer/Respondent

15IWCC0848

On 1/13/2015, 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:

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

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

0558 ASSISTANT ATTORNEY GENERAL
FARRAH L HAGAN
601 S UNIVERSITY AVE SUITE 10
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

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

JAN 13 2015

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

15IWCC0848

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Donna Jones
Employee/Petitioner

v.

State of Illinois/Pinckneyville Corr. Ctr.
Employer/Respondent

Case # 10 WC 38807

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **August 6, 2014 and November 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [x] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] 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 _____

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FINDINGS

On **September 29, 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 **$56,105.50**; the average weekly wage was **$1,078.95**.

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

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

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

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

Respondent is entitled to a credit of $**all benefits paid under group** under Section 8(j) of the Act.

ORDER

Respondent shall pay the reasonable and necessary medical expenses as outlined in Petitioner's group exhibit. Respondent shall have credit for all amounts paid through its group carrier, but shall indemnify and hold Petitioner harmless from any claims regarding payment of any amount for which it is receiving this credit, pursuant to §8(j) of the Act.

Respondent is liable for the temporary total disability benefits of $719.30/week for 8 3/7 weeks, which Petitioner has been paid, as provided in Section 8(b) of the Act. No overpayment of benefits has been made.

Respondent shall pay Petitioner permanent partial disability benefits of $647.37/week for 107.3 weeks, because the injuries sustained caused the 20% loss of the right and left hands (82 weeks), and the 5% loss of the right and left arms (25.3 weeks), 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.

Edward Lee
Signature of Arbitrator

1/6/15
Date

JAN 13 2015

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

15IWCC0848

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

DONNA JONES
Employee/Petitioner

v.

Case # 10 WC 38807

STATE OF ILLINOIS/PINCKNEYVILLE CORR. CTR.,
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Testimony of Petitioner

At the time her repetitive injuries manifested, Petitioner was a 51-year-old Correctional Officer at Respondent's Pinckneyville Correctional Center. (Transcript of 8/26/14, p.9-10; AX1). She began her career with Respondent as a Correctional Officer on July 1, 1998, and worked for two-and-a-half months as a trainee at Joliet Correctional Center until Respondent opened its Pinckneyville facility. (Transcript of 8/26/14, p.10, 44). She testified that her job title has not changed since she began her career. (Transcript of 8/26/14, p.10). Petitioner also testified that she works a lot of double shifts. (Transcript of 8/26/14, p.64).

Petitioner testified that during the 16 years of her employment with Respondent, she has spent the overwhelming majority of her time, 60%-70%, as a Wing Officer. (Transcript of 8/26/14, p.14, 49). Petitioner testified that typically there are 56 cells on a wing, with 2 inmates per cell, totaling 112 inmates on a wing. (Transcript of 8/26/14, p.14-15). However, there are two wings which 4 inmates per cell. (Transcript of 8/26/14, p.15). Petitioner testified that Officers are assigned either one or two wings per shift. (Transcript of 8/26/14, p.15). Petitioner testified that she normally had the AB wing, which consisted of two wings, 80% of the time. (Transcript of 8/26/14, p.60). Petitioner prepared a Work History Timeline/Job Description which was admitted into evidence as Petitioner's Exhibit 21. (Transcript of 8/26/14, p.15). Petitioner described her job duties as:

> Daily counting of inmates, movement of inmates, maintaining security. This is locking and unlocking of doors throughout the shift. Each shift – all day long. (PX21).

Petitioner testified that she does not suffer from any systemic predisposing factors for compression neuropathy such as gout, diabetes, or rheumatoid arthritis. (Transcript of 8/26/14, p.16). Petitioner is 5'4" and weighs 140 pounds. (Transcript of 8/26/14, p.16). Petitioner testified

that she has never been morbidly obese. (Transcript of 8/26/14, p.16). Petitioner's only hobby that involves the use of her hands and arms is gardening. (Transcript of 8/26/14, p.17, 42). Petitioner estimated that she spent an hour per week in her garden. (Transcript of 8/26/14, p.64). Petitioner currently works the 3 to 11 shift and has Saturdays and Sundays off. (Transcript of 8/26/14, p.17). While the Officers are supposed to be rotated every 90 days, Petitioner testified that she was only rotated a few times. (Transcript of 8/26/14, p.18).

When asked to describe the cell doors on the wing that she is required to open, she described them in her testimony as follows:

A: The cell doors on the wing are metal doors that take a small key to insert. You turn it and hopefully it opens the first time. If not, you wiggle it, or you have another set of keys and you'll try that key, and sometimes it will work.

Q: Are they difficult to open?
A: Some are and some aren't.

Q: Are they made – well, you tell me, what are the doors made of?
A: Metal.

Q: Steel?
A: Steel. Very heavy doors, for a purpose.

Q: Does it require force to use a key to open the doors?
A: Yes, it does. . .

Q: Does it require grip?
A: Yes.

Q: Does it require multiple times to open these doors?
A: Sometimes it does, yes. (Transcript of 8/26/14, p.18-19).

Petitioner testified that the steel doors stick and even swell in the summer months. (Transcript of 8/26/14, p.23). She testified that this made it very difficult to close the doors. (Transcript of 8/26/14, p.23). She stated:

> Well, actually when you have a wing, if a door looks like it's shut, it's usually not. You have to physically go down and shut it. Pull on it. Pull on the handle. Sometimes you actually have to open the door and then shut it. (Transcript of 8/26/14, p.23).

As a result, Petitioner testified that wing officers are required to perform wing checks every 30 minutes. (Transcript of 8/26/14, p.24). During wing checks, officers go down their assigned wings and forcefully pull on every door to confirm that each is closed and then log the results. (Transcript of 8/26/14, p.24). This means that Officers pull on 56 to 112 doors, and in addition any closet doors and the outer wing doors, every 30 minutes. (Transcript of 8/26/14, p.24-25).

Petitioner also testified to difficulty with the locks on a daily basis. (Transcript of 8/26/14, p.75-78). Petitioner testified that she was personally told by Robert Schuchert that there is no equipment to fix the locks. (Transcript of 8/26/14, p.75-76). She testified:

> It's on a daily – it's just daily. There's no equipment that can fix these locks, we've been told. The locksmith has nothing to fix them with. So we can report it, which we do all the time, but nothing ever gets fixed. (Transcript of 8/26/14, p.75).

Petitioner testified that extra care is needed when operating the locks. (Transcript of 8/26/14, p.77-78). While strength, and some jiggling, of the key is needed to turn the key because the locks stick, the key will snap if too much force is used. (Transcript of 8/26/14, p.78). Petitioner testified that as she is turning the key, she has to hold the handle and sometimes move the door to get the lock to release. (Transcript of 8/26/14, p.78). Petitioner also testified that she has to firmly grip her key and key ring because there are a lot of keys on her ring and it cannot be dropped. (Transcript of 8/26/14, p.78).

Petitioner also described a chuckhole, which is an opening in the cell door approximately 4 x 8 in measurement through which inmates are cuffed and delivered items such as food trays and laundry. (Transcript of 8/26/14, p.19-20, 77). Petitioner testified that chuckholes are opened with a much larger Folger Adams key. (Transcript of 8/26/14, p.21). When asked to describe the condition of the chuckholes and the Folger Adams keys used to open them, Petitioner stated:

> A: The chuckholes have access for the inmate to throw all kinds of stuff outside of the chuckhole. So sometimes they were nasty; they get stuck, they have to be cleaned. If there's liquid thrown on it, it gets rusted. They're very hard to open.
>
> Q: Okay. Are Folger Adams keys easy to use?
> A: Not really.
>
> Q: Why not?
> A: They're rather large, and you have to stick it in there, and once again, sometimes it opens and sometimes it doesn't. (Transcript of 8/26/14, p.21-22).

Petitioner testified that using Folger Adams keys requires force, grip and strength. (Transcript of 8/26/14, p.22). For the first 10 years of her employment, Petitioner worked the midnight shift and opened chuckholes every night to feed breakfast. (Transcript of 8/26/14, p.61-62). Petitioner also used/uses the chuckhole after the wing has been locked up to deliver laundry that the inmates may need for the next day's work. (Transcript of 8/26/14, p.77).

Correctional Officers also perform shakedowns, or cell searches, to make sure that the inmates don't have anything in the cells that they should not have. (Transcript of 8/26/14, p.27-28). Petitioner testified that she used both of her hands and arms to go through all of the inmates possessions. (Transcript of 8/26/14, p.28-30). She described the process as follows:

> . . . To do that, we go in the cell, and the inmates go to the back of the wing if they're there. And I go through all of their paper work, their electronics to

> make sure everything's right, their TV's, their radios. They have a property box that they keep theirs supplies in. (Transcript of 8/26/14, p.28).

Petitioner testified that she looks under mattresses, checks behind vents and lifts boxes. (Transcript of 8/26/14, p.29-30). If an inmate is in possession of an item that he is not supposed to have, he is given a ticket. (Transcript of 8/26/14, p.28). Petitioner testified that the property boxes weigh up to 50 pounds. (Transcript of 8/26/14, p.28)..

Petitioner also testified that at times the facility is placed on lockdown, a time when inmates are confined to the wing cells. (Transcript of 8/26/14, p.20-21). Petitioner testified that the duties of Correctional Officers increase during lockdown because there are no inmate workers to assist with routine tasks. (Transcript of 8/26/14, p.20-21). Petitioner explained that during this time, everything has to be passed to the inmates through the chuckholes, including ice in the summer time. (Transcript of 8/26/14, p.20-21). Petitioner testified that this increases the strain placed on the arms and hands of Correctional Officers. (Transcript of 8/26/14, p.21). Petitioner believed that her symptoms manifested during a period of time when Respondent's facility was frequently on lockdown. (Transcript of 8/26/14, p.20, 80).

Petitioner also spent a modest amount of time (15%) in the R5 Segregation Unit, where inmates are sent for disciplinary measures or investigation. (Transcript of 8/26/14, p.25, 55). Petitioner was assigned two wings while in segregation, and inmate workers were not available in segregation during the time frame she worked there. (Transcript of 8/26/14, p.56-57). Petitioner testified that in segregation, the inmates cannot move unless a Correctional Officer cuffs them through the chuckhole door and moves them. (Transcript of 8/26/14, p.25-26). The chuckholes in segregation are padlocked and require two hands to open. (Transcript of 8/26/14, p.30). Petitioner testifies that inmates occasionally resist, which creates strain she described as "a yank on your arms a little bit." (Transcript of 8/26/14, p.26). Petitioner testified that she has bar rapped the shower bars in segregation and described the tingling sensation that it created in her hands and arms. (Transcript of 8/26/14, p.26-27). Since the segregation unit was not depicted in Respondent's video, Petitioner demonstrated the chuckhole opening process for the Arbitrator. (Transcript of 8/26/14, p.30-31). Petitioner testified that during her career at Pinckneyville Correctional Center, she has pulled on cell doors, opened chuckholes and turned keys hundreds of thousands of times. (Transcript of 8/26/14, p.32).

Petitioner testified that she reviewed the deposition transcripts of other Pinckneyville correctional employees, as well as the video analyses offered by Respondent. (Transcript of 8/26/14, p.11-13). Petitioner testified that the videos did not accurately depict the duties of a Correctional Officer at Pinckneyville Correctional Center because it lacked detail. (Transcript of 8/26/14, p.13). She testified that it did not depict the day-to-day occurrences in each area that the Officers work, and that it lacked detail with regard to arm-and-hand activity required to open doors, shut doors, open chuckholes, and move inmates from one place to another. (Transcript of 8/26/14, p.13-14). It did not depict the frequency of the activities engaged in, and it did not show any of the locks or chuckholes sticking or malfunctioning. (Transcript of 8/26/14, p.27). Petitioner also offered her testimony by way of deposition regarding Respondent's analyses. (PX15).

Deposition of Petitioner, Donna Jones (PX15)

Petitioner testified that she worked at Respondent's Pinckneyville Correctional Center as a Correctional Officer/Wing Officer since July 1, 1998, and has worked all 3 shifts. (PX15, p.4-5). There was no part of the facility in which she had not worked. *Id.* at 5. She reviewed both the video and the Job Site Analysis prepared by Respondent. *Id.* at 5-6.

With regard to the video, she acknowledged while the video showed cuffing and un-cuffing the inmates, there was no difficulty or inmate resistance shown in the activity, which she testified happens quite often. *Id.* at 9. She testified that it did not show the difficulty opening cell doors, contrary to daily events:

Q: Are the doors difficult to open?
A: Yes, they are. Some of them are.

Q: Why?
A: Well, they're heavy steel doors, and just because you stick a little key in it doesn't mean they're going to open right away.

Q: What do you have to do?
A: Well, first of all, you have to – I personally—I work two wings, so I have a lot of doors that I have to deal with.

Q: How many?
A: On each wing, there's 50-some-odd doors.

Q: 56.
A: 56. Thank you very much. 56 doors, that's just cell doors. Just to enter institutions—of course, we don't have to use a key to enter the institution, but we have to go through—one, two, three, four—there's probably six doors that we physically have to open. These are heavy metal doors. They're not like a wooden door that you open in a regular house or—they're very heavy. Very, very heavy.

Q: And when you say 56 steel doors, is that on your wing?
A: Yes.

Q: When you're working two wings, is that 112?
A: Yes, it is. *Id.* at 7-8

When asked to explain why key turning was difficult, she testified that Folger Adams keys in segregation are difficult to use in general. (PX15, p.10). She testified that the pace of the work was not shown accurately in the video and testified that the majority of the work was done while in a "real big hurry." *Id.* at 13. While walking or making rounds, a Wing Officer forcefully pulls on each door to check its integrity and make sure it was properly closed. *Id.* at 14. This activity was not depicted in the video. *Id.* at 14. Her testimony regarding the frequency of shake downs corroborated Petitioner's testimony regarding same. *Id.* at 15. She described a Wing Officer as having to shake down two wings every 30 days. *Id.* at 15. Each wing has 56 cells and two inmates to a cell, which equates to 224 shake downs every month. *Id.* at 7-8. During this

process, she has to lift heavy objects, use her arms and hands to turn things over, look under beds, and physically move things to see if contraband exists. *Id.* at 15-17. Each phase requires the forceful use of her arms and hands. *Id.* at 16.

Petitioner described the property boxes contained in the cells as large plastic boxes which she could not lift. (PX15, p.16). She has to slide them out from under the bed, and remove all the objects using her arms and hands. *Id.* at 17. She confirmed that the video did not show any portion of this activity. *Id.* at 17. She enumerated the lengthy process of taking an inmate to the shower as opening a chuckhole, which was difficult, cuffing the inmate through the chuckhole, keying open the door, escorting the inmate to the shower key, opening the shower door with the Folger Adams key, shutting the lock, and key the cuffs off the inmate. *Id.* at 18-19. She described that this was very difficult, and she testified she performed this activity thousands of times in her 13 years of employment with Respondent. *Id.* at 19.

She testified that there was no mention of movement in the housing unit or how many passes are run on any given day in the video or in the Job Site Analysis. *Id.* at 20. There was nothing about moving inmates to the transfer bus, writs, furloughs, medical visits, lifting medical bags, passing commissary workers to the chuckholes, or keying and lifting radios hundreds of thousands of times in her career. *Id.* at 20-21. She also confirmed that pieces of metal were altered by the inmates, either through kicking or pounding. *Id.* at 23. She testified that when there was a lockdown in place, the amount of keying doubles and triples. *Id.* at 24. The video did not show any opening or closing of the closet doors, or any officer performing the daily count of inmates. *Id.* at 25. After reviewing the video, she stated, "It's not very accurate at all." *Id.* at 25.

Testimony of Jason Thompson

Lt. Jason Thompson testified that he currently serves at Pittsfield Work Camp, a satellite facility of Respondent's Jacksonville Correctional Center. (Transcript of 11/13/14, p.16). Lt. Jason Thompson began working at Pinckneyville Correctional Center in July of 1998 as a Correctional Officer. (Transcript of 11/13/14, p.17). In October of 1998, he became a Correctional Lieutenant and remained in that position until November 31, 2011. (Transcript of 11/13/14, p.17). Lt. Thompson testified that the keys at Respondent's facility were of decent quality during the time that he worked there, but acknowledged that they did sustain wear and tear and needed to be replaced. (Transcript of 11/13/14, p.19). He estimated that there was one bad lock on average per wing. (Transcript of 11/13/14, p.19). He prepared an Estimation of Key Usage analysis for Pinckneyville Correctional Center, which was admitted as Respondent's Exhibit Number 6. (Transcript of 11/13/14, p.20-22). He testified that he had no problems with any of Petitioner's testimony. (Transcript of 11/13/14, p.24). He testified that Petitioner is a good employee. (Transcript of 11/13/14, p.25). He also affirmed his previous testimony as to the duties of a Pinckneyville Correctional Officer. (Transcript of 11/13/14, p.26-27).

Deposition of Jason Thompson (PX17)

Lieutenant Thompson testified that during his time at Pinckneyville Correctional Center, he was present in x-wing style housing units 3 and 4, which held 448 inmates. (PX17, p.6). These are 112 cells in 2 wings, holding 2 inmates each. *Id.* at 6. He saw Dr. Williams' attempt to

open one key on the R3-C wing door and one handcuff key. *Id.* at 7. He testified that Dr. Williams was awkward while trying to get the hand position movements, and had trouble hitting the double lock key portion of it. *Id.* at 7.

When asked to explain the difficult double lock key portion, he testified:

> A: Basically, with your handcuff keys, you've got the keyhole, which the key portion fits in. You turn that to unlock it. (Indicating.)
>
> Q: Yes, sir.
> A: On either the side—either the edge side or on the opposite of the keyhole, you also have what's called a double-locking mechanism. (Indicating.) If it's a pin-type, you have a small pin that you press in with the non-key end of the key—of the cuff key. It's just like a pinpoint.
>
> Q: Yes, sir.
> A: And you press it in, and that double-locks the cuffs. (Indicating.) If not, you've got—it's basically a wire-type double lock, where you—also using the same end of that key, you stick it in there and you push it in, and that also double-locks the cuffs.
>
> Q: Very good. And the reason that they're double-locked is why?
> A: So they can't be compressed any further and they're harder to jimmy.
>
> Q: Safety reasons?
> A: Yes. Absolutely. *Id.* at 7-8.

Lieutenant Thompson testified that keying cells and chuckholes, opening and closing doors, cuffing and un-cuffing inmates, turning difficult keys, opening difficult doors, pulling on bars, checking cell doors, weapons training, working mandated double shifts, performing extra duties on lock down, opening and closing chuckholes, lifting property boxes, carrying trays upstairs, restraining inmates, guiding inmates through lines, and performing various amounts of paperwork were the duties of a Correctional Officer. He further agreed that there was not a single part of the job that did not involve using one's arms, hands, or elbows. *Id.* at 38. In addition, he acknowledged that these activities involved force and stress. *Id.* at 40.

Deposition of Melanie Welch (PX10)

Ms. Welch is an employee of CorVel, which is a national corporation providing services to employers, third party administrators, insurance companies, and government agencies. (PX10, p.44). When asked if she had ever done a Job Site Analysis for an injured worker, the following interchange took place:

> Q: As far as performing a job site analysis for an injured worker, have you ever done that?
> A: Yes.

Q: Ma'am, I took your deposition on—in the case of Darin Hathaway versus IYC, State of Illinois on June 9, 2011, and I specifically asked you on line 14 through 18 on page 23, "As far as performing job site analysis for an injured worker, have you ever done that?" Your answer under oath at that point, ma'am, was, line 16 through 17, "For the employer. The injured worker did not call us, no." Do you remember that answer, ma'am? Have you done one since June 9, 2011?

A: Since June 9, 2011. Oh, you mean requested by an injured worker.

Q: No, ma'am. My question was pretty clear, and I caught you in a lie right out of the box. Now, my question now is very simple. Have you performed a job site analysis for an injured worker since June 9?

A: Not requested by an injured worker, but when I do, like, an ergonomic assessment, I consider that to be for the injured worker, for their behalf.

Q: Well, was this done on behalf of the employees at Pinckneyville Correctional Center or was it requested by the State of Illinois?

A: It's requested by the State of Illinois.

Q: I see.

A: For the injured worker.

Q: I don't think it's very funny, ma'am.

A: Okay.

Q: I note for the record you're laughing, but I consider that a sign of disrespect for all parties involved. *Id.* at 44-45.

Ms. Welch received her training in Job Site Analysis from ErgoRehab Incorporated. *Id.* at 45-46. This certification was obtained by mail and through the Internet, and was paid for by Corvel. *Id.* at 47-48.

Ms. Welch could not remember the last time she did any work on behalf of an injured worker, did not know the age of Pinckneyville Correctional Center, did not know that during the 5 to 7 years prior to the video being shot that the facility was short staffed, and admitted that the video was edited. *Id.* at 50-51.

Ms. Welch also believed that it was a requirement that 20% of the entire staff rotate every 90 days, despite the consistent testimony from other witnesses that some Correctional Officers stay in their positions for years. *Id.* at 55. She did not take into account overtime and she mistakenly believed that the segregation unit was contained in the video that she filmed. *Id.* at 56-58. The video did not show any of the locks that would not open, did not show how hard the locks were to open, did not show any bending or breaking of keys, did not show any new keys which were hard to put into the locks, and did not show the heaviness or the weight of the wing doors. *Id.* at 58-59.

Ms. Welch testified that she had neither seen nor lifted a property box, and was completely unaware that they contained TVs, radios, books, paperwork, computers, clothing. *Id.* at 63-64. She further acknowledged that the video showed nothing about Correctional Officers having to carry crates filled with cartons of milk or juice weighing hundreds of pounds up flights of steps to feed inmates. *Id.* at 66. When asked whether it would be important in consider whether a Correctional Officer had to carry a milk carton and/or food tray and simultaneously open and close difficult chuckholes that often stick, Ms. Welch answered, "I don't know, I didn't try it." *Id.* at 67. She also believed that restraining a combative inmate at a Respondent's Pinckneyville Correctional Center would fall in the "medium" category of job requirements. *Id.* at 64.

She further acknowledged that there was nothing in the Job Site Analysis or video about keying and un-keying doors for moving of inmates through the housing units in passes run on any given day; nothing about the transfer box, writs, medical furloughs, medical and furlough bags. *Id.* at 68-69. Nothing was contained in the video about keying out passes for clothing, barber shop, and commissary, or weapons and tactical training. (RX8; RX9).

She did not videotape or observe any cell shake downs and, in fact, believed that shake downs were performed on Correctional Officers themselves when they entered the prison. *Id.* at 76. She did not video tape the Correctional Officers having to push buttons and operate toggles to open doors, which required the officers to hold down the button with their thumb and toggle the switch with their little and pinky fingers at the same time. *Id.* at 77-78. She had no idea that this happened almost 250 times in an hour and thousands of times in a day. *Id.* at 78. After going through all this information, Ms. Welch testified that whether Correctional Officers are constantly and repetitively using their arms and hands in a forceful manner depended on their post. *Id.* at 88-89.

Deposition of Robert Schuchert (PX11)

Mr. Schuchert was employed at Respondent's Correctional Center as the facility's locksmith. (PX11, p.4). He also operates an outside business called Schuchert's Lockshop in Chester, Illinois. *Id.* at 4. He began working for the State of Illinois in 1981 at Menard Psychiatric Center, and transferred to Pinckneyville Correctional Center on August 16, 1998. *Id.* at 5-6. He served as a Correctional Officer, like Petitioner, from 1998 until January 2004. Since 2004, he has been a locksmith at Pinckneyville. *Id.* at 6. Schuchert viewed the videos from Menard Correctional Center and Pinckneyville Correctional Center. *Id.* at 7. He also reviewed the Job Site Analysis. *Id.* at 7-8. He testified that while employed as a locksmith at Pinckneyville, he developed bilateral compression neuropathies and filed a Workers' Compensation Claim that was accepted by Respondent. *Id.* at 8. He was voluntarily paid for his time off and received a settlement. *Id.* at 8, 33-34. He attributed his injuries to his repetitive work at Menard and Pinckneyville Correctional Centers. *Id.* at 9-10. He testified that his problems began while working in the segregation at Menard and progressed while performing his job duties at Pinckneyville. *Id.* at 9-10. He testified that, "It got to the point where if I had a tool box full of locks I couldn't carry them with my left hand, especially from one cell house to the next. I had to keep switching hands because it hurt so bad." *Id.* at 9-10. When asked to describe the difference between the locks in the segregation unit and the general population, he stated:

> The seg unit—the difference between the locks in the seg unit and general pop over there is they have a mogul key—a bigger electronic lock in their unit over there than general pop. General pop has a Medeco lock, which is a smaller key, which is compared to your house key. The mogul keys that are over in the seg unit—they're a bigger key. I would say probably about that big on the head. The length of the key is probably about that long. (Indicating.) *Id.* at 10.

He acknowledged that all Correctional/Wing Officers had to key open chuckholes, cell doors, cabinets, and medical cabinets; and diary each item that had to be keyed out, logged out, keyed back in, and logged back in. *Id.* at 11-12. The same requirements existed in medical. *Id.* at 12. When asked to describe the locks at Pinckneyville, he stated:

> They have gotten worse, naturally, through the years. When we first arrived, the inmates had their own keys to their locks, so there was a lot of wear and tear. I was trying to remember last night how long it's been since we got rid of the—we pulled the inmate keys out over there. *Id.* at 12.

He testified that approximately 7 to 8 years ago, the inmates had their own keys. *Id.* at 13. However, the keys were taken away due to the atrocious wear and tear on the locks from constant inmate traffic. *Id.* at 13. He described the current condition of the locks as fair to poor. *Id.* at 13-14. When asked to describe the locks where Petitioner has worked the last 5 years, he stated:

> . . .We had a lot of wear on the locks then, and it's been—the chuckhole locks have got a lot of wear, especially in the seg, because they get keyed all the time. You're feeding them three meals a day, plus you're transporting them in and out, if you're—if they're going to – they're going to the yard; they're going to passes, and right now, you're—in warm weather, pass ice, mail, anything else—you got to open that chuckhole. *Id.* at 13.

He acknowledged that Respondent's witness, Lieutenant Thompson, was correct when in stating that the locks and the chuckholes were very difficult to open. *Id.* at 16-17. The difficulty stemmed not only from the locks, but from the food spilled in them. *Id.* at 18. He estimated that he switched out between 2 to 5 locks per week, or at times, 4 or 5 locks will go out in a day. *Id.* at 22.

Demands of the Job Form (RX1)

Respondent submitted a "Demands of the Job" form, which is designed to quantify Petitioner's arm and hand usage in the performance of her job duties. (RX1). However, the evasive manner in which the form was completed nearly negates its purpose, as mostly exclusive rather than inclusive details were provided. *Id.* Simply stated, the individual completing the form gave more effort in detailing what Petitioner did not do, rather than indicating what she did do.

Id. The form indicates that Petitioner *never* performs any lifting without intermittent rest rather than indicating how much lifting was performed with rest and the number of iterations per day. *Id.* The form indicates that Petitioner uses her hands for gross manipulation such as grasping, twisting and handling up to 2 hours per day, and for fine manipulation such as typing and good finger dexterity up to 2 hours per day. *Id.*

Job Site Analyses (RX5)

The CorVel Analyses indicate that 70% of the key turning is done by Wing Officers. (RX5). Both of Respondent's Job Site Analyses categorizes the strength demands Petitioner's job as "Medium" which is defined as "lifting 50 pounds maximum with frequent lifting and/or carrying up to 25 pounds. *Id.* "Frequent" is defined as 2.5 to 5.5 hours per day, 34% to 66% of a day, or 33 to 200 repetitions per day. *Id.* Petitioner also engages in "frequent" wrist turning and "frequent" finger manipulation. *Id.* The wrist turning was associated with the opening of doors and chuckholes up to 150 times per shift in the housing unit. *Id.* More keys would be turned during lockdown. *Id.* The hand-and-arm usage evaluation in the Analyses quantifies more activity than what is indicated in Respondent's "Demands of the Job" form. (RX1; RX5).

Post Description and Key Usage Estimate

Respondent submitted a Post Description for a Housing Unit Wing Officer which enumerates the job duties of a Correctional Wing Officer. (RX5). Pertinent job duties involve:

- Restricting the activity of inmates and ensuring that they do not move from wing to wing;
- Searching inmates leaving and returning to the Unit on call passes or schedule movement;
- Completing cell searches every 60 days and logging the results on a form; Officers are required to shakedown all areas of the unit;
- Completing cell condition checks when inmates are assigned to different cells, noting any irregularities on a form and completing disciplinary reports if any damage has occurred;
- Performing inmate counts and inventory counts and completing count and inventory logs;
- Monitors the issue and use of caustic/toxic substances used in the cleaning area;
- Checking I.D. Cards when passing inmate mail;
- Make constant rounds checking all doors to inmate rooms and ensure that all security doors are closed and locked at all times, except when allowing authorized persons to pass through;
- Check all windows, doors and screens in the housing units in accordance with established procedures;
- Complying with D.R.'s, A.D.'s, I.D.'s, Warden's Bulletins, or special order bulletins, and performing other duties as required or assigned, which are reasonably within the scope of the duties enumerated in the Post Description. *Id.*

The key usage estimate indicates that general population Wing Officers turn 55 large keys and 50 small keys per shift by totaling the key usage estimate under the categories of wing checks, inmate traffic, laundry, utility closet, shakedowns, property box checks, and miscellaneous wing traffic. *Id.* However, it does not appear that this estimate takes into account inmate feeds on the night shift, which is done through a chuckhole and requires use of a large key. *Id.* The estimate also contains disclaimers regarding its inadequacies and cautionary statements regarding the combing of posts and resulting usage increases:

> It must be stressed that these are estimations based on visual observations, average inmate movement experienced on the post, estimated amount of staff movement during the shifts, and the assumption that the institution is not on lockdown. Lockdown situations will increase these estimations considerably for posts that are normally open for inmate movement . . . [Emphasis Original].
>
> There are several posts, especially on the 3-11 and 11-7 shifts, in which the duties of two or more posts are combined into one post. An example of this is the 11-7 post 1250, in which the R1 A WING officer is also responsible for R1 B WING. This is a combined post. These posts are identified on the rosters in the same manner as the split posts. **A regular post can become a combined post at any time** by closing a non-mandatory post and placing the responsibility for the closed post on the mandatory post officer. [Emphasis added]. This can be done on any shift, and when it occurs, the affected post will see usage increase by the amount of usage on the closed post.

The Arbitrator notes that Petitioner testified that she was responsible for two wing posts for 80% of her time with Respondent. (Transcript of 8/26/14, p.15, 60).

Medical Care and Treatment

During the course of her job duties, Petitioner began developing symptoms of pain and numbness in her right and left upper extremities. (Transcript of 8/26/14, p.32). Petitioner testified that her symptoms were greater in her right side and that she is right hand dominant. (Transcript of 8/26/14, p.32). Petitioner testified that these symptoms made it difficult for her to sleep because her entire arm would go numb. (Transcript of 8/26/14, p.32). She would wake during the night and take over-the-counter medication in an attempt to manage her symptoms. (Transcript of 8/26/14, p.32).

Petitioner also testified to treating with a chiropractor for neck pain and pain and tingling in her hands as early as 2002. (Transcript of 11/13/14, p.9-10). Petitioner thought her problem was coming from her neck. (Transcript of 11/13/14, p.10-12). Petitioner underwent electrodiagnostic testing in 2007, but could not recall where she had the nerve conduction study. (Transcript of 11/13/14, p.11-12). The records indicate that Petitioner reported that a "*possible cause*" for some of her pain was opening several heavy steel doors going from one work area to

another. (Transcript of 11/13/14, p.12). Petitioner testified that she was told in 2008 or 2009 that she *probably* had carpal tunnel. (Transcript of 8/26/14, p.83-84).

Petitioner saw Dr. Brown on September 29, 2010. (PX3, 9/29/10). Dr. Brown noted that Petitioner had worked at Pinckneyville Correctional Center since 1998 repeatedly opening and closing heavy steel doors and turning keys throughout her day. *Id.* Physical examination demonstrated positive direct compression test and Phalen's test over the carpal tunnels bilaterally, and a mildly positive Tinel's sign over her cubital tunnels bilaterally. *Id.* Dr. Brown suspected bilateral carpal tunnel syndrome with possibly a component of cubital tunnel syndrome and referred Petitioner for electrodiagnostic nerve studies with Dr. Daniel Phillips. *Id.* These revealed findings consistent with severe right carpal tunnel syndrome, moderate left carpal tunnel syndrome, and mild ulnar neuropathy at both elbows. (PX3, 9/29/10; PX4). Due to the chronicity and severity of Petitioner's carpal tunnel syndrome, Dr. Brown recommended that Petitioner undergo bilateral carpal tunnel releases. (PX3, 9/29/10). He recommended conservative treatment for Petitioner's elbow neuropathy. *Id.* Dr. Brown stated, "Based on Ms. Jones' job description as a correctional officer at Pinckneyville for the past 12 years, I do believe her work at Pinckneyville would be considered an aggravating factor in the need for further evaluation and treatment for carpal tunnel syndrome and/or cubital tunnel syndrome. *Id.*

Following her appointment with Dr. Brown and Dr. Phillips, Petitioner completed and submitted an incident report to her shift commander. (Transcript of 8/26/14, p.33; PX7). Petitioner testified that September 29, 2010, was the date that she first realized that she had a work-related condition. (Transcript of 8/26/14, p.34).

On November 5, 2010, Petitioner underwent a right carpal tunnel release. (PX5, 11/5/10). Petitioner underwent the same procedure on her left side on November 19, 2010. (PX5, 11/19/10). The objective intraoperative findings during both procedures noted that Petitioner's nerves had a flattened appearance within the carpal tunnel. (PX5). Petitioner testified that she received pre-approval for surgery and was paid for her time off work. (Transcript of 8/26/14, p.40-41). Petitioner's condition progressed following surgery and therapy, and she was released to return to work light duty on December 14, 2010, and full duty work on January 3, 2011. (PX3, 12/14/10; PX6).

Petitioner testified that despite the improvement resulting from surgery, she continued to have soreness around the surgery site when she uses her hands a lot or when she puts downward pressure on her hands. (Transcript of 8/26/14, p.35). Petitioner testified that she continues to experience numbness in her hands that comes and goes. (Transcript of 8/26/14, p.36). She testified that her hands and arms are tired and very heavy at the end of her shift. (Transcript of 8/26/14, p.36). Petitioner also testified to loss of grip strength. (Transcript of 8/26/14, p.36). She testified that she has to take things a lot slower than she used to. (Transcript of 8/26/14, p.36). Petitioner takes Tylenol as needed for her symptoms. (Transcript of 8/26/14, p.37).

Testimony of Dr. James Williams

Respondent had Petitioner's records reviewed under §12 of the Act by Dr. James Williams. (RX10, p.10). Dr. Williams testified that he reviewed Respondent's Job Site Analyses, Job Descriptions, videos, key usage estimate, and the medical records from Dr. David Brown and

Dr. Daniel Phillips. *Id.* at 11, 14. He agreed that Petitioner suffered from bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome based on the results of Petitioner's clinical examination and the results of the nerve conduction study. *Id.* at 12, 28. He believed that Petitioner was predisposed to the development of carpal tunnel syndrome due to her sex, her postmenopausal secondary to her hysterectomy, and her elevated body mass index. *Id.* at 13. Based on his review of Respondent's information, he did not believe that Petitioner's work as a Correctional Officer at Pinckneyville Correctional Center was a factor in the development or aggravation of Petitioner's carpal tunnel syndrome or cubital tunnel syndrome. *Id.* at 13-15. He testified that Petitioner's job activities did not involve any vibratory activity or impact, and he believed that there was significant rest in between key turning. *Id.* at 14. He testified that he did not see any activities such as prolonged flexion of the elbow or vibration through the arm that would cause or aggravate cubital tunnel syndrome in Respondent's videos. *Id.* at 15.

Dr. Williams testified that from observing Respondent's videos, he could see that the keys were not always turned, and that the smaller keys were used rather than the larger Folger Adams key. *Id.* at 16-17. He testified that the key turning he observed in the video was not sufficiently repetitive so as to bring about carpal or cubital tunnel syndrome. *Id.* at 16-17. Dr. Williams also believed that Petitioner's job was not repetitive because of a segment of Petitioner's assignment roster was offered to him, which demonstrated that Petitioner was not always assigned to the same job post. *Id.* at 18. On cross examination, Dr. Williams candidly acknowledged that if the information upon which he based his causation opinion was incorrect, then his opinion would be flawed. *Id.* at 29. Dr. Williams noted that he did not have the opportunity to examine Petitioner and take a history from her. *Id.* at 29.

Dr. Williams acknowledged that Respondent's video did not depict the segregation unit, or any of the difficulties encountered by Correctional Officers such as locks that malfunction. *Id.* at 30. He was also uninformed of the existence of a locksmith at the facility. *Id.* at 30-31. He did not know the number of wings for which Petitioner was responsible. *Id.* at 31. He did not see any of the activity surrounding the shaking down of cells or property boxes, and did not know how often Petitioner performed those activities. *Id.* at 32. When provided details from Petitioner's counsel regarding her responsibility in caring for two wing units and asked whether those activities would be aggravating or contributing factors to the development of bilateral carpal tunnel syndrome, he stated, "They could be." *Id.* at 34-35.

Testimony of Dr. David Brown

Petitioner's treating orthopedic surgeon testified by way of deposition on November 5, 2013. (PX9). In addition to practicing as a board-certified orthopedic hand specialist, he serves as a consultant for the St. Louis Cardinals. (PX9, p.4). He also testified that Dr. Daniel Phillips is a board-certified expert in electrical diagnostic medicine with accredited facilities, considered to be the top expert in this community, and has limited his practice to that specific field. *Id.* at 9-11. Dr. Brown testified that he has been invited to tour facilities and render opinions on behalf of the State of Illinois, as well as other plants and facilities in the State of Illinois and Missouri, and is asked to review job analyses and videos for the purpose of rendering causation opinions for independent medical evaluations and second opinions. *Id.* at 19-20, 68. He testified that he has

also testified against Petitioner's attorney and given causation opinions favorable to respondents. *Id.* at 5.

Dr. Brown testified to his clinical examination, the results of the objective diagnostic studies, and his diagnosis of chronic significant bilateral carpal tunnel, right greater than left, and mild bilateral ulnar neuropathy. *Id.* at 9, 13-14. He testified that he sought approval for surgery, which was granted, and received an explanation of benefits stating the amount payable pursuant to the Medical Fee Schedule from the State of Illinois. *Id.* at 15-16.

Dr. Brown testified that he reviewed a job description provided by Petitioner in her new patient questionnaire, and an additional written job description, Respondent's Job Site Analyses, Respondent's videos, the key usage study, multiple post descriptions, the records review of Dr. Williams, the deposition testimony of Dr. Williams, and the deposition testimony of the Pinckneyville locksmith and four Correctional Officers, including Petitioner. *Id.* at 18-19. Based on this information and Petitioner's job description, Dr. Brown felt that Petitioner's performance of those activities over 12 years were a causative aggravating factor in Petitioner's conditions and need for treatment. *Id.* at 21. He specifically noted that Petitioner was healthy, with no history of diabetes hypothyroidism or arthritis. *Id.* at 21. The only non-occupational contributory factors were Petitioner's age and female gender. *Id.* at 26. Dr. Brown testified that he could not see how Petitioner's hysterectomy could have played a part in the development of her condition, as Petitioner's hysterectomy occurred after her condition had already established and advanced by the time the procedure was performed. *Id.* at 27. Petitioner testified at Arbitration that the purpose of her 2010 surgery was simply to have some cysts removed, but she "opted to take everything out." (Transcript of 8/26/14, p.63). Dr. Brown also testified that Petitioner's body mass index was only 27.5. (PX9, p.27). He testified that a person is only considered obese when they have a body mass index over 30; therefore, Petitioner's weight was a very weak associated risk factor for compression neuropathy. *Id.* at 27-28. Dr. Brown testified, however, that pinch force, the force that's measured with doing pinching activity such as turning a key in a lock, is a well-known occupational risk factor for carpal tunnel syndrome. *Id.* at 29.

Dr. Brown found the insight provided by the testimony of Respondent's locksmith probative, and specifically noted his description of the wear and tear on the locks and the typical frequency of their replacement. *Id.* at 22-23. He noted that 70% of the key turning is done by Wing Officers, Petitioner's predominant job title, and that the analyses could not account for the increased keying that occurs during lockdown. *Id.* at 23-24. He noted that Petitioner engaged in frequent lifting up to 50 pounds. *Id.* at 24. While the analysis left out a lot of information that he would have liked to have, he testified that it gave him some idea of the frequency of the activities Petitioner engaged in. *Id.* at 24. He testified that he would like to do a sampling of multiple keys and locks throughout the facility to get a better idea of the type of problems Officers encounter and the type of forces involved in working with the condition of the locks. *Id.* at 24. He testified that the analyses also omitted details concerning wing checks, which involved gripping and pulling on the cell doors to make sure that they are closed. *Id.* at 24-25. He testified that even though incomplete, the analyses supported his opinion:

> This additional information, like I said, provided additional data which, I think, supports that opinion. It demonstrates a frequency of hand-keying

> done mostly by the wing officers, which Ms. Jones was. It also notes that key-turning is done on a frequent basis, which according to the JSA is 2.5 to 5.5 hours per day. So this additional information, including the testimony from the locksmith and the other correctional officers, supports a causal relationship between the job duties, especially performed over 12 years, and the development of Ms. Jones' conditions. *Id.* at 25-26.

Dr. Brown did not believe that the videos demonstrated significant rest between Petitioner's keying. *Id.* at 65. He testified:

> . . . If you look at the DVD, it takes the officer maybe a few seconds to walk between the two cell doors, so I don't think that would be significant rest interval. I would consider that frequent keying if it's only a few-second interval between the activity. *Id.* at 65.

Dr. Brown thus testified that the additional documentation created by and/or for Respondent supported a finding of causal connection. *Id.* at 22.

CONCLUSION

Issue (C): Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent? And;
Issue (F): Is Petitioner's current condition of ill-being causally related to the injury?

In a repetitive trauma case, issues of accident and causation are intertwined. *Elizabeth Boettcher v. Spectrum Property Group and First Merit Venture,* 99 I.I.C. 0961. "The word 'accident' is not a technical legal term, and has been held to mean anything that happens without design, or an event which is unforeseen by the person to whom it happens...Compensation may be allowed where a workman's existing physical structure, whatever it may be, gives way under the stress of his usual labor." *Laclede Steel. Co. v. Industrial Comm.*, 6 Ill.2d 296 at 300, 128 N.E.2d 718, 720 (1955) citing *Baggot Co. v. Industrial Comm.*, 290 Ill. 530, 125 N.E. 254 (1919). Under Illinois law an injury need not be the sole factor, or even the primary factor of an injury, as long as it is a causative factor. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill.2d 193, 205, 797 N.E.2d 665 (Ill. 2003) [Emphasis added]. Even when other non-occupational factors contribute to the condition of ill-being, "[*A*] Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury." *Fierke v. Indus. Comm'n*, 309 Ill.App.3d 1037, 723 N.E.2d 846 (3rd Dist. 2000). Allowing a claimant to recover under such circumstances is a corollary of the principle that employment need not be the sole or primary cause of a claimant's condition. *Land & Lakes Co. v. Indus. Comm'n*, 834 N.E.2d 583 (2d Dist. 2005). Employers are to take their employees as they find them. *A.C.& S. v. Industrial Comm'n*, 710 N.E.2d 837 (Ill. App. 1st Dist. 1999) citing *General Electric Co. v. Industrial Comm'n*, 433 N.E.2d 671, 672 (1982). The Supreme Court in *Durand v. Indus. Comm'n* noted that the purpose of the Illinois Workers' Compensation Act is best served by allowing compensation where an injury is gradual but linked to the employee's work. *Durand v. Indus. Comm'n*, 862 N.E.2d 918, 925 (Ill. 2006).

In the repetitive trauma case of *Fierke*, the Appellate Court specifically applied the foregoing legal standard of causation specifically to a repetitive trauma case and noted that non-employment related factors that contribute to a compensable injury do not break the causal connection between the employment and a claimant's condition of ill-being. *Fierke,* N.E.2d at 849. The Court specifically stated, "The fact that other incidents, whether work related or not, may have aggravated a claimant's condition is irrelevant." *Id.*

The Appellate Court's decision in *Edward Hines Precision Components v. Indus. Comm'n* highlights that there is no standard threshold which a claimant must meet in order for his or her job to classify as sufficiently "repetitive" to establish causal connection. *Edward Hines*, 365 Ill.App.3d 186, 825 N.E.2d 773, 292 Ill.Dec. 185 (Ill.App.2d Dist. 2005). In fact, the Court expressly stated, "There is no legal requirement that a certain percentage of the workday be spent on a task in order to support a finding of repetitive trauma." *Id.* at N.E.2d 780. Similarly, the Commission recently noted in *Dorhesca Randell v. St. Alexius Medical Center*, 13 I.W.C.C. 0135 (2013), a repetitive trauma claim, a claimant must show that work activities are a cause of his or her condition; the claimant does not have to establish that the work activities are the sole or primary cause, and there is no requirement that a claimant must spend a certain amount of time each day on a specific task before a finding of repetitive trauma can be made. *Randell* citing *All Steel, Inc. v. Indus. Comm'n*, 582 N.E.2d 240 (1991) and *Edward Hines supra.* The Appellate Court in *Darling v. Indus. Comm'n* even stipulated that quantitative evidence of the exact nature of repetitive work duties is not required to establish repetitive trauma injury in reversing a denial of benefits, stating that demanding such evidence was improper. *Darling v. Industrial Comm'n*, 176 Ill.App.3d 186, 195, 530 N.E.2d 1135, 1142 (1st Dist. 1988).

In 2009, the Appellate Court issued a favorable decision in a repetitive case to a claimant in which the claimant's work was "varied" but also "repetitive" or "intensive" in that he used his hands, albeit for different task, for at least five (5) hours out of an eight (8) hour work day. *City of Springfield v. Illinois Workers' Comp. Comm'n*, 388 Ill.App.3d 297, 901 N.E.2d 1066, 327 Ill.Dec. 333 (Ill.App. 4th Dist., 2009). As was noted by the Commission and reiterated in the Appellate Court decision in *City of Springfield v. Illinois Workers' Compensation Comm'n*, "while [claimant's] duties may not have been 'repetitive' in a sense that the same thing was done over and over again as on an assembly line, the Commission finds that his duties required an intensive use of his hands and arms and his injuries were certainly cumulative." *Id.* Based upon the aforementioned law, Petitioner can establish a claim for repetitive trauma even though she worked various assignments and has an underlying condition. Petitioner's job duties involve the performance of tasks distinctly related to her employment which pose risks to which the public is not equally exposed. This risk is both qualitative and quantitative. This is buttressed by Respondent's own Job Site Analysis, despite its limitations in accuracy and detail.

The Arbitrator finds Petitioner's description of her job duties to be credible based on the overwhelming weight of the evidence, and the fact that Respondent's witness, Jason Thompson, testified that he did disagree with any of Petitioner's testimony. (Transcript of 11/13/14, p.24). The independent analyses performed by Respondent, despite omitting some of Petitioner's job duties, clearly demonstrate that Petitioner frequently or repetitively uses her hands throughout her work day for at least 5 hours per day, similar to the claimant in *City of Springfield.* (RX5).

Although Petitioner may have rotated posts, the evidence demonstrates that Petitioner continued to use her hands to complete her assignments, no matter what those assignments were.

The CorVel Analyses indicate that 70% of the key turning is done by Wing Officers. (RX5). Both of Respondent's Job Site Analyses categorizes the strength demands Petitioner's job as "Medium" which is defined as "lifting 50 pounds maximum with frequent lifting and/or carrying up to 25 pounds. *Id.* "Frequent" is defined as 2.5 to 5.5 hours per day, 34% to 66% of a day, or 33 to 200 repetitions per day. *Id.* Petitioner also engages in "frequent" wrist turning and "frequent" finger manipulation. *Id.* The wrist turning was associated with the opening of doors and chuckholes up to 150 times per shift in the housing unit. *Id.* More keys would be turned during lockdown. *Id.* Dr. Brown testified that he believed this supported a finding of causal connection. (PX9, p.22-26).

The Arbitrator notes that Dr. Brown had more information available to him than Dr. Williams, particularly information regarding poor conditions in the facility which would increase the amount of pinch or grip force required to complete necessary job tasks. (PX9). Dr. Brown testified that these forces are a factor in the development of compression neuropathy. (PX9). Dr. Brown had the opportunity to review the deposition testimony of the locksmith at Pinckneyville Correctional Center, as well as the testimony of Correctional Officers, including Petitioner, which he testified confirmed his existing opinion. (PX3; PX9). Although Petitioner has some non-occupational risk factors for the development of carpal tunnel syndrome, namely her age and gender, these are not major systemic factors such as diabetes or hypothyroidism. Petitioner testified that she does not suffer from any systemic predisposing factors for compression neuropathy such as gout, diabetes, or rheumatoid arthritis. (Transcript of 8/26/14, p.16). Petitioner's only hobby that involves the use of her hands and arms is gardening, which she engages in approximately 1 hour per week. (Transcript of 8/26/14, p.17, 42, 64). Nevertheless, non-work related contributing factors do not sever the causal link between Petitioner's employment and her resulting injury. As the *Fierke* Court noted, employment need only be *a* factor in the total condition of ill-being. *Fierke supra.* The Arbitrator finds it significant that Petitioner's condition is more severe on her dominant side. (Transcript of 8/26/14, p.32; PX3). The Arbitrator agrees that Petitioner's hysterectomy would not be a factor based on the timing of the operative procedure in relation to the development and/or establishment of Petitioner's condition. (PX9).

Dr. Williams testified that if the information upon which he based his opinion was incomplete or incorrect, his opinion could be flawed. (RX10, p.29). Dr. William based his impression of Petitioner's job duties largely on Respondent's videos, which he acknowledged during his deposition lacked considerable detail. Dr. Williams acknowledged that Respondent's video did not depict the segregation unit, or any of the difficulties encountered by Correctional Officers such as locks that malfunction. *Id.* at 30. He was also uninformed of the existence of a locksmith at the facility. *Id.* at 30-31. He did not know the number of wings for which Petitioner was responsible. *Id.* at 31. He did not see any of the activity surrounding the shaking down of cells or property boxes, and did not know how often Petitioner performed those activities. *Id.* at 32. When provided details from Petitioner's counsel regarding her responsibility in caring for two wing units and asked whether those activities would be aggravating or contributing factors to the development of bilateral carpal tunnel syndrome, he stated, "They could be." *Id.* at 34-35.

The Commission has also found the at the job duties of a Correctional Officer at Pinckneyville Correctional Center aggravate and contribute to the development of repetitive injuries. *Dustin Bowles v. Pinckneyville Corr. Ctr.*, 14 I.W.C.C. 0842 (2014); *Samuel Burns v. Pinckneyville Corr. Ctr.*, 14 I.W.C.C. 0482 (2014); *Chris Walter v. Pinckneyville Corr. Ctr.*, 13 I.W.C.C. 0634 (2013); *Craig Briley v. Pinckneyville Corr. Ctr.*, 13 I.W.C.C. 0519 (2013). Based upon the foregoing, the Arbitrator finds the causation opinion of Dr. Brown to be credible and finds that Petitioner met her burden of proof in establishing that she sustained accidental injuries that arose out of and in the course of her employment with Respondent which are causally related to her current condition of ill-being.

Issue (D): What was the date of the accident?
Issue (E): Was timely notice of the accident given to Respondent?

Repetitive-trauma injuries occupy an odd niche between accidental injury, compensable under the Act, and occupational disease, compensable under the Workers' Occupational Diseases Act. *A.C. & S. v. Indus. Comm'n*, 304 Ill. App. 3d 875, 879, 710 N.E.2d 837, 840 (Ill. App. 1st Dist., 1999). In choosing to cover such injuries as accidental injuries, as noted by the Appellate Court in *A.C. & S.*, the Supreme Court **deliberately** modified the standards for determining the date of injury for repetitive trauma cases in order provide protection for injured workers. *A.C. & S. v. Industrial Commission*, 304 Ill.App.3d 875, 710 N.E.2d 837, 840-841 (Ill. App. 1st Dist., 1999). Even though carpal tunnel syndrome is not treated as an occupational disease in Illinois, we still look to the Occupational Diseases Act for guidance. *Id.*

The Workers' Compensation Act is a humane law of a remedial nature that should be liberally construed to achieve its purpose. *Hagene v. Derek Polling Const.*, 388 Ill. App. 3d 380, 902 N.E.2d 1269 (2009). Hence, the Supreme Court has established a flexible but fair standard for determining manifestation dates. *Durand v. Industrial Commission*, 224 Ill.2d 53, 862 N.E.2d 918 (2007). Although the date on which the employee becomes aware that he has a condition related to work was the first method for determining a manifestation date, it is not the only permissible means for alleging or proving manifestation. The manifestation date can be set as: **(a)** the date the employee actually became aware of the physical condition and its relation to work through medical consultation; **(b)** the date the employee requires medical treatment; **(c)** the date on which the employee can no longer perform work activities; or **(d)** when a reasonable person would have plainly recognized the injury and its relation to work. *Durand v. Industrial Commission*, 224 Ill.2d 53, 862 N.E.2d 918 (2007), *see also Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987); *Oscar Mayer & Co. v. Industrial Commission*, 176 Ill.App.3d 607, 531 N.E.2d 174 (3rd Dist. 1988); *Three "D" Discount Store v. Industrial Commission*, 198 Ill.App.3d 43, 556 N.E.2d 261 (4th Dist. 1989).

Although a claimant is aware of symptoms and carries a suspicion that these are work-related, the Supreme Court has stated, "The 'fact of injury' is not synonymous with the 'fact of discovery'" *Durand*, N.E.2d at 927. In short, claimants are not charged with filing a claim as soon as they believe they *may* have a work-related condition, nor are they penalized for failing to realize a condition is work-related when the employer feels that he or she should have. In fact, the Supreme Court stated that to rely solely on a claimant's testimony concerning symptoms, without accurate knowledge of the cause of those symptoms, would essentially be asking them to "rely on 'expert' medical testimony from a layperson." *Id.* at 929. The Court likewise noted that

the claimants would have had difficulty proving injury with a sketchy and equivocal understanding of same. *Id.* at 930. The standard that "the 'fact of injury' is not synonymous with the 'fact of discovery'" has since become a safety measure employed by all Courts to ensure that the employers do "penalize an employee who diligently worked through" his or her symptoms. *Durand v. Indus. Comm'n*, 862 N.E.2d at 927, 930. In *Oscar Mayer*, the Court embraced the "date of collapse" method of determination (setting the manifestation date on the date of surgery, or the date the employee could no longer work), allowing compensation to be awarded to a claimant despite his full knowledge that his condition was work-related well before he filed a claim because the claimant diligently served his employer until he could no longer do so without intervention for his repetitive injuries. *Oscar Mayer supra.* The Court noted that no prejudice can occur in employing such a method, since it is not until the employee actually misses work for his injuries that the employer becomes adversely affected; and the notice provisions were not impugned as this flexible and fair provision in no way interfered with an employer's ability to effectively investigate the claim.

In *Three "D" Discount Store v. Industrial Commission*, 198 Ill.App.3d 43, 556 N.E.2d 261 (4th Dist. 1989), the Appellate Court held that even though the claimant had previously sought treatment and received a diagnosis for his condition, his injuries manifested on the date that he was advised by a physician that his condition was work-related. *Three "D" Discount Store v. Industrial Commission*, 198 Ill.App.3d 43, 556 N.E.2d 261 (4th Dist. 1989).

In *Three "D" Discount,* the claimant sought treatment with his family physician, Dr. Johnson, who referred him to a Dr. Block for evaluation. *Three "D" Discount Store v. Industrial Commission*, 198 Ill.App.3d 43, 556 N.E.2d 261 (4th Dist. 1989). Dr. Block performed an EMG study and a physical examination of the claimant, and sent the EMG results to Dr. Johnson. *Id.* Dr. Block's report stated that his examination suggested bilateral carpal tunnel syndrome. *Id.* Dr. Johnson **discussed the results of the EMG with the claimant** and referred him to a Dr. McKechnie. Claimant reported to Dr. McKechnie and gave a history of his symptoms, **but did not state that his condition was work-related or that Dr. Johnson had so informed him.** Dr. McKechnie scheduled the claimant for surgery, and the claimant notified his employer that he required surgery and that it was his physician's opinion that that the condition was related to work. The Appellate Court found that Petitioner's manifestation date was the day he met with Dr. McKechnie and stated the following:

> The evidence in this case establishes that Dr. Carl Johnson discussed Dr. Block's report of the EMG results with petitioner. . . **No direct evidence was presented regarding whether Dr. Johnson ever told Petitioner that his injury was work related.** . . . It was not until July 10, when petitioner met with Dr. McKechnie, that it became clear that petitioner's condition necessitated surgery. . . Based on the evidence of record, it could be reasonably inferred that petitioner first learned that his condition of ill-being was work-related at some point between July 10, and the first of August, 1984. Applying the reasonable person test to these facts, we find that although petitioner persisted in his employment until August 10, a reasonable person in these circumstances would have been on notice that the condition was both work-related and medically disabling on July 10,

1984. *Three "D" Discount Store v. Industrial Commission*, 556 N.E.2d 261, (1989) [emphasis ours].

The Arbitrator finds *Three "D" Discount Store v. Industrial Commission*, 198 Ill.App.3d 43, 556 N.E.2d 261 (4th Dist. 1989) dispositive in Petitioner's case. Although Petitioner sought treatment for her symptoms in the past and possibly received a tentative diagnosis of carpal tunnel syndrome, it is clear that Petitioner did not have a clear understanding of her condition and her relation to work. Significantly, Petitioner was seeing a chiropractor rather than a hand specialist. She testified that she thought her symptoms were coming from her neck. (Transcript of 11/13/14, p.9-12). The Arbitrator thus finds her testimony credible. Petitioner testified that her condition and its relation to her employment first became clear to her when she sought treatment with Dr. Brown and was advised that her condition was related to work. (Transcript of 8/26/14, p.34).

The law also allows Petitioner to select a manifestation date that coincides with discovery of injury and its relation to work after medical consultation. See *Steven Beal v. Town of Normal,* 06 IL.W.C. 25261, 10 I.W.C.C. 0380 (2010); *see also White v Worker's Compensation Commission*, 374 Ill.App.3d 907, 873 N.E.2d 388, 392-393 (4th Dist. 2007) (holding Petitioner could select accident date); *A.C. & S. v. Industrial Commission*, 304 Ill.App.3d 875, 710 N.E.2d 837, 841-842 (1st Dist. 1999).

The Arbitrator therefore finds that Petitioner met her burden of proof in establishing that her injuries manifested on September 29, 2010. Petitioner completed and submitted a Notice of Injury on October 8, 2010. (RX3). Therefore, Petitioner provided timely notice of her accidental injuries under the Act.

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? And;
Issue (K): What temporary benefits are in dispute? (TTD)
Issue (N): Is Respondent due any credit?

Respondent provided temporary total disability benefits to Petitioner for the period claimed, but disputes liability and requests credit. Respondent also disputes liability for medical expenses. (AX1).

Upon a claimant's establishment of a causal nexus between injury and illness, employers are responsible for the employees' medical care reasonably required in order to diagnose, relieve, or cure the effects of the claimant's injury. *Plantation Mfg. Co. v. Indus. Comm'n,* 294 Ill.App.3d 705, 691 N.E.2d 13 (2000); *F & B Mfg. Co. v. Indus. Comm'n*, 325 Ill.App.3d 527, 758 N.E.2d 18 (1st Dist. 2001).

Causal connection has been resolved in Petitioner's favor, and Respondent's records reviewer, Dr. Williams, agreed with Petitioner's diagnosis and the reasonableness of her treatment. (RX10). Respondent is therefore ordered to pay the medical expenses contained in Petitioner's group exhibit and shall have credit for any amounts paid through its group carrier. Respondent shall indemnify and hold Petitioner harmless from any claims from these medical

providers arising out of the expenses for which it claims credit. The Arbitrator further finds that Petitioner is entitled to the temporary total disability benefits for her period of disability from November 5, 2010, to January 2, 2011, a period of 8 3/7 days. Petitioner is therefore entitled to $6,062.98 in TTD benefits, of which Respondent only paid $4,932.48 due to the issuance of service connected benefits. Therefore, the Arbitrator finds that no overpayment in benefits has been made.

Issue (L): What is the nature and extent of the injury?

Petitioner's injuries occurred before the effective date of the Amendment of §8.1b of the Act.

As a result of her work-related injuries, Petitioner developed severe chronic bilateral carpal tunnel syndrome, right greater than left, and bilateral cubital tunnel syndrome. (PX3; PX4). Objective intraoperative findings during her right and left carpal tunnel releases included a flattened nerve within the carpal tunnels. (PX5). Petitioner testified that despite the improvement resulting from surgery, she continued to have soreness around the surgery site when she uses her hands a lot or when she puts downward pressure on her hands. (Transcript of 8/26/14, p.35). Petitioner testified that she continues to experience numbness in her hands that comes and goes. (Transcript of 8/26/14, p.36). She testified that her hands and arms are tired and very heavy at the end of her shift. (Transcript of 8/26/14, p.36). Petitioner testified that she has to stretch her arms out to improve her symptoms. (Transcript of 8/26/14, p.36). Petitioner also testified to loss of grip strength. (Transcript of 8/26/14, p.36). She testified that she has to take things a lot slower than she used to. (Transcript of 8/26/14, p.36). Petitioner takes Tylenol as needed for her symptoms. (Transcript of 8/26/14, p.37).

Based upon the foregoing, Petitioner sustained serious and permanent injuries that resulted in the 20% loss of her right and left hands and the 5% loss of her right and left arms.

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

Teddy Ray Price,
Petitioner,

15IWCC0852

vs.

NO: 11 WC 13882

SOI/Shawnee Correctional Center,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 28, 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: NOV 2 0 2015
o10/21/15
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0852

PRICE, TEDDY RAY Case# **11WC013882**

Employee/Petitioner

SOI/SHAWNEE CORRECTIONAL CENTER

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:

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

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

0558 ASSISTANT ATTORNEY GENERAL
KENTON J OWENS
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MANAGEMENT SYSTEMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JAN 28 2015

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

15IWCC0852

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Teddy Ray Price
Employee/Petitioner

v.

State of Illinois/Shawnee Correctional Center
Employer/Respondent

Case #**11** WC **13882**

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**, 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. [x] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] 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 [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other Fraud

FINDINGS

On **02/10/11**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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 $**56,141.25**; the average weekly wage was $**1,079.64**.

On the date of accident, Petitioner was **35** years of age, ***single*** 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 $-for TTD, $- for TPD, $- for maintenance, and $- for other benefits, for a total credit of $-.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $647.78/week for 50 weeks, because the injuries sustained caused the 10% loss of the person as a whole pursuant to Section 8(d)2 of the Act.

Respondent shall pay reasonable and necessary medical services as set forth in PX 1 subject to the Medical Fee Schedule and with Respondent receiving credit pursuant to Section 8(j) of the Act for any bills that have been paid by its group medical plan. 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 to Petitioner compensation that has accrued between February 10, 2011 and December 4, 2014 and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

January 25, 2015
Date

JAN 28 2015

Teddy Ray Price v. State of Illinois/Shawnee Correctional Center 11 WC 13882

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

On February 11, 2011 Petitioner presented to the office of Dr. Watters (Primary Group Care) complaining of left shoulder pain which he attributed to lifting a gun tower door weighing about 100 lbs. while at work the day before. Petitioner complained of pain and decreased range of motion. An x-ray and medication were prescribed. (PX 3; PX 4)

Petitioner returned to Dr. Watters' office on February 16, 2011 reporting improvement but some limited range of motion. Petitioner's exam was consistent with his complaints and he was formally diagnosed with a strain and asked to return in five days. (PX 3)

As of February 21, 2011 when Petitioner returned to Dr. Watters' office, Petitioner had been doing better but he had re-injured his shoulder when the wind caught a door and pulled his left shoulder. Petitioner was advised to try therapy. (PX 3)

Petitioner remained symptomatic and by March 9, 2011 Dr. Watters was ordering an MRI. (PX 3)

Petitioner then returned to see Dr. Watters on March 31, 2011 reporting that the MRI had been denied by workers' compensation. (PX 3)

Petitioner was examined by Dr. Paletta on April 6, 2011, a visit arranged by his attorney. Petitioner gave a history of bending to open the floor door hatch in the gun tower on February 10, 2011 at which time he felt a pop in his left shoulder. Dr. Paletta suspected a SLAP tear and ordered an MRI. He further felt Petitioner's mechanism of injury was consistent with a possible traumatic SLAP tear and that his current complaints were causally related to his work injury. He felt Petitioner should remain off work. (PX 5)

On April 11, 2011 Petitioner filed his Application for Adjustment of Claim in this case alleging left shoulder injuries due to a lifting accident on February 10, 2011. (AX 2)

Petitioner underwent an MRI of his left shoulder on April 13, 2011 which revealed a superior labral tear and secondary subacromial bursitis. (PX 3; PX 5; PX 6)

Petitioner returned to see Dr. Watters on April 15, 2011 reporting that he had been examined by Dr. Paletta and undergone an MRI which revealed a slap tear. Petitioner had chosen to proceed with surgery. (PX 3)

Dr. Paletta performed left shoulder surgery on April 19, 2011. (PX 5, 7, 8) Dr. Paletta repaired a partial thickness rotator cuff tear and repaired a labral tear. (Id.) Petitioner followed up with Dr. Paletta post-operatively. (PX 5)

Petitioner's case went to trial before Arbitrator Nalefski on May 11, 2011 pursuant to a Petition for Immediate Hearing filed under Section 19(b) of the Act. The issues in dispute at that time were: accident; causal connection; medical bills; and temporary total disability benefits. (PX 10)

At the first hearing Petitioner testified that he was employed by Respondent on February 10, 2011 at which time he injured his left shoulder while working in the tower near the end of his shift. Petitioner testified that the relief officer was coming into the tower and as Petitioner unlocked the tower door to let him in, he heard a pop in his shoulder. Petitioner estimated the weight of the door at between 80 and 100 lbs. and explained that the door was located in the floor and had to be lifted open to let the relief officer in. Petitioner further testified that he reported it the next day after it got worse at home that evening. Petitioner then proceeded to obtain treatment at Primary Care Group in Harrisburg. (PX 10)

During the hearing Petitioner acknowledged that he was a pretty athletic guy and worked out. He denied having injured his shoulder or arm prior to his accident on February 10, 2011. (PX 10)

On cross-examination Petitioner was asked about a trip he took to Florida around March 14, 2011. He also denied working out after February 11th. He acknowledged sending an e-mail or text message to someone on February 5, 2011 in which he discussed having undergone an "awesome chest workout" the day before and getting ready for his Florida vacation. Petitioner was also asked about an altercation involving law enforcement that took place in Harrisburg about a month before his arbitration hearing -- more specifically, the same day he underwent his left shoulder MRI. Petitioner acknowledged being charged with battery. Petitioner also denied hurting his shoulder lifting weights. He denied any other workers' compensation claims involving his shoulder. (PX 10)

In a decision dated May 20, 2011 Arbitrator Nalefski found in favor of Petitioner on the issue of accident and awarded temporary total disability benefits from February 11, 2011 through May 11, 2011, and medical bills. In his decision the Arbitrator specifically found Petitioner's testimony to be credible. He also noted that no direct testimony was provided as to what occurred when Petitioner was arrested for battery and that no documents were offered regarding the incident. (PX 9)

Petitioner underwent physical therapy for his left shoulder from May 4, 2011 through August 10, 2011. (PX 8)

Petitioner last saw Dr. Paletta on August 8, 2011. (PX 5) It was noted that Petitioner was doing "exceedingly well." At that time it was noted that an examination of Petitioner's left shoulder was "entirely normal." (Id.) The exam also noted that Petitioner had full unrestricted pain-free

range of motion equal to the opposite side. (Id.) Petitioner stated his shoulder felt great and he was anxious to return to work and begin full weightlifting activities. Dr. Paletta noted that Petitioner had an excellent outcome, was able to resume full activities, had no restrictions and did not require any additional care and treatment. (Id.)

The Commission affirmed the Arbitrator's Decision on January 19, 2012. (PX 9)

On May 15, 2012 a hearing was held before Arbitrator Granada after the parties requested to go on the record for a pre-trial conference. Petitioner had set the case for hearing on the issue of nature and extent; however, Respondent wished to also raise issues of accident, notice, and causal connection after having conducted some investigation and concluding that it did not believe Petitioner suffered a workplace injury. Since Respondent was raising the issue of fraud, Respondent felt the issues of accident, notice, and causation could be revisited. The Arbitrator advised the parties that if they proceeded to hearing that day he would allow evidence as to fraud to come in. (RX 5)

On November 13, 2012 a hearing was held before Arbitrator Granada as the case had again been set for hearing on the issue of nature and extent by Petitioner's attorneys. At the hearing the Arbitrator was advised that Respondent wished to place the issues of accident and causal connection as disputed issues in the case. Petitioner objected and raised a Motion in Limine to prohibit certain testimony as to fraud arguing that the issues of accident and causal connection had already been decided by the Commission and that re-litigating those issues was prohibited by the law of the case doctrine, res judicata, collateral estoppal, jurisdiction, res judicata, and prejudice. At the conclusion of the hearing Arbitrator Granada entered an order denying Petitioner's Motion in Limine. Petitioner's case did not go forward to trial. An appeal of the Arbitrator's Order followed. (RX 7, 8)

In a decision entered on January 15, 2014 the Commission remanded the case back to Arbitrator Granada for further proceedings and affirmed the Petition for Review filed December 18, 2012. (RX 9)

On September 3, 2014 the case was noticed up for hearing before this Arbitrator. Petitioner failed to appear and, by agreement, the case was continued for hearing until December 1, 2014. (RX 7)

Petitioner's case proceeded to arbitration on December 4, 2014, by agreement. The disputed issues were accident, notice, causation, fraud and nature and extent. Witnesses testifying at the hearing included Petitioner and Sabrina Stout-Mason.

Petitioner testified that shortly before his first 19(b) hearing he proceeded to have surgery on his left shoulder. Thereafter, he received some physical therapy and faithfully did his home exercises.

Respondent submitted evidence showing that on July 19, 2011 Petitioner was charged with violating an order of protection involving Sabrina Rae Stout. On September 27, 2011 Petitioner was charged with domestic battery. On September 29, 2011 Petitioner was charged with a Felony criminal damage to property charge in Saline County case number 11-CF-301 stemming from alleged damage to a Grand Am and Chevy automobiles occurring on May 28, 2011. (RX 3)

Petitioner testified he was laid off/terminated from the prison in 2011. Petitioner recalled going back to work at the prison for a brief period of time after his surgery. He returned to work as a correctional officer. There were then some disciplinary proceedings and Petitioner was terminated.

On March 16, 2012 Petitioner was charged with violating an order of protection involving Gary W. Mason. (RX 3)

Petitioner further testified that after his termination from Respondent, Petitioner worked for Mike Dover Construction Corporation doing mine construction. That lasted about 4-5 months. He then went to work for Local 143, the concrete finishers union and worked out of the hall for about a year and a half.

According to exhibits tendered by Respondent a jury trial was held beginning on June 6, 2012 regarding the Saline County felony charge and Petitioner was found guilty of two counts of felony criminal damage to property by the jury on June 8, 2012. (RX 2) On October 18, 2012 Petitioner was sentenced to Probation for the two felony counts of criminal damage to property. (RX 1)

Petitioner testified that despite his surgery he still has some problems with his shoulder including a pretty high level of pain inside his shoulder. When he uses it a lot, it hurts. Petitioner also testified that he can't use his left arm when he drives and has to "switch up" a lot.

Petitioner has been employed by Pattiki Coal Mine for the last two months where he lifts heavy things and runs machines. At the end of his shift he hurts. Petitioner testified that he takes Ibuprofen every day before he goes. Petitioner also testified that he can't help his daughter with her cheerleading exercises and can't his hold son when he wants to be held. Petitioner further testified that he can no longer ride his 4-wheeler without being in pain. When he lifts his left arm overhead it gets to a certain degree and he is real leery of it because of pain.

On cross-examination Petitioner acknowledged he has not been back to see Dr. Paletta since August 8, 2011. Petitioner could not recall telling Dr. Paletta he was ready to begin full weightlifting activities at the time of that visit. It was also difficult for him to remember telling the doctor his shoulder felt great. However, if the records stated that, he had no quarrel. Petitioner did, however, disagree with Dr. Paletta's note that Petitioner's left shoulder had full unrestricted pain-free range of motion equal to the opposite side as he didn't feel his left shoulder has ever been equal to his right side. He acknowledged meeting all of his therapy goals and

cancelling his last appointment because Dr. Paletta had released him. Petitioner testified that his pain level may have been a "0/10" on his last visit with Dr. Paletta but that was because he wasn't really doing anything with it.

Petitioner testified that he no longer belongs to a gym and doesn't bow hunt because the last time he tried it his shoulder hurt.

Petitioner was also shown some photographs (RX 13) but could not recall when they were taken.

Petitioner acknowledged being convicted of a felony but added that the case is being appealed. He acknowledged that he was sentenced to probation as a result of the conviction. His probation will be finished in March of 2015.

Concerning his accident of February 10, 2011 Petitioner recalled that he was working the day shift and injured himself near the end of the shift. He testified that he was in gun tower 4 and an officer was coming to relieve him. As he was coming up the stairs Petitioner had to open a hatch/door in the floor to admit him and when he stood up and pulled with his arm to pull it up, he felt a pop in his shoulder. Petitioner recalled telling the officer about how he felt the pop. Petitioner denied any prior left shoulder injuries.

Petitioner denied being in a bar fight in Carbondale in December of 2010 or January or February of 2011 and injuring his shoulder. Petitioner testified, "No, I never said I hurt my shoulder about any bar fight."

Petitioner acknowledged a prior workers' compensation claim (RX 12) for back injuries that was settled.

Petitioner acknowledged that he is right handed.

Respondent called Sabrina Stout-Mason as a witness. Ms. Mason, age 29, testified pursuant to subpoena. Ms. Mason works as a family nurse practitioner at the Harrisburg Medical Center.

Ms. Mason testified that she dated Petitioner from 2008 to the "end" of 2010. Following the break-up Ms. Mason and Petitioner spoke on occasion. Ms. Mason was aware of a settlement Petitioner received in 2010. Ms. Mason was also aware that Petitioner had filed a workers' compensation claim for an accident that happened in February of 2011 involving his left shoulder. Ms. Mason was asked if Petitioner ever told her how he injured his left shoulder and she said he did. Ms. Mason testified that Petitioner came over to her house some time after they had broken up and in the morning and when she asked him why he wasn't working that day he told her he had hurt his shoulder. According to Ms. Mason, Petitioner said he had been in Carbondale the night before and got into an altercation at one of the bars over there and he went to hit a man with his right arm and a bouncer grabbed his left shoulder. Ms. Mason also testified that she and Petitioner have had some "legal involvement" since 2011.

On cross-examination Petitioner testified that the fight occurred in the winter and she thought it was in February or January. She didn't know if Petitioner kept working after the bar fight. She didn't know if Petitioner received any medical care or treatment for injuries as a result of a bar fight. She never saw a police report concerning any fight. She never called the police or asked if what he told her actually happened. Ms. Mason also acknowledged that when Petitioner came over that morning she didn't see him without his shirt on so she didn't know if he had any physical signs of a fight on his person. She also acknowledged that she had absolutely no way of knowing whether or not he injured himself at work on February 11, 2011.

On rebuttal Petitioner testified that he has a Facebook account and anyone who is his friend can look at the pictures that have been posted. (RX 13)

Respondent tendered additional exhibits at the December 4, 2014 hearing. RX 10 is Petitioner's Workers' Compensation Log. This includes accident/incident reports for the February 11, 2011 accident. According to the Incident Report completed by Petitioner on February 12, 2011,

> On the above date/time approx. this R/O Price 7963
>
> unlocked tower door (on the floor) to let C/O R. Alsip
>
> in for shift change. When this R/O grabbed the door
>
> handle and lifted the door this R/O felt his left shoulder
>
> pop. This R/O has been to [the doctor] for treatment. (RX 10)

Petitioner was off work on February 8th and 9th, 2011. (RX 11) Petitioner worked on February 10, 2011 and received five service connected dates thereafter and then went on a leave of absence beginning February 18, 2011. (RX 11)

The Arbitrator concludes:

Issue (O) Fraud:

The Arbitrator is taking the issue of fraud with the case as directed by the Commission.

Section 19(b) of the Act states the "[t]he decision shall become the decision of the Commission and in the absence of fraud shall be conclusive." 810 ILCS 305/19(b) (2011)

Section 25.5 of the Workers' Compensation Act makes it unlawful for any person to intentionally present or cause to be presented any false or fraudulent claim for the payment of workers' compensation benefits or to intentionally make or cause to be made any false or fraudulent material statement or representation for the purpose of obtaining any workers' compensation benefit.

The Arbitrator concludes that Respondent has failed to show Petitioner made any statement, intentional and material, or pursued a false or fraudulent claim in order to recover workers' compensation benefits. Respondent appears to be contending that Petitioner's testimony regarding his accident is insufficient to support an award as it is uncorroborated being based solely upon his testimony. Respondent also contends that Petitioner's testimony as to an accident at work on February 10, 2011 is contradicted by evidence regarding a bar fight taking place in Carbondale in January or February of 2011 at which time Petitioner allegedly injured his left shoulder. Respondent argues that Ms. Stout-Mason's testimony is more credible that Petitioner's, especially given his felony conviction.

During both trials in this matter Petitioner testified that he injured his left shoulder on February 10, 2011 while opening a hatch while working for Respondent. (PX 10, pg. 11) Additionally, Petitioner denied ever injuring his left shoulder prior to February 10, 2011. (PX 10)

Petitioner sought medical treatment on February 11, 2011 with Dr. Roger Watters. (PX 3)
Petitioner first reported his injury to Respondent on February 13, 2011. (RX 10)

The problem with Respondent's argument is that Ms. Stout-Mason's testimony and Petitioner's testimony were not that inconsistent. Petitioner may have been in a bar fight and may have had his left shoulder/arm grabbed by a bouncer; however, there is no evidence that he really injured his left shoulder at that time. Furthermore, Ms. Stout-Mason's testimony does not negate that an accident occurred at work on February 11, 2011. First, Ms. Mason could not recall exactly when her conversation with Petitioner occurred -- only that she thought it was in January or February of 2011. Furthermore, she could not deny that Petitioner injured his shoulder at work on February 10, 2011. In addition, and of great significance, is the fact there was a witness to the accident at work. Petitioner testified at the first 19(b) hearing that he told the officer taking over his shift that he had felt a pop in his shoulder. He identified the officer in his written report of injury. That officer never testified to rebut Petitioner's testimony. Thus, Petitioner's testimony as to an accident on February 11, 2011 at work for Respondent is unrebutted. It is also corroborated by the treating medical records.

Based upon her decision on the issue of fraud, the issues of accident, date of accident, causal connection, and temporary total disability are moot, having been previously decided by the Commission. It is well-settled law that in Workers' Compensation, each §19(b) hearing is a separate proceeding and constitutes a separate and appealable order. *Weyer v. Illinois Workers' Comp. Comm'n*, 900 N.E.2d 360 (1st Dist. 2008) citing *R.D. Masonry, Inc.*, 830 N.E.2d 584 (Ill. 2005); *Elmhurst-Chicago Stone Co. v. Indus. Comm'n*, 646 N.E.2d 961 (2nd Dist. 1995). However, once a specific issue or question of law or fact has been decided in the course of litigation, it cannot be rehashed at a subsequent time. The law-of-the-case doctrine is a fundamental legal principle which provides stability and an equitable means by which Parties can proceed through litigation with reasonable expectations as to their burdens of proof. Specifically, the Appellate Court has held that:

> The rule of the law of the case is a rule of practice, based on sound policy that, where an issue is once litigated and decided, that should be the end of the matter and the unreversed decision of a question of law or fact made during the course of litigation settles that question for all subsequent stages of the suit. *Irizarry v. Indus. Comm'n*, 786 N.E.2d 218 (2nd Dist. 2003) citing *McDonald's Corp. v. Vittorio Ricci Chicago, Inc.*, 466 N.E.2d 1116 (Ill. 1984).

The Appellate Court has held that the law-of-the-case doctrine applies to the unreversed decision of an Arbitrator or the Commission in Workers' Compensation proceedings. *Weyer* citing *Irizarry v. Indus. Comm'n*, 786 N.E.2d 218 (2nd Dist. 2003).

The Arbitrator thus concludes that, under the law of the case, the Commission's Decision of January 19, 2012, regarding accident and causal connection stands.

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

Petitioner's current condition of ill-being in his left shoulder is causally related to his February 11, 2011 accident. This conclusion is based upon Petitioner's testimony, the treating records, and a chain of events. Respondent failed to produce any evidence or witness testimony to show that there was an intervening accident in which Petitioner injured his shoulder. While Respondent has been charged with additional criminal offenses since his February 10, 2011 accident, no evidence was presented establishing injuries to Petitioner's left shoulder occurred during those alleged events.

Issue (J) - Medical services.

Petitioner's medical bills are found in PX 1. Pursuant to the agreement of the attorneys at the time of arbitration and consistent with her decision herein, Petitioner is awarded those bills found in PX 1 that have been incurred since the initial 19(b) hearing held on May 11, 2011. Respondent shall receive credit for any medical bills previously paid or paid by its group medical plan for which credit may be allowed under Section 8(j) of the Act with Respondent indemnifying and holding Petitioner harmless from any requests for reimbursement.

Issue (L) - What is the nature and extent of the injury?

The credibility of Petitioner is called into doubt given his conviction of a felony, a crime punishable by more than a year in prison under Illinois law, in Saline County case number 11-CF-301. (RX 1)(Ill. Sup. Ct. Rule 609(West 2011) Additionally the Arbitrator found Petitioner's testimony regarding his ongoing symptoms and complaints in his left shoulder somewhat troubling, given the gap in time since he was released by Dr. Paletta and his failure to return to see him for those complaints. He has certainly had time to return to see if him if he felt he

needed to. Furthermore, the Arbitrator was troubled by Petitioner's difficulty in recalling just how good his left shoulder was when he last saw Dr. Paletta. Petitioner has been working for other employers for several years now in quite physical jobs. There is no evidence suggesting he could not perform any of these jobs or moved on to other jobs due to problems or concerns with his left shoulder. In sum, the Arbitrator is not entirely convinced about the true nature of Petitioner's left shoulder disability given the lack of objective corroboration for any such complaints.

As a result of his work injury, Petitioner sustained a SLAP tear which required surgery. Objectively, Petitioner has had an excellent recovery and returned to his regular job for Respondent. His termination from Respondent's employment had nothing to do with his injury. Despite subjective complaints of pain and limitation, Petitioner has continued to work in physically demanding jobs and has not returned to Dr. Paletta in over three years for any care. Petitioner's injury was to his non-dominant extremity. The Arbitrator therefore concludes that Petitioner has sustained serious and permanent injuries that resulted in the 10% loss of his body as a whole.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Carl White,

Petitioner,

vs.

NO: 11WC 21495

15IWCC0858

EHC Industries,

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 average weekly wage, vocational rehabilitation 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 13, 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 $9,100.00. 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: NOV 2 3 2015
o111215
DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

WHITE, CARL
Employee/Petitioner

Case# **11WC021495**

15IWCC0858

EHC INDUSTRIES
Employer/Respondent

On 3/13/2015, 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 0.09% 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:

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

1454 THOMAS & ASSOCIATES
STEVEN COSTELLO
300 S RIVERSIDE PLZ SUITE 2330
CHICAGO, IL 60606

15IWCC0858

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

- [ ] 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)

Carl White,
Employee/Petitioner

v.

EHC Industries,
Employer/Respondent

Case # 11 WC 21495

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 **Peter M. O'Malley**, Arbitrator of the Commission, in the city of **New Lenox**, on **11/13/14**. 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [x] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] Is Petitioner entitled to any prospective medical care?
L. [ ] 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 **Vocational Rehabilitation**

15IWCC0858

FINDINGS

On the date of accident, **8/18/10**, 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 current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned $66,922.49; the average weekly wage was $1,442.10.

On the date of accident, Petitioner was **40** 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 **$173,587.24** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$173,587.24**. (Arb.Ex.#1).

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 $961.40 per week for 188-4/7 weeks, commencing 8/19/10-4-24-11, 5/6/11-5/6/11, 5/25/11-6/5/11, 6/12/11-6/25/11, 8/14/11-8/20/11, 8/28/11-9/10/11, 9/18/11-1/7/12, 1/29/12-2/11/12, 2/26/12-6/17/12, 9/21/12-11/13/14, as provided in Section 8(b) of the Act. (See Arb.Ex.#1).

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 8/19/10 through 11/13/14, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $173,587.24 for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services of $1,257.00, as provided in Sections 8(a) and 8.2 of the Act.

Petitioner is entitled to ongoing vocational rehabilitation services in the form of a vocational assessment, and Respondent shall pay the reasonable and necessary costs associated therewith, as provided in §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

3/2/15
Date

ICArbDec19(b)

MAR 13 2015

15IWCC0858

STATEMENT OF FACTS:

Petitioner, a 40 year old asbestos and lead removal foreman, testified that he left school and got married at the age of 17 in 1987 when his girlfriend became pregnant. During his junior year in high school, Petitioner was awarded a grant to attend summer classes at Rensselaer Polytechnic School in New York for college credit. However, Petitioner never attended these summer classes. Instead, he began working in a factory and took a second job delivering pizzas. In 1989 he received his GED and took some colleges courses at Moraine Valley Community College, including trigonometry and calculus 1.

In June of 1989 Petitioner joined Laborer's Local 225 union when he started working with asbestos abatement. He is currently still a member. Petitioner worked for Diversified Abatement Corporation and as part of his job, removed hazardous material asbestos in piping, steeling, tile, floor tiles, and plaster. He would also set up an area with frames and construct plastic, put in abatement machines. The asbestos abatement field is more a demolition side of the construction field. As part of his job, Petitioner would lift, and use plastic and tape and caps, roll of 20 foot by 100 foot by 6 millimeters that weighs approximately 50 pounds. While working for Respondent, Petitioner would use tools, such as hand scrapers and sledge hammers. The jackhammers were some of the pneumatic tools he would use, and the jackhammers would weigh 30, 60, and 90 pounds. Petitioner started working for Respondent in 1993. He worked 17 years straight for Respondent, from 1993 through the accident date in 2010.

At the time of the accident, Petitioner was a working foreman. He noted that he started working as a foreman supervisor in 1994 and that as part of his job he would at times supervise crews of up to 40 men. Respondent's business involved demolition and removing of asbestos, lead and mold. At the time of the accident, he was earning $36.45 per hour, or $1.25 over the union scale of $35.20 per hour. Petitioner earned this amount above scale from 1995 up until his injury. The current pay for local 225 laborers is $38.20 per hour. As a foreman, Petitioner would earn $39.45 an hour. He testified that overtime was mandatory and that he would at times work on Saturdays, which was also mandatory. He also indicated that he would have to pay the Illinois Department of Environmental Protection a yearly fee to keep his license in standing for both worker and asbestos supervisor. In addition, he has to take an annual 8 hour refresher course and he also carries a license for a lead supervisor.

On August 18, 2010, Petitioner was working for Respondent at Argonne National Laboratory assisting with duct work removal. He was on a ladder checking an outlet or junction box when the duct work fell and knocked the ladder, which caused Petitioner to fall off the ladder. He fell between 3 and four feet, landing on his wrist, fracturing his collar bone, ribs, and striking the side of his head. Prior to that date, Petitioner had not suffered any serious injury to his right arm, shoulder, neck, or head. Petitioner has not suffered any injuries since his August 18, 2010 work injury. He is right handed.

On the date of the injury Petitioner was transferred to Bolingbrook Adventist Hospital and had surgery to his right wrist. Petitioner continued to follow up with Dr. Gross, and underwent physical therapy in 2010 for his right arm and right wrist. On January 7, 2011, Petitioner underwent a second surgery to his right wrist. The record shows that Petitioner's clavicle was not surgically repaired and was left to heal itself.

Petitioner completed a Functional Capacity Evaluation (hereinafter "FCE") on June 5, 2012. (RX6). The FCE concluded that Petitioner could function in the Medium Physical Demand Category. (RX6). Dr. Gross released Petitioner from care on August 13, 2012 at which time Petitioner was given permanent restrictions of lifting floor to waist 40 pounds occasionally, waist to shoulder about 30 pounds frequently and 40 pounds occasionally, and floor to shoulder 30 pounds frequently and 40 pounds occasionally.

Petitioner has been paid disability benefits since September of 2012, but there were periods where Petitioner was working light duty for Respondent following his date of accident. Petitioner has not worked at all during the past few years but has remained in contact with his union. He also keeps in touch with Respondent. He indicated that he looks for jobs online but has seen anything paying $10.00 per hour.

At the request of Respondent, Petitioner was seen by Dr. Richard Thomas on February 23, 2012 for purposes of a §12 examination. (RX4). Following his examination and review of the record, Dr. Thomas concluded that Petitioner sustained a traumatic arthropathy to his wrist as a result of the work injury along with joint stiffness in his wrist.(RX4). Dr. Thomas noted that Petitioner has posttraumatic arthritis in his right wrist. (RX4). At the time of the exam, Dr. Thomas noted that Petitioner was currently working in a light duty capacity and believed that Petitioner could continue to work in such a capacity. (RX4).

Respondent hired a vocational rehabilitation counselor to perform a Labor Market Survey on December 17, 2012. (RX1). Counselor Dean Geroulis found jobs which offered positions within the restrictions per the August 13, 2012 report from Dr. Mark Gross. (RX1). The job earnings ranged from $8.50 per hour to $17.67 per hour. (RX1).

Petitioner testified that he would like to study accounting in light of what he considers his natural aptitude for numbers. He indicated that he has talked to counselors at Joliet Junior College and Lewis University about accounting programs. Lewis University has a four year program and when he graduates, Petitioner can sit for the CPA exam. Tuition at Lewis University is $27,830 per year. Petitioner agreed that he has never worked a desk job, and that the last time he took a sit down class was in 1997. He has had 20 years of experience in the asbestos abatement field and has worked as a foreman since 1994 earning $39.45 an hour. In 1997, Petitioner and two other foremen who were working for Respondent started a company called CAS Demolition. He indicated that he was officially secretary of the company, but that he did a little bit of everything, including physical labor. He noted that the business was very small and lasted less than one year.

Petitioner agreed that the asbestos industry does have office jobs that are not labor intensive. He indicated that an estimator working for Respondent would be a position that was not physical. He noted that a job in the field would be labor intensive, even as a foreman. He did acknowledge, however, that sometimes there was help available for lifting. Petitioner remains a current member of local 225, which covers most of the environmental works and demolition workers, and his licenses remain up to date. He indicated that the last time he contacted local 225 was possibly one month ago at which time he was told that they did not have anything within his restrictions.

On cross examination, Petitioner acknowledged that he had never tried to intern at an accountant's office and that he had never taken a class in accounting. He also agreed that there is no guarantee he will get a job following graduation. However, he indicated that there are plenty of openings in account, and that he would be willing to relocate. He noted that his goal was to earn a salary comparable to prior job, or in the $70,000 to $80,000 range. Petitioner agreed that he had not looked into obtaining any other degree besides accounting and that he had not looked into any potential scholarship money to help him attend college. He noted that Joliet Junior College would cost $5,000 each year and would take two years and that he would then have to transfer to Lewis University. He stated that he had not created a LinkedIn account. He also indicated that he had a Monster.com account but then went to CareerBuilder.com. Petitioner testified that he had spoken with Illinois Department of Public Health inspectors onsite in the past and had been told he would need a college degree. He noted that the last time he spoke to an inspector was six years ago.

Petitioner testified that he stays in contact with Respondent, having last spoken with Kevin Murphy about three weeks ago. He noted that he has never applied for a position with any federal agency like OSHA or its equivalent. He also indicated that he is proficient with a computer and can search the internet, email, text, and knows how to use various computer programs. When asked about working for a company that does consulting on asbestos removal, Petitioner answered that if he could find such a position, it would likely be part-time since he cannot physically do everything that they need He indicated that he does not belong to any organization as a hobby. He also noted that since September of 2012, he has not tried to get any unpaid internships in an accounting office or another office job. Instead, Petitioner stated that he primarily stays at home and watches over his autistic son. He described the pain he currently experiences in his right wrist as a "2" on a scale of 1 to 10, with 10 being the most painful. Finally, he noted that he does not have any family members or close friends that are accountants that could tell him about the accounting business.

Susan Entenberg was retained by Petitioner and testified by evidence deposition on September 29, 2014. (PX12). Ms. Entenberg is a vocational rehabilitation counselor who has been working in the field since 1978. (PX12, p.4). Ms. Entenberg met with Petitioner on April 16, 2014. (PX12, p.6). She noted that Petitioner was 44 years of age, divorced, with two dependent children. (PX12, p.7). He completed eleven and a half years of high school but didn't graduate, and obtained his GED in 1988 or 1989. (PX12, p.7). Ms. Entenberg testified that Petitioner could not return to his job as an asbestos remover, due to the restrictions from Dr. Gross on August 13, 2012. (PX12, p.13). Ms. Entenberg thought Petitioner was a good candidate for vocational rehabilitation. (PX12, p.14). Ms. Entenberg testified that when she met with Petitioner, he told her that he had a strong interest in being an accountant. (PX12, p.14). When asked about potential starting salaries for accountants, Ms. Entenberg said that the National Association of Colleges of Employers, the average starting salary was $52,900.00. (PX12, p.18). According to the Illinois Department of Employment Security, the entry level wage is $43,846.00. (PX12, p.18). Ms. Entenberg testified that she would recommend Petitioner move forward with completing a Bachelor's degree in accounting. (PX12, p.20). Using just his current experience to find a job, Ms. Entenberg stated that Petitioner would find more office clerical, customer service types of positions, which range from $12.00 to $17.00 an hour. (PX12, p.20). When asked about Petitioner's typical day, Ms. Entenberg mentioned that Petitioner just moved into a new house and during the day he will paint with both hands, he will cook, he will clean the house, he will do the laundry, and he does grocery shopping and can use a snow blower using only his left hand. (PX12, p.23). Petitioner told Ms. Entenberg that he enjoys fishing and shooting, having learned to pistol shoot with his left hand. (PX12, p.23). With regard to computer skills, Ms. Entenberg testified that Petitioner is proficient in the use of the internet, email, Excel, Word, and MS project. (PX12, p.23).

On cross-examination, Ms. Entenberg testified that she met with Petitioner for an hour and a half in person, and then spoke with him in a couple of telephone discussions. (PX12, p.25). Ms. Entenberg referenced the FCE completed on June 5, 2012 with regard to Petitioner's lifting restrictions. (PX12, p.29). Petitioner does not take any medications. (PX12, p.30). With regard to job searches, Ms. Entenberg testified that Petitioner told her that he has not sought employment since September of 2012. (PX12, p.35). Petitioner told Ms. Entenberg that he had not looked for work because he was told by his employer that they may have something for him. (PX12, p.46). Ms. Entenberg never contacted local 225 to see if there is a position somewhere which can accommodate Petitioner's physical restrictions. (PX12, pp.35-36). Ms. Entenberg never contacted any state or federal government agency to see if there are any positions which would be available to Petitioner. (PX12, p.36). It was Petitioner's idea to go back to school to study accounting. (PX12, p.37). Ms. Entenberg never discussed another area of studies, such as obtaining a degree in education. (PX12, p.41). However, she noted that they did not look at a degree in education because Petitioner had no interest in that field and "... those salaries are not as high as in the business [of] accounting." (PX12, p.41).

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

Based on the above, and the record taken as a whole, as well as the chain of events and Petitioner's credible testimony, the Arbitrator finds that Petitioner's current condition of ill-being, including his permanent restrictions, is causally related to the undisputed accident on August 18, 2010.

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

§10 of the Illinois Workers' Compensation Act provides the basis for computing a claimant's average weekly wage and states, in pertinent part, as follows:

> "'Average weekly wage' shall mean the actual earnings of the employee in the employment in which he was working at the time of the injury during the period of 52 weeks ending with the last day of the employee's last full pay period immediately preceding the date of injury excluding overtime, and bonus divided by 52; but if the injured employee lost 5 or more calendar days during such period, whether or not in the same week, then the earnings for the remainder of such 52 weeks shall be divided by the number of weeks and parts thereof remaining after the time so lost has been deducted. Where the employment prior to the injury extended over a period of less than 52 weeks, the method of dividing the earnings during that period by the number of weeks and parts thereof during which the employee actually earned wages shall be followed. Where by reason of the shortness of the time during which the employee has been in the employment of his employer or of the casual nature or terms of the employment, it is impractical to compute the average weekly wages as above defined, regard shall be had to the average weekly amount which during the 52 weeks previous to the injury 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." 820 ILCS 305/10 (West 2010).

"[S]ection 10 provides four different methods for 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 the 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.' (4) Finally, 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 three above 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 v. Industrial Comm'n*, 197 Ill. 2d 225, 230-31, 756 N.E.2d 822, 826, 258 Ill. Dec. 548 (2001).

Petitioner submitted into evidence, in addition to an average weekly wage analysis, a Chartis "Wage Statement" at PX6. This document reflects combined wages totaling $81,329.88, including overtime paid at varying rates that exceed his normal hourly rate, for the 52 week period extending from the week ending 8/23/09 through the week ending 8/15/10. (PX6). A review of this document reveals that Petitioner worked during 51 of the 52 weeks in question. Thus, it would appear that Petitioner lost five or more calendar days during the 52 week period, and as such, the second method of calculating average weekly wage would apply – namely, dividing Petitioner's earnings by the weeks and parts thereof remaining after the time so lost has been deducted.

As previously mentioned, the gross amount of earnings included overtime paid at varying rates, from $54.68 to $66.39. (PX6). The wage statement also reflects that Petitioner worked overtime in 20 of the 51 weeks that he worked, and that he worked a total of 1,836 in regular hours and 238.5 in overtime hours during the year preceding the injury. (PX6). Breaking this down, and using the varying overtime rates noted, Petitioner earned $66.922.49 in regular pay and $14,407.39 in overtime pay (for a grand total of $81,329.88). (PX6). The question is whether this overtime pay should be included in the calculation of Petitioner's average weekly wage.

In the case of *Airborne Express, Inc. v. Workers' Compensation Comm'n*, 372 Ill.App.3d 549, 865 N.E.2d 979, 310 Ill.Dec. 259 (1st Dist. 2007), the Illinois Appellate Court noted that Section 10 of the Act "... explicitly states that overtime is to be excluded in calculating an employee's average week wage..." and that "[o]vertime includes those hours in excess of an employee's regular weekly hours of employment that he or she is not required to work as a condition of his or her employment or which are not part of a set number of hours consistently worked each week." *Airborne Express, Inc.*, 865 N.E.2d at 982, 984.

In the present case, Petitioner testified that he worked five days a week, 32 hours per week, and that overtime was mandatory. He indicated that as foreman he had to be present on site per regulatory rules pertaining to asbestos removal. However, Petitioner did not submit into evidence any employee handbook or other documentation, such as a union contract, that would support his claim along these lines, nor did he produce any additional witnesses that would substantiate the claimed mandatory nature of these overtime hours. In addition, the wage statement submitted into evidence reflects that Petitioner did not work any set number of hours in excess of his regular work week. In fact, the wage statement reflects that Petitioner worked an irregular number of overtime hours during the course of the year preceding the injury, ranging from one (1) hour to 28 hours of overtime during a given week, and that was in addition to the 31 weeks he worked that did not include any overtime hours. Therefore, as in the case of *Airborne Express, Inc.*, supra, the Arbitrator finds that since Petitioner did not work a set number of overtime hours each week, and otherwise failed to produce documentary evidence to support his claim that said hours were mandatory, the 238.5 in overtime hours that Petitioner worked during the preceding year cannot be considered part of the regular hours that Petitioner was required to work as a condition of his employment. As such, said overtime should not be included in the calculation of Petitioner's average weekly pursuant to *Airborne Express, Inc.*, supra, and the express dictates of §10 of the Act.

Thus, utilizing the second method of calculation enunciated in *Sylvester*, supra, and using the "weeks and parts thereof," Petitioner's average weekly wage would be equal to $1,312.21 ($66,922.49 ÷ 51 weeks).

However, the Arbitrator notes that in the Request for Hearing form signed by the parties and admitted into evidence as the parties' stipulation sheet, Respondent alleged that Petitioner's average weekly wage was $1,442.10. (Arb.Ex.#1).

Section 7030.40 of the Rules Governing Practice Before the Commission provides, in pertinent part, that "... [t]he completed Request for Hearing form, signed by the parties (or their counsel), shall be filed with the Arbitrator as the stipulation of the parties and a settlement of the questions in dispute in the case." 50 Ill.Adm. Code §7030.40.

It has been held that the language of section 7030.40 indicates that the request for hearing is binding on the parties as to the claims made therein. *Walker v. Industrial Commission*, 345 Ill.App.3d 1084, 1088, 804 N.E.2d 135, 138, 281 Ill.Dec. 509 (4th Dist. 2004).

Therefore, based on the stipulation sheet, the Arbitrator finds that Respondent is bound by the claim therein that Petitioner's average weekly wage was $1,442.10. (Arb.Ex.#1). The Arbitrator further finds that Petitioner earned $66,922.49 during the year preceding the injury based on the wage statement admitted at PX6, given that said document represents the best evidence on the issue.

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:

Based on the above, and the record taken as a whole, and in light of the Arbitrator's determination as to causation (issue "F", supra), the Arbitrator finds that Petitioner is entitled to reasonable and necessary medical expenses relating to the services provided by vocational rehabilitation consultant Susan Entenberg in the amount of $1,257.00 pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

WITH RESPECT TO ISSUE (O), VOCATIONAL REHABILITATION, THE ARBITRATOR FINDS AS FOLLOWS:

§8(a) of the Act provides, in pertinent part, that "... [t]he employer shall also pay for treatment, instruction and training necessary for the physical, mental and vocational rehabilitation of the employee, including all maintenance costs and expenses incidental thereto..."

A claimant is generally entitled to rehabilitation expenses if he sustained an injury which caused a reduction in earning power and there is evidence rehabilitation will increase his earning capacity. *National Tea Co. v. Industrial Commission*, 97 Ill.2d 424, 454 N.E.2d 672, 73 Ill.Dec.575 (1983). In *National Tea Co.*, supra, the Illinois Supreme Court attempted to delineate what it termed "more flexible guidelines" for determining the reasonableness of a particular vocational program, when the employer and employee cannot agree on the proper course of rehabilitation. *National Tea Co.*, 454 N.E.2d at 675. Along these lines, the court noted that "[r]elated factors concern a claimant's potential loss of job security due to a compensable injury [Citation], and the likelihood that he will be able to obtain employment upon completion of his training. [Citation.] In contrast, rehabilitation awards have been deemed inappropriate where the claimant unsuccessfully underwent similar treatment in the past [Citation]; where he received training under a prior rehabilitation program which would enable him to resume employment [Citation]; where he is not 'trainable' due to age, education, training and occupation [Citation]; and where claimant has sufficient skills to obtain employment without further training or education [Citation]." *Id.*, at 675. Further factors noted by the Illinois Supreme Court include the costs and benefits to be derived from the rehabilitation program, the employee's work life expectancy, his capacity and motivation to undertake the program, and his prospects for recovering work capacity through medical rehabilitation or other means. *Howlett's Tree Service v. Industrial Comm'n*, 160 Ill.App.3d 190 (1987).

Prior to *National Tea*, supra, the Illinois Supreme Court determined that the Commission had properly determined that an injured pipefitter, who could not return to his prior job and had moved back to New York to complete his college degree, which in turn would be used to obtain a job teaching pipefitting and plumbing, qualified for rehabilitation benefits. *Hunter Corp. v. Industrial Comm'n*, 86 Ill.2d 489, 427 N.E.2d 1247-1251, 56 Ill.Dec. 701 (1981). However, the court went on to find that the Commission's award for rehabilitation in the form of the cost of a college education was against the manifest weight of the evidence given that there was no evidence that such a degree was a qualification to teach pipefitting. *Hunter Corp.*, at 1247. The court also found that there was no evidence that there would be teaching positions available in the field, given the

claimant's age, physical limitations, experience and background, and that perhaps the claimant could be qualified for some other remedial or vocational training. *Id.*, at 1247.

In the present case, there would appear to be sufficient proof to show that Petitioner has sustained an injury that has resulted in his inability to return to his previous job as an asbestos removal supervisor and as a result has caused a significant reduction in earning power -- given that he was earning $39.45 per hour at the time of the injury, and in light of the labor market survey obtained by Respondent which shows he is currently capable of earning between $8.50 and $17.67 per hour, a range that Petitioner's vocational consultant Susan Entenberg had pegged at $12.00 to $17.00 per hour. Furthermore, it would appear that the rehabilitation being recommended would increase Petitioner's current earning capacity – with Ms. Entenberg noting that the most recent salary survey from the National Association of Colleges of Employers showed an average starting salary for someone with an accounting degree to be $52,900.00 while the Illinois Department of Employment Security showed an entry level wage for the Chicago metropolitan area of $43,846.00 and a median wage of $68,168. (PX12, p.18).

In addition, it would appear that Petitioner has indeed sustained a potential loss of job security due to his compensable injury, at least in the field of asbestos removal, and that obtaining a college degree in accounting would greatly increase the likelihood that he will be able to obtain employment upon the completion of his training. Also, there is no evidence to suggest that Petitioner had unsuccessfully underwent similar training or treatment in the past or that he had received training under a prior rehabilitation program that would enable him to resume employment. Indeed, there is no evidence that Petitioner has done anything other than work in the asbestos removal business since 1989, and as a supervisor in that field since 1994. Furthermore, there is strong evidence to suggest that Petitioner would do quite well in the recommended program, given his professed motivation and apparent aptitude with numbers, despite his age (currently 45 years old) and in spite of the fact that he has not been in a classroom setting since 1997 when he took some math courses at a community college. Indeed, based on this evidence, and Petitioner's credible testimony, the Arbitrator has little doubt that Petitioner is entirely capable of finishing the program and obtaining an accounting degree.

However, questions arise as to the reasonableness of such a plan when one considers the anticipated cost of a formal four-year college education ($120,000+) versus the benefits to be derived from such a program from a vocational standpoint, particularly in light of Petitioner's current age (45) and expected work-life expectancy (16.3 years for a male with a GED). More to the point, the question would appear to come down to whether or not Petitioner already has sufficient skills to obtain employment without further training or education, and if not, whether Petitioner has proven that a four-year college education is reasonable under the circumstances.

As already mentioned, since dropping out of high school to get married in 1987, Petitioner has done nothing more than work in a factory, deliver pizzas and work in the asbestos removal business, a job he cannot return to given his permanent restrictions. Since 1994 he has been employed as a working foreman or supervisor for Respondent, a job that required the supervision of up to 40 men, the taking of an annual exam and the payment of a licensing fee to the Illinois Department of Public Health. In 1997 he started his own business, CAS Demolition, with several fellow foremen, only to have the company fold in less than a year.

Petitioner testified that following the injury, Respondent was able to provide him with light duty work for two years before he was let go on September 21, 2012. He indicated that since that time he has tried to obtain work in the asbestos field and that he has stayed in touch with his union. However, he noted that once companies hear about his restrictions they refuse to hire him. He also testified that he has looked for work on websites such as CareerBuilder.com and Monster.com, but that he has been unable to find any positions within his restrictions that pay more than $10.00 an hour. Petitioner provided no documentation to support his claim of any job search along these lines. Furthermore, there is no indication that Petitioner has been offered any

assistance in the form of a formal job search, either by Respondent or Ms. Entenberg. In fact, Petitioner testified that Ms. Entenberg had not recommended that he continue to look for work.

Instead, Ms. Entenberg believes Petitioner is a good candidate for vocational rehabilitation, recommending that he pursue his interest in accounting by obtaining a Bachelor of Science degree. She testified that a recent survey by the National Association of Colleges of Employers revealed the average starting salary for an accounting major was $52,900.00 while the Illinois Department of Employment Security noted an entry level wage of $43,846.00 and a median wage of $68,168. Under his current restrictions, Ms. Entenberg noted that Petitioner would be looking at office clerical or customer service types of positions which range from $12.00 to $17.00 per hour. With regard to his job search, she indicated that Petitioner had told her that he had not sought employment since September of 2012 given that he had been told by his employer that they may have something for him. Ms. Entenberg never contacted local 225 to see if there is a position somewhere which could accommodate Petitioner's physical restrictions. She never contacted any state or federal agency to see if there were any positions available for Petitioner. Indeed, Ms. Entenberg acknowledged that it was Petitioner's idea to go back to school to study accounting. In addition, Ms. Entenberg never discussed another area of study, such as obtaining a degree in education.

Based on the above, and the record taken as a whole, the Arbitrator is not persuaded that the awarding of a four-year college education is reasonable under the circumstances. More to the point, the Arbitrator questions whether other alternative vocational rehabilitation options, in the form of retraining or less costly educational programs, have been adequately explored. Petitioner is bright, motivated and has extensive experience as a supervisor in a specialized field – namely, hazardous waste disposal. And while Ms. Entenberg clearly believes Petitioner would do well in the recommended accounting program, there is no evidence to suggest that any formal job search or possible job training was ever seriously considered, let alone implemented. Petitioner testified that he has attempted to stay in touch with both his union and Respondent, and that he has looked on the internet for jobs he feels would fit his restrictions. However, Petitioner submitted no documentary evidence of this job search, and his claims along these lines were contradicted by Ms. Entenberg who testified that she was told that Mr. White had stopped looking for employment in September of 2012. Needless to say, this is less than convincing proof that no other options exist for Petitioner other than the costly and time-consuming undertaking associated with acquiring a bachelor's degree in a field of study he has absolutely no experience in.

Accordingly, the Arbitrator finds that Petitioner failed to prove that the vocational rehabilitation plan recommended by Ms. Entenberg – namely, a four-year college education with the goal of obtaining a Bachelor of Science degree in accounting – is reasonable and necessary under the circumstances. Therefore, Petitioner's claim relative to this plan is hereby denied.

However, as previously noted, the record clearly shows that Petitioner suffered a reduction in earning power as a result of the injury and that there is sufficient evidence to suggest rehabilitation will increase his earning capacity. The Arbitrator is simply not persuaded that a four-year college education in accounting is the only, or even most realistic, way to do that. Thus, the question is not so much whether Petitioner is entitled to ongoing vocational rehabilitation benefits, but what form such a rehabilitation program should take. Along these lines, the Arbitrator is reluctant to make any specific award, absent a recommendation by a physician or rehabilitation consultant, beyond the performance of a vocational assessment. Once such an assessment is performed, the parties should be in a better position to more fully evaluate Petitioner's vocational rehabilitation prospects, and quite possibly reach an understanding as to the nature and extent of the injuries. In the meantime, the Arbitrator hereby orders Respondent to pay for the reasonable and necessary costs associated with a vocational assessment aimed at exploring possible alternatives to the current recommendation, and Petitioner is hereby ordered to cooperate fully with Respondent's efforts in this regard.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ALAN MITTELSTEADT,

Petitioner,

vs. NO: 11 WC 24579

STATE OF ILLINOIS / ILLINOIS STATE UNIVERSITY,

15IWCC0847

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under 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 and permanency, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below.

The Petitioner worked for Respondent as a building mechanic. On March 29, 2011, his duties involved caulking windows. To caulk, he used a ladder and had to bend and twist to get to the window corners. It took him most of the day (five to six hours) to caulk four to five windows. He had been caulking windows in this fashion frequently for a couple of months. On his way to the lounge for his break on March 29, 2011, he noticed a defect in the leg of a loveseat couch, so he flipped the couch over, straightened it, and put the couch back down. He believed the couch weighed 50 to 60 pounds. He sat at his desk for his 15 minute break, and when he arose noticed back stiffness. (Tr. 6-10).

He returned to caulking windows but his back progressively worsened. He completed his shift but stopped caulking for the day. As he walked the two blocks to his truck he got sharp pains down his leg, and it was difficult to use the clutch. He visited chiropractor Dr. Camden on

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the way home, and thereafter continued to follow up with him. He was sore for the next couple of days, and it was hard to get out of bed and to move. After about three days the pain became less sharp and more of an ache and stiffness. Dr. Camden held him off work from March 30 to April 10, 2011, and documentation from Dr. Camden (Petitioner's Exhibit 3; Respondent's Exhibit 6) and Respondent (Respondent's Exhibit 8) indicates Petitioner was released to and returned to work on April 11, 2011. (Tr. 28-29). He continued to improve daily with therapy, but activities like longer walks remained painful (Tr. 10-13, 17).

On cross examination, Petitioner testified that he called his supervisor, Arnold Hernandez, to report the accident. While the report Hernandez completed (Respondent's Exhibit 3) indicated Petitioner wasn't sure how he was injured, Petitioner testified this was: "because I am not sure how it happened, whether it was the caulking the window or whether it was moving the couch." (Tr. 21-23).

Petitioner testified he had treated with Dr. Camden in the past, between mid-2006 and January 2007 after he had been moving concrete blocks, but he had completed all treatment and had been working full duty the entire five years he was employed with Respondent, and had no back injuries during that time (Tr. 13-14, 23-25). At the time of the hearing, Petitioner testified he still has some occasional low back pain, and he tries to avoid prolonged standing and any twisting. (Tr. 16-17).

Several exhibits entered into evidence contain the records of Dr. Camden. (Petitioner's Exhibits 1, 2and 5; Respondent's Exhibit 10). The medical records in evidence indicate Petitioner saw Dr. Camden on multiple visits between 2007 and 2010. Petitioner testified that he visits Dr. Camden "quite often", but while he had continued to have low back pain prior to March 29, 2011, the pain had never been as severe as it was after that date. (Tr. 25-26). Dr. Camden's records reflect ongoing low back complaints, but the visits were very intermittent, and the last note indicating lumbar complaints was on June 14, 2010.

Petitioner testified that he would visit the chiropractor because it was better than taking pills. His doctor had never discussed surgery or therapy prior to March 29, 2011. No diagnostic testing was performed after March 29, 2011. He has no current prescriptions or medical work restrictions regarding his low back, but he takes ibuprofen as needed. Petitioner testified: "I mean I have things after that accident that I can't do or am afraid to do, but as of, I mean my back does not hurt today." (Tr. 26-33).

Petitioner's Exhibit 6 contains sample photos of Petitioner caulking windows. He testified the photos were taken after he returned to work, and were taken in a different location than where he was injured, but depicted the same type of windows he had caulked on March 29, 2011. (Tr. 14-16).

The Commission finds that the Petitioner sustained his burden of proof that he sustained an accidental injury arising out of and in the course of his employment with the Respondent on

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March 29, 2011. The Petitioner was performing work that involved having to twist, bend and to put himself into awkward positions in order to caulk windows. He also had to do this while on a ladder, and did so for several months prior to his injury. He then lifted a couch, estimated to weigh 50 to 60 pounds, to repair one of the legs, and he developed pain 15 minutes later after he sat down for his break.

The Commission notes that upon questioning at oral arguments on September 21, 2015, Respondent's counsel indicated an admission that Petitioner had aggravated a preexisting condition with his March 29, 2011 activities at work. We agree. The Petitioner appears to have had ongoing low back pain prior to the accident date, but that the accident resulted in a significant symptomatic increase that resulted in Petitioner losing time from work. We also note that the only lumbar MRI in evidence took place at the time of Petitioner's 2006 injury, and it was indicated to be unremarkable. (Respondent's Exhibit 10). Based on the chain of events and the proximity of his pain to the caulking and lifting activities noted above, we agree with Dr. Camden's opinion that the Petitioner's back injury on March 29, 2011 is related to his work activities that day. (Petitioner's Exhibits 1 & 2).

The Commission finds that Petitioner was temporarily totally disabled from March 30, 2011 through April 10, 2011, a total of 1-5/7 weeks. Petitioner is also entitled to payment of his related medical expenses of $876.00. (Petitioner's Exhibit 4).

With regard to permanency, the Commission finds that the Petitioner has failed to prove entitlement to permanent partial disability. The Petitioner essentially had a temporary exacerbation of a preexisting condition. He was off work for less than two weeks, and returned to full duty employment in the same position he had been working when he was injured. As noted, he has had consistent low back treatment with chiropractor Dr. Camden since 2006. We see no evidence to indicate anything other than that Petitioner returned to his pre-accident baseline condition. There is no evidence that he sustained any diminution in his wages or ability to earn wages as a result of the March 29, 2011 accident. As such, the Commission awards no permanency benefits.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision is modified with regard to permanency benefits, as noted above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $564.56 per week for a period of 1-5/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act; the parties have stipulated that Respondent has paid all temporary total disability owed, and is entitled to credit for same.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $876.00 for medical expenses under §8(a) of the Act.

15IWCC0847

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner has failed to prove that he sustained permanent partial disability as a result of the March 29, 2011 accident, and thus awards no permanency benefits.

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

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

DATED: NOV 2 0 2015
TJT: pvc
O 09/21/15
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MITTELSTEADT, ALAN
Employee/Petitioner

Case# **11WC024579**

SOI/ILLINOIS STATE UNIVERSITY
Employer/Respondent

15IWCC0847

On 12/9/2014, 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 0.09% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0564 WILLIAMS & SWEE LTD
STEVEN R WILLIAMS
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 6M
P O BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

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

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

DEC 9 = 2014

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

15IWCC0847

STATE OF ILLINOIS)
)SS.
COUNTY OF McClean)

☐ 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

Alan Mittlesteadt
Employee/Petitioner

Case # 11 WC 24579

v.

State of Illinois/Illinois State University
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **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 **March 29, 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*** 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 $**42,900.00**; the average weekly wage was $**846.84**.

On the date of accident, Petitioner was **42** 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 is entitled to a credit for any medical bills paid by Petitioner's group health carrier under Section 8(j) of the Act.

ORDER

The Arbitrator has found that the Petitioner failed to meet his burden of proof with regard to the issues of accident and causal relation. The Petitioner's claim for compensation is, therefore, 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 3, 2014
Date

DEC 9 - 2014

15IWCC0847

FACTS:

On March 29, 2011 the Petitioner was employed by the Respondent and was performing the regular duties of that employment. The Petitioner testified that on that particular day, and for about one month prior to that day, he was engaged in caulking five to six windows per day. The Petitioner testified that the caulking required him to stand on a ladder and to bend and twist his body in order to apply the caulk to all of the appropriate areas of each window. The Petitioner testified that on March 29, 2011 he had finished caulking four to five windows and went to take a break. He testified that on his way to the break room, he noticed a couch with a crooked leg that needed to be dealt with. The Petitioner testified that the couch weighed approximately fifty to sixty pounds and that he flipped the couch onto its back, fixed the leg, and then flipped the couch back into its proper position. He testified that he then took his fifteen minute break sitting at his desk.

The Petitioner testified that when he stood up after having sat at his desk for fifteen minutes he began to notice stiffness in his back. He testified that the returned to caulking windows and that the stiffness got worse as he continued to work. The Petitioner testified that when he was walking to his car at the end of that work day, he experienced pain in his back and down into his leg. The Petitioner sought treatment with a chiropractor, Darren Camden, that same day and, the following day, he reported the incident to the Respondent. The Petitioner testified that he continued to treat with Dr. Camden and that, after three or four days, the sharp pain he was having went away. The Petitioner testified that he was off work from March 30, 2011 through April 11, 2011 and that his pain got a little better each day.

The Petitioner acknowledged that prior to March 29, 2011, he had sought and received chiropractic treatment for persistent back pain. The Petitioner's chiropractic treatment records begin on August 28, 2002 and show that he received intermittent treatment continuing until November 22, 2010. These records show that the Petitioner had frequent bouts of back pain that caused him to seek chiropractic treatment. Only one interval (the one beginning on April 12, 2006 and ending June 19, 2006) states a singular incident as the cause of Petitioner's back pain; the remaining treatments, excluding the treatments after March 29, 2011, appear to be idiopathic. These records are included as numbered pages in Respondent's Exhibit 10.

After the March 29, 2011 incident, the Petitioner continued to seek chiropractic treatment with Darren Camden on thirteen different occasions with May 10, 2011 being the last. During this time the Petitioner underwent: manipulative therapy, or manual manipulation and movement of the spinal cord, and ultrasound therapy.

Four months later, on September 22, 2011, the Petitioner again sought chiropractic treatment with Darren Camden. After this date, the Petitioner sought treatment three more times: once on March 19, 2012; once on May 21, 2012; and, once on June 22, 2012. It is not clear from the records or testimony offered at trial whether this later chiropractic treatment was related to the alleged work accident.

The Petitioner testified that he currently experiences some back pain "once in a while".

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In a letter report dated February 29, 2012 and directed to the Petitioner's attorney, Dr. Camden wrote;

> An assessment of the patient's condition, based on examination, radiographs and complaints exhibits reasonable chiropractic probability consistent with the injury that would have been evident from the type of accident that this patient has described. Although there was obviously pre-existing radiographic anomaly which contributed to the symptomatology, it was neither non-disabling (sic), nor symptomatic, until aggravated by this accident. Absence of this accident would not have resulted in the symptomatology. Therefore, it is my professional opinion that the patient did receive an injury as a result of the accident. (PX1).

Dr. Camden opined that the Petitioner did receive an injury as a result of a work accident on March 29, 2011 and that, because the Petitioner discontinued care, there was a great potential for exacerbation and aggravation of his low back condition.

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, (.), Is Petitioner's current condition of ill-being causally related to the injury, and (.), What is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

The Arbitrator notes that the Petitioner did not testify as to a specific incident or accidental injury which occurred while he was working. Rather, the Petitioner testified that he noticed stiffness in his back when he stood up after he sat for fifteen minutes while on a break. The Petitioner did not testify that he experienced an onset of pain or stiffness while he was caulking windows or while he was moving a couch. He merely testified to an onset of stiffness which occurred sometime after he had performed those activities and got worse as he continued to perform his job duties for the remainder of his shift. The Petitioner's claim appears to be more in the nature of a repetitive trauma type injury which manifested itself on March 9, 2011.

A claim for a repetitive trauma injury must be supported by competent medical evidence which indicates that there is a causal relationship between the work activities and an injury. In addition, the claimant must prove by competent medical evidence that there is a causal relationship between the work injury and the claimant's condition of ill-being. The Arbitrator finds that the Petitioner failed to meet his burden of proof in both of these regards.

First, the Arbitrator notes that the Petitioner clearly had pre-existing ongoing complaints of back pain for which he had sought and received chiropractic treatment prior to March 9, 2011 While the Petitioner testified that his prior low back complaints were never as bad as they were subsequent to March 9, 2011, there is no other evidence that there was any

15IWCC0847

change in the Petitioner's low back condition.

Next, the Arbitrator notes that not only do the opinions expressed by Chiropractor Camden in his report of February 29, 2012 make no sense; they are expressed in terms which do not satisfy the standard of proof required under the Act. Chiropractor Camden expresses his opinion based upon a "reasonable chiropractic probability" standard and not a "reasonable degree of medical or chiropractic certainty" standard. Chiropractor Camden also omits the basis for his conclusions. While he notes that the Petitioner had pre-existing low back conditions, he dismisses them as "neither non-disabling, nor symptomatic." Chiropractor Camden offers neither a basis for this conclusion, nor an explanation as to how he arrived at such a conclusion. Similarly, Chiropractor Camden offers the conclusion that "[a]bsence of this accident would not have resulted in the symptomatology," without any basis or explanation. This conclusion is suspect in light of the fact that Chiropractor Camden's own records show that the Petitioner had numerous temporary flare-ups of lower back pain over the nine years preceding February 29, 2012.

The Arbitrator finds the opinions of Chiropractor Camden to be unpersuasive and unreliable in the instant matter.

Based on the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that Petitioner has failed to prove that an accident arising out of and in the course of his employment occurred and failed to prove that his condition of ill-being is causally related to the injury alleged.

Notwithstanding the Arbitrator's findings regarding the issues of accident and causation, the Arbitrator finds that that Petitioner has no permanent injuries as a result of the alleged accident of March 29, 2011. As a result of the pain that he felt on March 29, 2011, the Petitioner sought conservative treatment for a little less than two months. His treatment stopped on May 10, 2011 and, while the records submitted at trial show that the Petitioner sought additional treatment on September 22, 2011, those records do no relate this treatment to any accident on March 29, 2011. The Petitioner returned to his regular work without restrictions and he testified that he currently experiences some back pain "once in a while". The medical records demonstrate that he had similar complaints prior to his alleged work accident. The Arbitrator finds that, at most, the Petitioner sustained a temporary aggravation of his pre-existing low back condition and that he sustained no permanent disability as a result thereof.

In light of the Arbitrator's findings 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 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

Nani Astefan,

Petitioner,

vs. NO: 11 WC 43819

15IWCC0844

Wal-Mart,

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, prospective medical, temporary total 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. 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.

15IWCC0844

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 $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: NOV 2 0 2015

MB/mam
o:9/24/15
43

Mario Basurto

David L. Gore

Stephen Mathis

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

ASTEFAN, NANI
Employee/Petitioner

Case# **11WC043819**

15IWCC0844

WAL MART
Employer/Respondent

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:

3029 FICHERA & MILLER PC
JACK MARSHALL
415 N LASALLE ST SUITE 301
CHICAGO, IL 60654

0210 GANAN & SHAPIRO PC
MELISSA McENDREE
210 W ILLINOIS ST
CHICAGO, IL 60654

15IWCC0844

STATE OF ILLINOIS)
)SS.
COUNTY OF)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Nani Astefan
Employee/Petitioner

v.

Wal-Mart
Employer/Respondent

Case # **11WC 043819**

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 **11/13/2014**. 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **7/30/2011**, 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 $**23,972.00**; the average weekly wage was $**461.00**.

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

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

Respondent shall be given a credit of $**746.11** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**746.11**.

Respondent is entitled to a credit of $**11,008.72** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary partial disability benefits of **$307.33**/week for **17 4/7** weeks, commencing **October 16, 2011** through **February 6, 2012** as provided in Section 8(a) of the Act.

Respondent shall be given a credit of **$746.11** for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, for medical treatment between July 31, 2011 and February 6, 2012 related to petitioner's treatment of the cervical spine and head injury as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of **$11,008.72** for medical bills paid through 8(j) credit for both workers compensation payments and group medical plans.

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

01-03-15
Date

ICArbDec19(b)

JAN 5 - 2015

FINDINGS OF FACT:

On July 30, 2011, Nani Astefan (Petitioner) was 56 years old and employed as an associate at Wal-Mart. (Respondent). Petitioner's duties consisted of folding and hanging clothes in the men's and boys' department.

On July 30, 2011 petitioner was performing her normal job duties of folding clothes when she stood up quickly and hit her head on a metal arm from a clothing rack. She did not see it because clothes were hanging on it. The arm hit her upper left eye to the left side of her head. She testified she did not hit any other body part.

She reported the injury that day. She put ice on her head and did not immediately seek treatment, but presented to the St. Alexius Medical Center emergency room the following day. (PX #1, p. 7) She testified she filled out an accident report on the date of accident.

At St. Alexius Medical Center Petitioner complained of a head injury and gave a history of hitting her head on a metal rack at work and "things went black for a second" and she was dizzy, could not see and had a headache. (*Id.)* The doctor's notes indicates she hit the left side of her head and was out for an unknown amount of time. The doctor performed a head CT scan that was negative and x-rays of her neck that found no fractures. (*Id.* at 18, 20) The diagnosis was head trauma and no diagnosis for the cervical spine was listed. (*Id.*, p. 15) The doctor recommended restrictions and a follow up with Dr. Hashemi. (*Id.*)

She testified she signed the "Accident Report" and an "Incident Report." She testified another co-worker fluent in Arabic and English wrote out the accident reports before she signed off. Petitioner testified her co-worker filled out the reports and she signed both reports. Both reports support Petitioner's history of accident. (RX # 5 and #6)

On August 20, 2011, she signed FMLA paperwork. (RX #8, p. 2) Dr. Hashemi signed the document and indicates her diagnosis is multiple sclerosis based on an abnormal MRI. (*Id.*, p. 2, 3) He placed Petitioner off work from August 1, 2011 to "unknown" for her multiple sclerosis diagnosis. (*Id.*, p. 15). Petitioner testified she treated with Dr. Hashemi but his records are not entered into evidence.

The first record after her emergency room treatment is from Dr. Yunez on September 22, 2011. (PX #4, p. 9) He was her family doctor and also treated her for unrelated health conditions. (*Id.*) She complained of headaches following a work accident. (*Id.*) She complained of a neck strain. The doctor made a recommendation for the head but not for the neck. (Px #4 p 9-11). He did not provide an off work note. (*Id.*)

After the initial appointment, Petitioner treated with Dr. Yunez from October 6, 2011 through March 24, 2012. (*Id.*) He first placed her off work on October 6, 2011. (*Id.* p. 21) Petitioner's headaches improved but she continued to complain of neck pain. (*Id.*) On occasion Petitioner

pain would be mild. (*Id.*, p. 31) He recommended conservative care including physical therapy. (*Id.*) He placed petitioner off work. (*Id.*)

While treating with Dr. Yunez, petitioner also treated with Dr. Malek, a neurosurgeon. (PX#3) She presented to Dr. Malek on October 19, 2011. (*Id.* p. 4) He treated petitioner for her neck and low back. (*Id.*) Petitioner did not testify the work accident caused low back pain. He initially recommended conservative care including physical therapy and injections. (*Id.*)

On October 27, 2011 she saw Dr. Yunez and stated her pain was improving, but she was not at 100%. (*Id.*, p. 31).

On November 19, 2011, she had an EMG for the neck that was negative. (PX#4, p. 58)

Petitioner also attended physical therapy at Total Rehabilitation with good results. (PX #6) At the recommendation of Dr. Yunez, she treated for her neck from November 1, 2011 to December 16, 2011. (*Id.*) On December 19, 2011, the therapist discharged Petitioner. (*Id.* p. 60) She had met all of her short and long term goals and was discharged to a home exercise program. (*Id.* p. 60) She was able to perform her ADL's without limitations. (*Id.*, p. 60)

Petitioner returned to Dr. Malek on December 7, 2011 before she was released from therapy. (PX # 3 p. 8) He recommended physical therapy and an injection. (*Id.*) He did not mention surgery. Petitioner returned again on December 21, 2011. (*Id.* p. 10) Petitioner had significant pain at night. (*Id.*) He again recommended an injection and a low back brace and to continue with physical therapy. (*Id.*) Petitioner was already released from physical therapy and never returned for her neck. (*Id.*)

Petitioner returned to physical therapy on January 16, 2012 and treated for her low back. (*Id.*, p. 70) She treated until February 17, 2012. (*Id.* 78) She did not attend after that date. On March 30, 2011 the therapist discharged petitioner for failure to attend therapy. (*Id.* p. 79) The discharge note states she reached her short term goal but only part of her long term goals. (*Id.*)

On January 23, 2012 she returned to Dr. Yunez for the first time since October 27, 2011.(PX#4, p. 43) She treated only for her low back without any mention of neck pain. (*Id.*) At Petitioner's last visit to Dr. Yunez on March 24, 2012, she again complained of moderate neck pain. (*Id.*, p.55) Dr. Yunez recommended conservative care and did not provide an off work note. (*Id.*, p. 56) There are not additional medical records from Dr. Yunez.

On March 21, 2012, Dr. Malek stated if she did well with physical therapy and injections, she would not need surgery and diagnosed a cervical strain. (PX #3, p. 12) Petitioner never attended physical therapy after this date for either her back or her neck.

Petitioner testified she had four months of improvement after her injections. Dr. Malek's notes indicates she was improved but only for two weeks after each. The injection were on January

13, 2012 and March 23, 2012. (PX#5 p. 9,17) Petitioner testified she had three injections, but the records support two injections.

Even though Petitioner had a good result from the injection and did not attempt another round of physical therapy, Dr. Malek recommended surgery for the first time on June 20, 2012. (PX#3, p. 16) He continued to recommend surgery from June 2012 to her last date of treatment on November 13, 2013. She had four visits during that time frame. (*Id.* p. 18, 21,24,27) She had another cervical MRI on July 1, 2013 (PX #8, p. 1)

Although Dr. Malek recommended surgery, Petitioner did not testify that she wanted to have surgery. Dr. Malek's records state she can have surgery or live with the condition.(PX#3, p. 16) He placed her off work throughout his treatment. Petitioner testify Dr. Malek is no longer her physician and she never sought treatment with another doctor for the cervical condition since November 13, 2013.

Dr. Bernstein examined petitioner on February 6, 2012. (RX #3, p. 1) Petitioner testified she missed the first IME appointment on November 21, 2011. The history of accident is consistent with the medical records. (*Id.*) He notes initially her doctor diagnosed her with multiple sclerosis. He notes she never returned to work. (*Id.*)

Petitioner complained of diffuse pain. (*Id.*) She complained of left sided head pain and left facial pain. (*Id.*) She complained of pain over the posterior neck and thoracic spine down to the lumbar spine and pain across the shoulders. (*Id.*) She advised she had no relief from physical therapy in contrast to the therapy records and her discharge from care. (*Id.*)

On examination petitioner was in no acute distress and comfortably sitting for the examination. (*Id.*) She had a normal gait and stood without difficulty. (*Id.*) She could not touch her toes due to severe back pain. (*Id.*) However, she was able to bend down to adjust the stool without difficulty to sit on the examination table. (*Id.*) Petitioner sat on the exam table in an overly protective fashion. (*Id.*)

Dr. Bernstein noticed she had full range of motion of her cervical spine. (*Id.*) She had normal strength, sensation and reflexes in the upper and lower extremities. (*Id.*) She had no neurologic deficit. (*Id.*)

Dr. Bernstein reviewed the August 5, 2011 cervical spine MRI and noted a broadly bulging disc at the C5-6 level associated with chronic degenerative disc changes. (*Id.*) He noted no evidence of a disc herniation or nerve root compression. (*Id.*)

Dr. Bernstein's diagnosed a slight contusion as a result of the work accident. (*Id.* p. 2) He found no positive objective findings on physical examination. (*Id.*) He found evidence of symptom magnification and exaggeration and stated the objective findings do not support her subjective complaints. (*Id.*)

He opined her current symptoms are not causally related to the work incident. (*Id.*) She was capable of performing full time, full duty work without restrictions. (*Id.*) She did not require any further medical care or treatment. (*Id.*)

Dr. Malek testified on December 18 , 2013. (PX#2) He testified petitioner did not need surgery for her low back but was a candidate for neck surgery related to the work accident. (*Id.* p. 23) He recommended a C5-C7 anterior cervical discetomy and fusion. (*Id.* p. 23) He opined the accident aggravated her pre-existing degenerative condition. (*Id.* p. 25)

He also testified her low back complaints began on the date of accident. (*Id.* p. 11) His statement is not supported by the initial treatment records as she did complain about her back until her first appointment with Dr. Malek on October 19, 2011, three months after the date of accident. (PX#3, p. 4)

Dr. Bernstein testified on March 25, 2012. (RX#1) He testified consistent with his IME report finding petitioner suffered a contusion or strain and the accident of hitting a metal rack was not sufficient to cause or aggravate a neck injury. (*Id.* p. 15) He found she had a broad based disc on the August 5, 2011 MRI. (*Id.* p. 16) She had multilevel disc bulging in her neck. (*Id.* p. 17) Any need for surgery after the accident would have appeared by the time of his examination six months after the accident date. (*Id.* p. 19-20)

Dr. Bernstein opined as of February 6, 2012, petitioner was at MMI and did require any surgery, injections, physical therapy or any treatment at all. (RX#1, p. 39) She did not require work restrictions. (*Id.*p. 21)

Prior to the deposition, he did not have the July 1, 2013 MRI film. He reviewed the film after the appointment, and found it was similar to the August 5, 2011 MRI. (RX#4) Petitioner had a bulging disc at C5-6 and C6-7 with anterior impingement on the cervical cord. (*Id.*) The MRI did not change his prior opinion. (*Id.*) He opined it may be reasonable for Dr. Malek to perform surgery based on her subjective complaints. (*Id.*) However, he did not feel she was a surgical candidate based on his examination. (*Id.*) She was at MMI at the time of his examination and any current complaints are not related to the work injury. (*Id.*)

Petitioner testified she still has pain in her head. She testified she was able to work around her house without restrictions following the injections. She also testified she was terminated in 2012 from Wal-Mart through a letter but did not have the letter available. She has not looked for work since the date of accident.

Conclusions of Law

In support of Arbitrator Findings relating to (F) are petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds the following:

The Findings of Fact as stated above are adopted herein. The Arbitrator finds the opinions of Dr. Avi Bernstein credible on the issues of causal connection and reasonableness and necessity of

medical treatment. Dr. Bernstein opined Petitioner had a contusion or strain as a result of the work injury. (RX #1, p. 18) Petitioner was MMI as of February 6, 2012 and did not require additional treatment based on his examination and review of the August 5, 2011 MRI films. (*Id.* p. 2) The accident as described by petitioner during the examination could not have caused a significant neck injury. (RX#1, 15)

Dr. Bernstein's opinion is supported by Petitioner's medical treatment between December 2011 and his IME on February 6, 2012.

Petitioner was released from physical therapy on December 19, 2011 having meet her long and short term goals.(PX #6, p.60) She then returned to physical therapy in January 2012, but only for her low back. (*Id.* p 70) She did not have therapy for her neck after December 2011. She presented to Dr. Yunez for other treatment after November 23, 2011 but did not treat for the neck again until March 24, 2012. (PX #4, p. 37, 40, 43, 46)

She presented to Dr. Yunez on December 2, 2012 treating only for her hypertension. (*Id.* p 37) She returned on January 9, 2011, again treating only for her hypertension. (*Id.* p 40) On January 23, 2012 she present to him for her lumbar spine and her hypertension. (*Id.* p 43) Not until March 24, 2012 did she report any cervical complaints to Dr. Yunez. (*Id.* p 46)

She also had minimal treatment for the cervical with Dr. Malek during that timeframe. She presented to Dr. Malek on December 7, 2011 before petitioner was released from her physical therapy. (PX#3, p. 8) She returned on December 21, 2012 and then had a cervical injection on January 13, 2012. (*Id.* p 10; PX #5, p. 9) She did not treat again with Dr. Malek until March 21, 2012, shortly before she returned to Dr. Yunez complaining of neck and back pain. (PX #3, p. 12)

The Arbitrator finds petitioner was MMI for her cervical condition as of the Dr. Bernstein's February 6, 2012 IME. No treatment after that date is causally related to the work accident. The Arbitrator also finds Petitioner's low back treatment is not related to the work injury as she did not have low back complaints until Dr. Malek's first appointment on October 19, 2011. (PX # 3, P. 4) Petitioner also did not testify she had low back complaints following her work accident.

In support of the Arbitrator findings relating to (J) were the medical services provided to Petitioner reasonable and necessary, the Arbitrator finds the following:

The Findings of Fact and Conclusions of Law as stated above are adopted herein. The Arbitrator adopts Dr. Bernstein opinion finding petitioner was at MMI as of Dr. Bernstein's February 6, 2012 IME. Dr. Bernstein found Petitioner was at MMI, could return to work full duty without restrictions, and no additional medical treatment was reasonable, necessary or causally related to the work injury. (RX #3, p. 2)

The Arbitrator finds Petitioner's treatment for her head and neck causally related to the work accident from July 31, 2011 to February 6, 2012. No treatment for the low back or any other body part is casually related to the work injury.

Further, the Arbitrator finds the following medical treatment related to the work accident; St. Alexian Brothers July 31, 2011 treated including the cervical x-rays and the CT scan of her head, Dr. Yunez treatment for the head and cervical spine from September 22, 2011 to November 23, 2011, Total Rehabilitation treatment from November 1, 2011 to December 19, 2011, Dr. Malek's treatment from October 19, 2011 through January 13, 2012, and the November 19, 2011 cervical EMG.

In support of the Arbitrator findings relating to (l) is petitioner entitled to TTD benefits, the Arbitrator finds the following:

The Findings of Fact and Conclusions of Law as stated above are adopted herein. Petitioner is owed TTD from October 6, 2011 until February 6, 2012 based on Dr. Bernstein's IME opinion. The first off work statement in the record is from Dr. Yunez on October 6, 2011. (PX #4, p. 21) Dr. Bernstein found petitioner could work full duty without restrictions as of the date of his IME on February 6, 2012. (RX #3, p. 2)

In support of the Arbitrator findings relating to (K) is petitioner entitled to any prospective medical care, the Arbitrator finds the following:

The Findings of Fact and Conclusions of Law as stated above are adopted herein. The Arbitrator finds no treatment after Dr. Bernstein's February 6, 2012 IME is reasonable, necessary and causally related to the work accident. Petitioner was at MMI. No additional treatment was reasonable, necessary or causally related to the July 30, 2011 work accident. (RX #3, p. 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

Teresa Stumps,

Petitioner,

vs. NO. 12WC 15475

Kroger Schnucks,

15IWCC0803

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary disability, permanent disability, 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 January 5, 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.

15IWCC0803

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: OCT 3 0 2015
SJM/sj
o-9/24/2015
44

Stephen J. Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STUMPS, TERESA
Employee/Petitioner

Case# **12WC015475**

KROGER SCHNUCKS
Employer/Respondent

15IWCC0803

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:

2489 LAW OFFICE OF JIM BLACK
JASON EDMOND
308 W STATE ST SUITE 300
ROCKFORD, IL 61101

0766 HENNESSY & ROACH PC
AUKSE R GRIGALIUNAS
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

15IWCC0803

☐ 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

Teresa Stumpf
Employee/Petitioner

v.

Kroger Schnucks
Employer/Respondent

Case # **12** WC **15475**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert Falcioni**, Arbitrator of the Commission, in the city of **Rockford**, on **11-14-14**. 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 **11-06-11**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident given to Respondent.

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

In the year preceding the injury, Petitioner earned $**2,700.00**; the average weekly wage was $**450.00**.

On the date of accident, Petitioner was **53** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**3,249.97** for other benefits, for a total credit of $**3,249.97**.

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

ORDER

THE PETITIONER FAILED TO SHOW BY A PREPONDERANCE OF THE EVIDENCE THAT SHE SUSTAINED AN ACCIDENT ARISING OUT OF AND IN THE COURSE OF HER EMPLOYMENT. THEREFORE, ALL BENEFITS ARE DENIED. ALL OTHER ISSUES ARE MOOT.

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

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

Robert E Dahn
Signature of Arbitrator

December 18, 2014
Date

JAN 5 - 2015

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

15IWCC0803

Teresa Stumpf, Petitioner,	)	
vs.	)	No. 12 WC 15475
Kroger Schnucks Respondent.	)	

MEMORANDUM OF DECISION OF THE ARBITRATOR

FINDINGS OF FACT

The petitioner testified that she worked at Kroger for 8 years. She worked as a meat wrapper and as a "boss" when her boss was not in. She stated her job duties included wrapping meat, filling counters, and weighing chickens, hams, turkeys. She stated she would place ground meat on 10-15 pound trays and lift the trays for weighing and put through the wrapper. She also testified that she would weigh 40-50 pound boxes of hams. She stated that she spent her day between wrapping, filling the counter, and weighing meat. Sometimes she would help unload trucks about 2-3 days per week which would require unloading 40-60 pound boxes for about three hours.

On November 6, 2011, the petitioner stated that her back was hurting when she got out of bed. After she showered, she lifted her leg to put her sock on and her back hurt more than it ever had before. She went to work that day until she couldn't stand the pain any more and then she went to see Dr. Sieradzki on November 7, 2011. (PX 1) She reported to the doctor that she was "feeling tired or poorly. Pt is here with recurrence of her back pain in the lower lumbar area – she states the flexeril and the meds used last year worked well and she just needs those again. . . and thinks it is related to her moving things about in her house as she puts things away for the season." (PX 1) She was prescribed medications at that time.

The petitioner was seen by Dr. Boswell on November 29, 2011. (PX 2, RX 3) At that time she complained of left leg pain. No accident history was provided at that time. She had two MRI's – one with and one without gadolineum on December 8 and December 9, 2011. (RX 3) The MRI of 12/8/2011 showed significant disc involvement from L3-L5. She was then referred to Dr. Soriano.

When the petitioner was seen by Dr. Soriano, she reported that she felt pain in her back after putting socks on at home, but that she also does lift at work. According to Dr. Soriano's handwritten notes, it stated that on November 20, 2011, she "felt pull LB when put sock on . . .

lifts a lot at work." (PX3, RX 2) The dictated note from Dr. Soriano to Dr. Boswell states that the petitioner is, "a delightful woman who in November of 2011 was putting on her sock, and felt a pull in her low back. She continued working in the meat department at Hilander, but two to three weeks later, she began experiencing pain in her left thigh and calf, on the outer surface. She does lift a lot at work, and stands eight hours a day." (PX 3, RX 2) The petitioner testified that she told Dr. Soriano about the sock incident because her pain got much worse after that. Dr. Soriano recommended epidural steroid injections which only helped for a couple days. He then recommended surgery.

The petitioner underwent surgery in the form of a left L4-5 microscopic hemilaminotomy and discectomy at the hands of Dr. Soriano on January 12, 2012. The postoperative diagnosis was herniated disk, left L4-5, with left L5 radiculopathy. (PX 3, RX 2) After the surgery, the petitioner testified that the pain in her leg completely went away. She was off work until March 26, 2012, during which time she received short term disability benefits. She did not file a workers' compensation claim at that time, nor did she request workers' compensation benefits.

The petitioner was released to return to work full duty by Dr. Soriano on March 26, 2012 without restrictions. (PX 3, RX 2) The petitioner did return to work, but has since retired. The petitioner hired Jim Black's office to represent her in April of 2012.

The petitioner was seen by Dr. Coe, an occupational medicine specialist, for a Section 12 examination at the request of her attorney on March 27, 2013. (PX 5) Dr. Coe reviewed the medical records from Dr. Sieradzki and Dr. Soriano. Dr. Coe did not mention that the petitioner told Dr. Sieradzki that her low back pain was related to moving things in her house. Dr. Coe also did not mention in his "History" section that the petitioner complained of increased pain in her low back after she put socks on at home. Nevertheless, Dr. Coe concluded that the petitioner suffered "repetitive strain injuries to her lower back while moving meat at work." (PX 5) Further, Dr. Coe stated that the history of the petitioner putting on socks at home "is different than that provided to me by Ms. Stumpf." (PX 5)

The petitioner was seen by Dr. Ghanayem, a board certified orthopedic surgeon specializing in the spine, for a Section 12 examination at the request of the respondent on June 27, 2013. (RX 1) The petitioner testified that she told the truth about her injury to Dr. Ghanayem. His detailed report states that on November 6, 2011, she "hurt her back. This occurred at home when putting her socks on. She was bent over putting her left sock on when this occurred. Throughout the course of the day, the pain became worse and eventually progressed into left-sided leg pain. She did not describe any particular work injuries. She does state that she does a lot of heavy lifting at work, which is her normal and routine job." (RX 1) Dr. Ghanayem reviewed the petitioner's medical records and found that the petitioner "has a history that she presented to me as bending over an [*sic*] putting on her sock for which she developed acute low back pain, which eventually progressed throughout the course of the day while she happened to be at work." (RX 1) Dr. Ghanayem stated that her treating records from

Dr. Soriano reflect the same history. Dr. Ghanayem also stated that the petitioner sustained an "acute" disc herniation at the L4-5 level according to the MRI scan which he reviewed. (RX 1) In support of his opinions, Dr. Ghanayem stated that:

> the fact that she had a progression of symptoms while at work does not constitute a work injury. She simply had an acute disc herniation from what she did at home while bending over to put her sock on her left foot and sustained a lumbar disc injury. While she does do lifting activities at work, it does not appear that she sustained an injury at work, given the history that I obtained from her, as well as the history that was generated in real time in the medical records. (RX 1)

Currently, the petitioner testified that her left leg pain had resolved, and that her back is better, however she does not sleep very well at night.

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE C: DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the petitioner did not sustain an accident arising out of and in the course of her employment. In so finding, the arbitrator relies on the following facts:

There was no single incident of trauma occurring at work to which the petitioner can point to. Indeed, the petitioner has alleged that her low back pain developed over time, thus alleging a repetitive-trauma type injury to her lumbar spine. While it is undisputed that the petitioner does do heavy lifting at work, there are several other possibilities as to what has caused, accelerated or exacerbated the petitioner's lumbar spine condition, none of which have to do with her lifting requirements.

On the date of the alleged accident itself, November 6, 2011, there is no medical treatment or allegation of an injury on that day. Nor is there any statement made in the medical records, or even by the petitioner that the low back injury was causally related to her work duties. When the petitioner came to see Dr. Sieradzki the next day, on November 7, 2011, the only accident history provided was that the petitioner was having low back pain which was very similar to the year before, and that the petitioner herself related the pain to moving things around at home. (PX 1) Next, when the petitioner came to see Dr. Boswell on November 29, 2011, no accident history was provided, and the petitioner simply complained of left leg pain. (PX 2)

Next, when the petitioner came to see Dr. Soriano, while she did state that she lifts heavy weights at work, she indicated that the worst of the back pain began after she put her sock on a few weeks ago at home. (PX 3)

Next, when the petitioner came to see Dr. Ghanayem, she also indicated that her low back pain began when she put her socks on at home. (RX 1) Indeed, even the petitioner's testimony was clear in that she stated that while she did have some previous back pain, the sock incident was the trigger that severely aggravated her symptoms to the point where she sought medical treatment.

To Dr. Coe, the petitioner's own Section 12 examiner, the petitioner did not relate the history of moving things at home, or injuring herself while putting socks on at home. (PX 5) Dr. Coe even ignored those accident histories in the "history" section of his narrative report, dismissing them completely because the petitioner did not report same to him.

Even though it is undisputed that the petitioner did lift heavy weights at work, it is clear that the petitioner herself attributed her condition to incidents occurring at home when she sought medical care. While some medical providers indicate that Petitioner reported performing heavy lifing at work, none until late in the process report that she experienced any pain while doing so. The only pain generator reported in the early medical records is either Petitioner doing things around the house or pulling on her socks. As such, based on the preponderance of the credible evidence, the Arbitrator finds that the petitioner did not sustain an accident arising out of or in the course of her employment. All other issues are moot.

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	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JACQUELINE CARPENTER,

Petitioner,

vs.

NO: 12 WC 32920

15IWCC0851

HOLTEN MEAT, INC.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident and medical expenses 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 Decision of Arbitrator Nancy Lindsay found that Petitioner failed to prove that she sustained an accident on June 14, 2012, that arose out of and in the course of her employment. Arbitrator Lindsay also found Petitioner failed to prove that her current condition of ill-being is causally related to said accident. Arbitrator Lindsay found that the inconsistencies in Petitioner's testimony together with the causation opinion of Dr. Donald Weimer, based solely upon Petitioner's history of working in a labor-intensive position, defeated her claim. Consistent with her findings, the Arbitrator denied Petitioner's claim for compensation and awarded no benefits under the Act. The Commission views the evidence differently and finds Petitioner proved that the claimed accident arose out of and in the course her employment, that her condition of ill-being is causally related to the accident, such that she is entitled to benefits under the Act. Accordingly, the Commission reverses the Decision of the Arbitrator.

15IWCC0851

Petitioner is a product line assistant. It requires her to pack frozen hamburger patties as fast as possible into boxes and then pack the boxes into bags. She testified to performing this activity for fifteen years and believes this caused her bilateral wrist pain and, consequently, bilateral shoulder pain that eventually caused her to seek medical help.

Petitioner presented to Midwest Occupational Medicine on November 17, 2011, with complaints of pain to her left wrist. She was diagnosed with deQuervain's Syndrome. A follow-up examination included a new complaint of right wrist pain. It was recommended she be seen by a hand surgeon and she was thereafter examined by Dr. Harvey Mirly.

Petitioner was seen by Dr. Mirly on January 17, 2012, and diagnosed with bilateral deQuervain's Syndrome and tenosynovitis as well as with a ganglion of the first extensor compartment in her left hand. These conditions were treated conservatively with splinting, NSAIDs and, eventually, injections into the left wrist. On February 10, 2012, EMG/NCS studies were conducted upon both wrists and resulted in findings of bilateral carpal tunnel syndrome. Dr. Mirly's suggested course of treatment was bilateral carpal tunnel release and a release of the first dorsal compartment in the left wrist. Petitioner was placed on light duty in response these diagnoses.

The light duty consisted of her scrubbing walls. This activity led to Petitioner experiencing increased pain in her shoulder. Petitioner complained of the shoulder pain to Dr. Mirly on April 25, 2012, Dr. Mirly, in turn, referred her to Dr. Donald Weimer as Dr. Mirly does not treat shoulder injuries.

Petitioner presented to Dr. Weimer on May 1, 2012, and provided him with a history of years-long bilateral shoulder pain that had worsened over the past two weeks. A physical examination of Petitioner was conducted and Petitioner underwent x-rays of her right shoulder. The examination and the x-rays led him to conclude Petitioner had signs of right rotator cuff pathology. Dr. Weimer then ordered MRIs to be taken of Petitioner's shoulders. The MRIs were performed on June 11, 2012.

The MRI of the right shoulder revealed mild tendinosis of the lateral supraspinatus with a small partial undersurface tear at the more extreme lateral insertion, a tear of superior labrum just posterior to the biceps anchor, synovitis suggested of the axillary recess, mild inferior spurring, mild tendinosis of the head of the biceps tendon in rotator interval and a degenerative cystic change of the greater tuberosity and posterolateral humeral head.

The MRI of the left shoulder revealed mild tendinosis of the lateral supraspinatus, no tear of the tendons of the rotator cuff, and mild osteoarthritis of the AC joint.

On June 14, 2012, Dr. Weimer recommended arthroscopy with decompression and repair of the rotator cuff tear for the right shoulder and arthroscopic decompression and debridement for the left shoulder. Contemporaneously, he also wrote in Petitioner's treatment records of his belief that Petitioner's "labor-intensive employment" more than likely contributed to her bilateral shoulder condition.

At Respondent's request, Petitioner was seen by Dr. William Stecker on November 6, 2012, pursuant to Section 12 of the Act. Petitioner related to Dr. Stecker a fourteen-year history of working on Respondent's production line and of developing problems with her wrists and hands and, more recently, problems with her shoulders as a result of washing walls. Dr. Stecker physically examined Petitioner and found Petitioner's bilateral shoulder symptoms to be consistent with on-going tendinopathy. He recommended nonsurgical treatment, specifically, NSAIDs, physical therapy and cortisteroid injections. He also expressed the opinion that the condition of Petitioner's shoulders could not be attributable her work activities as she only had washed walls over the course of few days.

Both Dr. Weimer and Dr. Stecker sat for evidentiary depositions, and both expounded on their previously expressed opinions. Dr. Weimer testified Petitioner told him that she had been a meat packer for thirteen years. He acknowledged that he was not provided with a job description, but he, nevertheless, indicated an understanding that Petitioner worked in "labor-intensive employment and also to his being "somewhat" familiar with the work activities of a meat packer, noted that his father had been one for a period of time.

Dr. Stecker testified that Petitioner told him that she lifted nothing heavier than twenty pounds on a continual basis and that the only overhead activity she performed was washing the walls. He indicated Petitioner's symptoms might have been provoked if she used only one arm but stated that she used both arms. He testified that Petitioner told him that "she wasn't doing overhead [work] with her left non-dominant [hand]. She was using her right [hand]."

The Commission agrees with the Arbitrator's finding that Dr. Weimer's causation opinion was lacking a testified-to understanding of Petitioner's actual work activities. However, the Commission finds that the opinion of Dr. Stecker, given during his evidence deposition, compels a finding that Petitioner's work activities, while on light duty, contributed to Petitioner's bilateral shoulder condition.

As noted above, Dr. Stecker testified that Petitioner's symptoms could have been made worse if Petitioner used one arm to wash walls. Per his own testimony, Dr. Stecker indicated that Petitioner used her right arm to wash Respondent's walls. The Commission finds this to explain the discrepancy in the differing conditions found in Petitioner's shoulders. Petitioner's greater use of her right arm contributed to the tears found in her right shoulder. Her left arm was used less actively and resulted in less severe injuries.

Petitioner is found to be credible. Her medical history indicates that she had an on-going tendinopathy, as Dr. Strecker found, that had recently worsened, as Petitioner so testified. The combination of the two resulted in repetitive injury to her shoulders and to her continuing need for medical treatment, including the surgeries recommended by Dr. Weimer.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the arthroscopy with decompression and repair of the torn superior labrum to Petitioner's right shoulder and the arthroscopic decompression and debridement to Petitioner's left shoulder as well as all related aftercare under §8(a) of the Act.

15IWCC0851

IT IS FURTHER ORDED BY THE COMMISSION 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 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 $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: NOV 2 0 2015
KWL/mav
O: 09/21/15

Thomas J. Tyrrell

Michael J. Brennan

DISSENT

I respectfully dissent from the decision of the majority. Arbitrator Lindsay's findings are both thorough and well reasoned. This decision is correct and should be affirmed.

Kevin W. Lamborn

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

15IWCC0851

CARPENTER, JACQUELINE
Employee/Petitioner

Case# **12WC032920**

HOLTEN MEAT INC
Employer/Respondent

On 6/23/2014, 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 0.07% 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:

0810 BECKER PAULSON & HOERNER PC
MIKE NOVAK
5111 W MAIN ST
BELLEVILLE, IL 62226

0725 HANSEN & ENRIGHT
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701 MARKET ST SUITE 200
ST LOUIS, MO 63101-1862

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)

15IWCC0851

Jacqueline Carpenter
Employee/Petitioner

v.

Holten Meat, Inc.
Employer/Respondent

Case # **12** WC **032920**

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 **April 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 _____

15IWCC0851

FINDINGS

On the alleged date of accident, June 14, 2012, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this 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 $**23,920.00**; the average weekly wage was $**460.00**.

On the date of accident, Petitioner was **50** years of age, ***single*** with **0** children under 18.

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

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

ORDER

Petitioner has failed to prove that she sustained an accident on June 14, 2012 that arose out of and in the course of her employment or that her current condition of ill-being is causally related to that accident or her employment duties. 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.

Nancy Lindsay
Signature of Arbitrator

June 12, 2014
Date

JUN 23 2014

ICArbDec19(b)

According to Commission records, this is one of three claims Petitioner has filed against this Respondent. The other two claims (11 WC 47478 and 11 WC 47480) involved injuries to Petitioner's hands and wrists (bilateral carpal tunnel syndrome and DeQuervain's Syndrome/Tenosynovitis). Those claims have been settled (October 22, 2013) and are not a part of this proceeding.

With respect to this case, Petitioner alleges bilateral shoulder injuries due to repetitive trauma which manifested themselves on June 14, 2012. (AX 2) At the time of arbitration, the issues in dispute were accident, causal connection, outstanding medical expenses, and prospective medical care. Respondent's dispute with regard to the outstanding medical bills is based on liability.

The Arbitrator Finds:

According to the medical records Petitioner was seen at Midwest Occupational Medicine on November 17, 2011 with complaints of left wrist pain for which she was diagnosed with DeQuervain's Syndrome and treated with casting. In follow-up at Midwest Occupational she was also complaining of right wrist pain and she was referred to a hand surgeon, Dr. Mirly. (RX A, dep. ex. 2, p. 2)

Petitioner presented to Dr. Mirly on January 17, 2012 who diagnosed her with bilateral DeQuervain's Syndrome (tenosynovitis) and a ganglion of the first extensor compartment on the left side. Conservative treatment was recommended and, as Petitioner's complaints continued, she underwent an EMG and nerve conduction studies on February 10, 2012 which were consistent with bilateral carpal tunnel syndrome. Injections to Petitioner's wrists reportedly showed some improvement but Dr. Mirly eventually recommended bilateral carpal tunnel releases and first dorsal compartment releases. (RX A, dep. ex. 2 -- pp. 2,3)

On April 25, 2012 Petitioner again presented to Midwest Occupational Medicine where she was examined by nurse Kimberly Brown for complaints of bilateral shoulder pain since November of 2011. (PX 2; RX A, dep. ex. 2 - p. 3) She acknowledged that she did not report it to the company in November of 2011 but that she had mentioned it to Dr. Mirly who was treating for her bilateral wrist complaints. Petitioner explained that she continued to have some shoulder discomfort, which she described as a "pinching pain" located mainly at the anterior of her shoulder and more on the right shoulder than the left one. Petitioner reported persistent shoulder pain since November despite the use of Aleve and other over-the-counter medications and that in the past week the pain had worsened bilaterally. Petitioner also reported that she had been on light duty since November for her wrist complaints and that her light duty had entailed no pinching activities. As a result she had been taping boxes, dusting, sweeping trash outside, and cleaning walls with a spray cleaner (a one time episode in March). Petitioner reported the pain just "increased over the past week and she does not note any specific activity that caused it to increase." (PX 2, p. 1)

Petitioner's shoulders were examined and revealed evidence of tenderness to palpation and some limited motion and complaints of pain with certain movements. Lift-off, Speeds test, Crossover impingement testing and Empty Can test all elicited anterior shoulder discomfort bilaterally. Realizing Petitioner was already on light duty, Nurse Brown instructed Petitioner to work "as tolerated limiting her overhead activities as that may aggravate her shoulder pain." Petitioner was also told she could use Aleve one to two tablets per day and use heat and ice alternatively three times per day. According to the office note they discussed Petitioner's activities at work in relation to her shoulder pain, at length, and as there was no specific activity over the past week that increased Petitioner's pain and Petitioner had reported that the pain had been present since November but was just reported yesterday, she recommended that Petitioner follow-up with her primary care physician as this was unrelated to her light duty activities. Petitioner was scheduled to follow-up in one week to see how she was progressing with the medication and limiting her activities should her work want us to continue to follow her. (PX 2, p. 2)

Petitioner next presented to Dr. Donald Weimer on May 1, 2012 with regard to bilateral shoulder pain. Prior to the examination she had completed a "Work Comp Intake Form" in which she indicated she was experiencing bilateral shoulder pain. Two dates of injury were listed: (1) 11-16-11 and (2) 4-23-12. The Intake Form indicates a 1st Report of Injury had been filed but Petitioner was unsure if her visit was authorized by workers' compensation; however, the carrier was to be billed for the visit. (PX (PX 4, pp. 7, 34)

When examined by Dr. Weimer Petitioner advised the doctor that she had been experiencing shoulder pain for several years and could usually treat it with Tylenol or non-steroidal anti-inflammatory medication; however, two weeks earlier the pain became more severe and she could no longer get any relief as she previously had. Petitioner denied any history of a specific injury and noted pain both with activity and rest. Petitioner was able to localize the pain in the anterior region of her shoulders and reported occasional popping, too. When Dr. Weimer elevated her shoulders Petitioner reported anterolateral deltoid pain. Dr. Weimer further noted that Petitioner was being treated by Dr. Mirly for bilateral carpal tunnel syndrome and she was scheduled to undergo surgery with him later on in May of 2012.[1] Dr. Weimer performed a clinical examination of both shoulders and reviewed x-rays which showed a type III acromion and moderate AC joint arthritis bilaterally. He concluded that Petitioner's symptoms were suggestive of rotator cuff pathology and recommended MRIs of both shoulders to further investigate the matter. In the interim Petitioner was advised to take Ibuprofen 800 mg. three times per day and not engage in any overhead activity at work. (PX 4, pp. 12, 14, 15, 30, 39-42)

Petitioner underwent a left carpal tunnel release and first dorsal compartment release per Dr. Mirly on May 12, 2012. (RXA, dep. ex. 2 - p. 3)

[1] According to PX 4, p. 15 (nurse's/doctor's handwritten notes of 5.1.12) Petitioner's accident date for her wrists was November 16, 2011, she has been working light duty for Respondent, and was scheduled for a carpal tunnel release on 5.14.12).

Petitioner underwent a left shoulder MRI, without contrast, on June 11, 2012. According to the radiologist's report, it revealed mild tendinosis of the lateral supraspinatus, no tear of the rotator cuff tendons, and mild osteoarthritis of the AC joint. (PX 4, p. 18)

That same day Petitioner also underwent a right shoulder MRI, without contrast, which was read as showing mild tendinosis of the lateral supraspinatus with a small partial undersurface tear at the more extreme lateral insertion, a tear of the superior labrum just posterior to the biceps anchor, possible synovitis of the axillary recess, mild osteoarthritis of the AC joint with mild inferior spurring, mild tendinosis of the long head biceps tendon in the rotator interval, and degenerative cystic change of the greater tuberosity and posterolateral humeral head. (PX 4, p. 20)

After her MRIs, Petitioner returned to see Dr. Weimer on June 14, 2012 in order to discuss the results. Dr. Weimer felt Petitioner had a less than 1 cm. near full-thickness tear at the anterior supraspinatus, as well as impingement, a posterior SLAP lesion, a subchondral cyst formation in the anterior humeral head, and some moderate to severe AC joint arthritis on the right side. Petitioner's left shoulder revealed tendinosis of the supraspinatus, impingement, and moderate AC joint arthritis. Dr. Weimer wrote,

> She is relatively young and has a labor-intensive job as a meat packer. I think likely her problems will worse[n] in both of these shoulders. I certainly think there is more likely than not chance that these problems were caused by or exacerbated by the type of work she does. (PX 4, pp. 23, 27)

Dr. Weimer recommended arthroscopic surgery on both shoulders with the right side being done first. He hoped to coordinate the procedure with Dr. Mirly in an effort to only have Petitioner go under anesthesia once. Workers' compensation approval was to be requested. In the interim Petitioner's restrictions were increased to include no pushing or pulling or lifting greater than five lbs. with both arms, along with no overhead reaching. (PX 4, pp. 22 - 25, 27)

Petitioner underwent a right carpal tunnel release and first dorsal compartment release per Dr. Mirly on July 16, 2012. (RXA, dep. ex. 2 - p. 3)

In a note dated August 9, 2012, Dr. Weimer's office indicated that workers' compensation was denying authorization/coverage for any bilateral shoulder treatment as it had no injury report regarding Petitioner's shoulders. Petitioner stated she had "just" filled out a report of injury and mailed it to work. Petitioner was to advise the doctor if she wished to proceed under her private insurance or pursue the workers' compensation issue. (PX 4, p. 26)

Petitioner underwent a physical therapy outpatient visit for her hands and wrists at Belleville Memorial Hospital on August 15, 2012. Petitioner reported she was getting sick "all over" when working with her hands and that it had happened before she

underwent surgery and was happening again. Petitioner reported feeling "bad" after therapy on Monday and the previous day. Petitioner was scheduled to see Dr. Mirly next weeks. According to the report Petitioner also expressed concern about her shoulders and returning to work. "She feels that there is a lot of pressure at work on her performance." (PX 3, p. 3)

On August 21, 2012 Petitioner presented to Dr. Mirly for a post-operative visit regarding her bilateral hand/wrist surgeries. Petitioner was undergoing therapy and experiencing some pain in association with it. He expected her to be able to return to work on August 27, 2012 with no restrictions and then to return in two months to ascertain whether she was at maximum medical improvement. Dr. Mirly noted Petitioner had some other "issues including her shoulder, which I am not treating." (PX 3, p. 1)

Petitioner signed her Application for Adjustment of Claim on September 4, 2012, alleging an accident (manifestation) date of June 14, 2012, the date of her diagnosis. (AX 2)

According to a Hand Therapy Objective Measures Evaluation dated October 9, 2012 Petitioner was working light duty for Respondent due to her shoulders. (PX 3, p.2)

At the request of Respondent Petitioner underwent an examination with Dr. William B. Strecker on November 6, 2012. Petitioner presented with complaints of bilateral shoulder and arm pain and provided a history of having been employed by Respondent for 14 years as a production line individual. According to the doctor's report issued after his examination (RX A, dep. ex. 2), Petitioner initially began having problems with both of her hands and wrists approximately one year earlier. She was seen and treated by Dr. Mirly who felt she had bilateral carpal tunnel syndrome and DeQervain's Syndrome. In March of 2012 she had been placed on light duty for her hands and she underwent surgery to her left hand and wrist in May of 2012 and her right hand and wrist in July of 2012. Petitioner reported that while she was on light duty for her hands and wrists she was required to wash down the walls in the hallway and after two to three days of doing so she began to develop pain in both shoulders as well as swelling in her hands. In washing the walls Petitioner was required to carry a water bucket, spray the walls and then wipe them down with a towel. She subsequently sought treatment from Dr. Weimer who ordered MRIs and, thereafter, recommended surgery to both shoulders.

At the time of the examination Petitioner's complaints included bilateral shoulder pain with any type of movement, including the swinging of her arms. Her only means of pain relief was to keep her arms at her side. Petitioner reported difficulty sleeping on her shoulders at night. Petitioner also reported numbness and tingling in her arms, and the palm of her hand to her elbow (the left side being more noticeable than the right side). Petitioner denied any cervical pain. She also reported not receiving any non-steroidal medications or injections.

Dr. Strecker's understanding of Petitioner's job was that she was a meat packer which required her to scoop and package hamburger and lift three pound bags of the product into a container. She also had to lift 10 to 20 pound boxes of meat and tape the boxes.

On examination of Petitioner's right shoulder Dr. Strecker noted no focal tenderness at either the AC joint or tip of her acromion, 120 degrees abduction, 140 degrees forward flexion, and a positive impingement sign at maximum abduction. Dr. Strecker further noted negative supraspinatus and negative Osborne. Petitioner had full internal and external rotation and no instability. Petitioner's left shoulder examination was similar except for a questionably positive supraspinatus sign. The doctor also examined Petitioner's hands, wrists, and elbow. Petitioner's left elbow had a positive Tinel's sign over the ulnar nerve.

As part of his examination and report Dr. Strecker noted that he had reviewed Petitioner's medical records from Midwest Occupational Medicine and Dr. Mirly (through July 16, 2012). He also reviewed Dr. Weimer's record of May 1, 2012 and the MRI reports of June 11, 2012. Based upon Petitioner's history and the doctor's review of her records, Dr. Strecker was of the opinion Petitioner had bilateral carpal tunnel syndrome and DeQuervain's Syndrome. He felt there was some evidence of symptom magnification as she complained of non-anatomic paresthesia with two-point sensation on the left side being abnormal in all digits other than her long finger and a "0" grip strength in either hand inconsistent with what was observed or the ability of self care. He felt she was symptomatic with some tendon subluxation on the left side and concurred with a recommendation that she undergo possible retinacular reconstruction for that condition. (RX A, dep. ex. 2 - p. 3)

With regard to Petitioner's shoulders, Dr. Strecker felt Petitioner displayed signs, symptoms, and imaging studies consistent with ongoing tendinopathy and he recommended non-steroidal anti-inflammatories, physical therapy, and cortiscosteroid injections, none of which had been tried yet. He agreed that if conservative care didn't alleviate Petitioner's symptoms, surgery would be a reasonable treatment option. He did not feel Petitioner was at maximum medical improvement for her wrists or her shoulders and that she was capable of limited duty with the restriction of no activity above chest height.

On the issue of causal connection, Dr. Strecker was of the opinion Petitioner's work activities for Respondent were an aggravating factor in the development of her carpal tunnel syndrome and her subsequent need for treatment. With regard to Petitioner's shoulder conditions, Dr. Strecker did not feel her job duty of wiping down walls was either a causative or aggravating factor for her tendinopathy. Dr. Strecker was of the opinion that Petitioner's MRIs revealed chronic and degenerative changes in Petitioner's labrum which would not have occurred within 2 to 3 days of wiping down walls. (RX A, dep. ex. 2 -- pp. 3,4)

The deposition of Dr. Weimer was taken on April 16, 2013. Dr. Weimer, an orthopedic surgeon, testified consistent with his office notes. He further testified that he believed Petitioner was probably referred to him by her primary care physician since that is who he sent a copy of each office note to. (PX 5, p. 4) He further testified that when he

initially examined Petitioner she gave him a history of being a meat packer for thirteen years and he is somewhat familiar with the job duties of a meat packer. (PX 5, pp. 4-5) At the time of his initial examination he suspected Petitioner was having rotator cuff pathology and as she was only 50 years old and had been having problems for several years he felt MRIs were reasonable. (PX 5, p. 6) Those were done and Dr. Weimer testified that he personally reviewed the MRIs himself because his practice specializes in shoulders. Based upon his review of the MRIs Dr. Weimer felt Petitioner had a right rotator cuff tear, a SLAP lesion, arthritis, and impingement. On the left side he felt she had tendinosis, impingement, and arthritis but no tear "yet." (PX 5, p. 8) Dr. Weimer further testified that Petitioner's job duties "more likely than not" caused or exacerbated the condition of her shoulders which required the surgery he was recommending. (PX 5, p. 8) In light of Petitioner's relatively young age, the type of job she was performing, and the length of time she had been experiencing her symptoms and the MRI findings, Dr. Weimer recommended surgery on the right shoulder to repair the rotator cuff tear, as well as perform subacromial decompression, and debridement. He further recommended arthroscopic decompression and debridement on the left side. (PX 5, p. 8-9)

Dr. Weimer went on to state that he did not feel conservative treatment would do Petitioner any good as they would only address her symptoms and not the disease. He also felt that cortisone injections could do more harm than good in light of Petitioner's labor intensive job and age -- the injections might increase the risk of a tear or enlarging tear. Dr. Weimer did not feel physical therapy would help Petitioner's rotator cuff tear. (PX 5, pp. 9, 12) During cross-examination Dr. Weimer was asked to expound on this and he testified that Petitioner had significant tendinosis on the left side and he felt she was a "real high likelihood" to go on and have a tear because of its severity. She was at the stage right before a tear and, therefore, he didn't feel therapy would help. He further testified that he wouldn't inject steroids into someone who was still performing manual labor because it puts them at a "very high risk" of increasing a tear or causing one (PX 5, pp. 12, 13)

On cross-examination Dr. Weimer was asked if Petitioner had described experiencing any additional problems while she was on light duty for some of her hand issues and Dr. Weimer replied, "She did not. She did - I did record there was no history of a specific injury to her shoulders." (PX 5, pp. 10-11) He acknowledged that an individual such as Petitioner who has a Type III acromion (and hers was bilateral)[2] is more prone to rotator cuff problems than those with Type I or II acromions. (PX 5, p.11) He also acknowledged that Petitioner's diagnostic findings could be explained just by her age, bilateral type III acromia, and normal wear and tear. (PX 5, p. 12)

As Dr. Weimer testified that he was generally familiar with the job duties of a meat packer, he was asked about that understanding and he replied that his dad had done meat packing when he was younger. Dr. Weimer explained that his father would describe wrapping and packing meat, boxing it up, carrying large boxes out to trucks, and stuff like that. (PX 5, p. 13) He acknowledged he did not have a description of

[2] Dr. Weimer testified that having read the MRIs himself, Petitioner's Type III acromions were bilateral and the radiologist's report regarding the left side was wrong.

Petitioner's exact job. (PX 5, p. 14) Dr. Weimer further testified that Petitioner's job duties "more likely than not" caused or exacerbated the condition of her shoulders which required the surgery he was recommending. (PX 5, p. 8)

At the time of his deposition Dr. Weimer also testified that as of his last visit with Petitioner she was still in need of further medical care including surgical intervention. PX 5, p. 10)

The deposition of Dr. Strecker was taken on May 16, 2013. Dr. Strecker is a board certified orthopedic surgeon specializing in upper extremity conditions. (RX A, p. 11) Dr. Strecker testified that Petitioner told him about her job duties and they included packing hamburger which involved packing meat into a box, scooping meat into plastic bags, and sometimes taping the boxes shut. The boxes could weigh anywhere from 10 to 20 lbs. (RX A, p. 13) Petitioner also told Dr. Strecker she had been engaged in light duty work in March of 2012 which involved using a spray bottle and washing down some walls and her shoulders began to bother her. (RXA, pp. 13-14) Based upon his examination and the MRIs he felt Petitioner had some rotator cuff tendonopathy, some bilateral degenerative arthritis, and a "little bit of question" about possible bicipital tendonitis. (RX A, p. 17) Dr. Strecker was of the opinion the findings were age appropriate and unrelated to Petitioner's work activities. In concluding there was no work-related injury Dr. Strecker relied upon Petitioner's job description to him, noting that "She basically told me that she never lifted things over 20 pounds. She wasn't doing on a continual basis, but she would pack the meat, close it, tape it and move the box, maximum weight 20 pounds." He further testified that beyond that Petitioner never described any time during "regular activities other than the one incident where she was using the spray bottle on the wall where she did anything that was over chest height." (RX A, p. 19) With regard to the wall washing episode, Dr. Strecker testified that it might have provoked some symptoms at times if she was using one arm but it wouldn't exacerbate the condition and she denied using her left non-dominant arm. She was using her right arm. (RX A, p. 19)

Dr. Strecker re-iterated his opinions regarding Petitioner's need for some treatment but not surgery. He felt she had not undergone any conservative care whatsoever and he did not believe she had any evidence of a rotator cuff tear. She would, however, be a surgical candidate after six months of continuous symptoms and no improvement from conservative care. (RX A, pp. 22-23) He also felt she should be restricted from no overhead work but such a restriction would not preclude her from working as a meat packer because, according to her description, it didn't involve overhead work. (RX A, p. 24)

On cross-examination Dr. Strecker was asked if he disagreed with Dr. Weimer's finding of a right rotator cuff tear and Dr. Weimer testified "If you review her MRI, she may have a partial thickness inferior tear, that's possible." (RX A, pp. 29-30)

Petitioner's case proceeded to arbitration on April 18, 2014. Petitioner testified she has been employed by Respondent for fifteen years. Petitioner is employed by Respondent as a production line assistant -- ie., a meat packer. Petitioner described her job duties as packing frozen hamburger/beef patties into plastic bags and loading the full bags into boxes. She testified that with the exception of scheduled breaks the job requires her to work as fast as she can and to be in motion constantly. Petitioner demonstrated, generally, the duties of a meat packer which included using her hands and arms to place beef patties into bags and then lifting the beef patties/bags up and into boxes. Petitioner testified that she must place her arms up high to put the bags of patties into boxes.

Petitioner testified that in the late spring/early summer of 2012 she went to Dr. Mirly for carpal tunnel syndrome. She further testified that she was also having pain in her shoulders and felt like "everything was breaking down." She further testified that while she was on light duty for her hand complaints, she was scrubbing "long" walls and noticed shoulder pain. She testified that she had been experiencing problems with her bilateral shoulders prior to this time. She indicated that the shoulder symptoms appeared to have been getting progressively worse. While Petitioner was performing the light duty activities the employer instructed her to scrub down hallway walls. She testified that in the process of scrubbing the walls the pain in her shoulders became significantly worse causing her to seek medical treatment. Petitioner testified that at the time of arbitration she continued to suffer from pain and other symptoms in both of her shoulders. She indicated that although she continues to work she must take pain medications to do so.

Petitioner denied any specific accident or trauma to her shoulders. She recalled being examined by Dr. Strecker and discussing her job duties with him. She acknowledged that she performed the hallway light duty job for two to three days.

It was noted on the record prior to commencement of testimony that Respondent's basis for denying medical services was based upon their dispute as to the issues of accident and causal connection. The medical bills submitted (with the exception of the Midwest Occupational Medicine bill which the Arbitrator has determined is not related to this claim) correspond to the evaluation and treatment of Plaintiff's orthopedic surgeon Dr. Weimer and the radiology charges corresponding to the MRI scans performed on Petitioner's shoulders.

The Arbitrator concludes:

Issues C.&F.Did an accident occur that arose out of and in the course of Petitioner's employment with Respondent? Is Petitioner's current condition of ill being causally related to the injury?

Petitioner failed to prove she sustained an accident on June 14, 2012 that arose out of and in the course of her employment with Respondent or that her current condition of

ill-being in her shoulders is causally related to that accident or her employment with Respondent.

Based upon her testimony Petitioner associates her shoulder problems with both her regular work duties and the light duty work she performed while treating for her carpal tunnel injuries. With respect to her regular work duties, it appears that she believes the problems began in November of 2011 which also corresponds with her treatment with Dr. Mirly. However, not all of Dr. Mirly's records are a part of the record. While Petitioner testified that she first mentioned her shoulder problems to Dr. Mirly who was treating her carpal tunnel syndrome and Dr. Mirly's report of August 21, 2012 (PX 3, p. 1) was presumably introduced in support thereof, that doesn't fully explain everything as Petitioner had indicated to the nurse on April 23, 2012 when seen at Midwest Occupational that she had mentioned it to Dr. Mirly. That visit pre-dated the August 21, 2012 report of Dr. Mirly.

When Petitioner initially presented to Dr. Weimer on May 1, 2012 she gave two dates of injury: (1) 11.16.11 and 4.23.12. The 2011 date seems consistent with Petitioner's testimony and histories to various medical providers indicating that Petitioner was having some type of problem with her shoulders in 2011 but she was able to continue working and manage it with over the counter medications. The date of April 23, 2012 fits in with Petitioner's presentation to Midwest Occupational Medicine. While the manner of how Petitioner got to Midwest at that time is unclear the Arbitrator reasonably infers Respondent was involved.[3]

Petitioner has consistently presented this history of two injuries to all the medical providers. While Dr. Weimer's typed office note of May 1, 2012 doesn't clearly state that history, his handwritten notes do -- "Meat packer [for] 13 years. Some pain for years, relieved by tylenol or "nsaid. 2 weeks severe pain, no longer relieved by conservative measures." [Emphasis original.] His notes further suggest that Petitioner notified work (Respondent) on April 23, 2012 thus explaining the referral to Midwest Occupational Medicine.

The problem is that Dr. Weimer did not render a causation opinion based upon that history. He believed her condition was work-related solely because she was in a labor intensive job as a meat packer, a job Petitioner really had never described to him with any particularity but one the doctor was familiar with, generally, because his father had performed it for years. Dr. Weimer's generic description of what his father did was not what Petitioner did. Dr. Weimer also testified that Petitioner never described experiencing any additional problems while on light duty nor did she ever mention a specific accident/injury to her shoulders. He never addressed what, if anything, might have happened on/about April 23, 2012 to cause Petitioner to experience severe pain. Petitioner was clearly not performing her regular job duties on April 23, 2012. She was still performing light duty with regard to her hands.

Based upon the presentation of the case and the proposed decisions, it does not appear that Respondent has an issue with the alleged manifestation date. Additionally,

[3] When Petitioner was seen at Midwest the nurse recommended a return visit if Respondent so wished.

notice was not in issue. Thus, the issue really seems to come down to whether Petitioner's shoulder conditions arise out of her employment with Respondent and are causally connected to her work duties for Respondent. The Arbitrator concludes that Petitioner has failed to meet her burden of proof on either issue. In so concluding she notes the missing records of Dr. Mirly and Dr. O'Neill (Petitioner's primary care physician who referred her to Dr. Weimer), the lack of testimony regarding what, if anything, happened on/around April 23, 2012, and the failure to provide a causation opinion based upon accurate facts. Dr. Weimer did not have a clear, accurate, and detailed understanding of Petitioner's history regarding her shoulder complaints or her job duties for Respondent. He did not know what she specifically did as a meat packer nor did he know what she had been doing while on light duty.

The Arbitrator also notes an inconsistency in Petitioner's testimony concerning dates, activities, and the worsening of her symptoms. Petitioner told the nurse at Midwest Occupational on April 15th that her symptoms had been ongoing for several years but worsened in the week preceding her visit there. She told Dr. Weimer her symptoms became more severe on/about April 23, 2012. While the time period could be, arguably, somewhat consistent, Petitioner then told Dr. Strecker that she associated the worsening of her symptoms with the activity of wall cleaning while on light duty; however, she acknowledged she only performed that task one or two times in March of 2012. Petitioner's inability to pinpoint exactly when and what caused an alleged increase in her symptoms is fatal to her claim.

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?

The Arbitrator, having previously found that Petitioner failed to prove accident or causal connection, denies Petitioner's request for payment of medical expenses and prospective care.

Petitioner's claim for compensation is denied and no benefits are awarded.

****

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

Tony Abernathy,

Petitioner,

vs.

NO: 13 WC 5492
13 WC 7571

Grane Transportation and Aim Management Leasing, Inc.,

15IWCC0845

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, 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).

Pursuant to the Commission's review of Petitioner's Exhibit 23, it appears that the only claimed outstanding medical bill awarded by the Arbitrator was a $1,229.00 bill from Athletic Imaging for a May 24, 2012 date of service. It should be noted that this determination was made solely for purposes of determining the proper review bond in this matter, and the Commission reiterates that it affirms the Arbitrator's award of medical bills, and the language used by the Arbitrator in doing so. Thus, it is possible that there may be further outstanding medical expenses that the Commission did not locate in our review of the voluminous medical bills

15IWCC0845

submitted by Petitioner, and if there are further outstanding expenses that were awarded by the Arbitrator, the Respondent remains liable for same notwithstanding our determination of the bond.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 20, 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.

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: NOV 2 0 2015
TJT:yl
o 10/13/15
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

ABERNATHY, TONY
Employee/Petitioner

Case# **13WC005492**
13WC007571

GRANE TRANSPORTATION AND AIM MANAGEMENT LEASING INC
Employer/Respondent

15IWCC0845

On 10/20/2014, 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:

0059 BAUM RUFFOLO & MARZAL LTD
RICHARD W BRAUM
33 N LASALLE ST SUITE 1710
CHICAGO, IL 60602

GRANE TRANSPORTATION
1001 S LARAMIE AVE
CHICAGO, IL 60644

2999 LITCHFIELD CAVO LLP
JOHNATHAN E BARRISH
303 W MADISON ST SUITE 300
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

TONY ABERNATHY
Employee/Petitioner

Case #13 WC 5492
#13 WC 7571

v.

GRANE TRANSPORTATION AND
AIM MANAGEMENT LEASING, INC.,
Employer/Respondent

15IWCC0845

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 September 22, 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

- On May 21, 2012, and November 8, 2012, the respondent was operating under and subject to the provisions of the Act.

- On those dates, an employee-employer relationship existed between the petitioner and respondent.

- On May 21, 2012, the petitioner sustained injuries that arose out of and in the course of employment.

- Timely notice of the accidents was given to the respondent.

- In the year preceding the injuries, the petitioner earned $38,584.00; the average weekly wage was $742.00.

- At the time of injuries, the petitioner was 51 years of age, married with no children under 18.

- The parties agreed that the respondent paid $37,094.21 in medical bills through its group medical insurance carrier and is entitled to a Section 8(j) credit for the amount.

ORDER:

- The petitioner failed to prove that he is entitled to any temporary total disability benefits after June 4, 2012.

- The petitioner's request 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 temporary total disability, medical benefits, or compensation for a permanent disability, if any.

- The medical care rendered the petitioner for his lumbar spine through June 4, 2012, was reasonable and necessary and is awarded. The medical care rendered the petitioner for his cervical spine and bilateral carpal tunnel syndrome and after June 4, 2012, 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.

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

October 20, 2014

Date

OCT 20 2014

FINDINGS OF FACTS:

The petitioner, a truck driver for one month with the respondent, injured his back on May 21, 2012, while cranking the landing gear on a trailer. The incident is the subject matter of claim #13 WC 7571. He received medical care with Dr. David Priebe at Advanced Occupational Medicine Specialists the same day and reported right-sided lower back pain with right side radicular pain. X-rays showed mild L4 and L5 degenerative changes. The petitioner had pain with lateral rotation, bilateral side bending, seated right straight leg raise and the hyperextension test on the right. Conservative care and work restrictions were recommended for a lumbar strain. On May 23rd, the petitioner reported increased lower back pain, shooting pain into his right buttock and tingling into his right foot. An MRI on May 24th revealed mild disc bulges from L3 through L5-S1 and degenerative changes with bilateral neural foraminal stenosis. The petitioner reported some improvement on May 25th and started physical therapy. On June 4th, the petitioner reported complete relief of back pain and radicular pain to the doctor and the physical therapist. He was discharged to regular work duties.

The petitioner had a cervical x-ray due to neck pain and bilateral upper extremity radiculopathy on September 18, 2012, which was unchanged when compared to the x-rays on March 17, 2012. The petitioner saw Dr. Robert Katz on October 3, 2012, for bilateral hand/wrist stiffness, heavy arms up to his shoulders and sensation deficits. An undated EMG test revealed right carpal tunnel syndrome. He saw Dr. Michael McDonnell at Mercy Hospital and Medical Center on October 19, 2012, for left shoulder pain after slipping and catching himself with his left arm. He also reported heaviness and

weakness for several months in both arms and off-and-on fatigue for five months that had worsened the past month.

The petitioner's claim #13 WC 5492 is for an injury on November 8, 2012. He saw Dr. Katz on November 8th and received a carpal tunnel injection on the 17th. He saw Dr. Jeffrey Kramer for paresthesias in his hands on January 2, 2013, and followed up on the 18th. An EMG on February 16, 2013, was suggestive of bilateral cervical polyradiculopathies involving mainly C5 to C7 roots and/or bilateral carpal tunnel syndrome, right greater than left. On February 25, 2013, Dr. Heller opined that the petitioner's primary pathology was cervical radiculopathy. The petitioner saw Dr. McDonnell on March 4, 2013, and stated that he had complained of upper extremity symptoms since May 2012 but the treatment provided was only focused on his lumbar spine. A cervical MRI on April 9, 2013, revealed multilevel severe cervical central canal stenosis due to a combination of diffuse disc bulges/osteophyte complexes and ossification of the posterior longitudinal ligament. A cervical MRI on April 26, 2013, revealed diffuse spondylosis with multilevel annular disc bulging and hypertrophy of posterior elements, a 4.5 mm diffuse disc/osteophyte complex mildly impinging the cord and moderate spinal and moderate/severe bilateral neural foraminal stenosis at C3-4, a 3 mm diffuse disc/osteophyte complex/herniation and bilobed subarticular protrusion causing moderate right and moderate/severe left neural foraminal stenosis at C4-5, bilateral bilobed disc protrusion and moderate/severe bilateral neural foraminal stenosis at C5-6 and a 3 mm diffuse disc bulge and moderate/severe bilateral neural foraminal stenosis at C6-7. Flexion and extension MRIs the same day were negative for instability or pathological disc alteration. Dr. Theodore Fisher re-evaluated the petitioner on May

13, 2013, and recommended surgery for C3-4 spinal stenosis and a C4-5 herniation. On June 11, 2013, Dr. Fisher performed a C3-4 anterior cervical discectomy and fusion with insertion of a biomechanical device. The petitioner complained of tingling and numbness in both hands to Dr. Fisher on November 22, 2013, and at physical therapy on January 24, 2014. An EMG on August 12, 2014, suggested bilateral cervical polyradiculopathies involving mainly the C5 through C7 roots and distal motor neuropathy of the right median nerve.

The petitioner's prior medical care includes care for aches and pain, left arm numbness and right lower back pain with Dr. McDonnell on March 3, 2012. X-rays of his left shoulder and cervical spine on March 17, 2012, revealed minimal spurring of the acromial tip and moderate degenerative changes of the cervical spine with some neural foraminal narrowing. X-rays of his lumbar spine on March 24, 2012, revealed unilateral, right-sided spondylolysis at the L5 neural arch, unilateral, left-sided osteoarthritis of the facet joint at L5-S1 and degeneration at L3-4.

FINDING REGARDING THE DATE OF ACCIDENT AND WHETHER THE PETITIONER'S ACCIDENT AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH THE RESPONDENT:

Based upon the testimony and the evidence submitted, the petitioner failed to prove that he sustained an accident on November 8, 2012, arising out of and in the course of his employment with the respondent. There is no medical evidence or testimony to support a traumatic or repetitive injury on November 8, 2012. The petitioner's request for benefits for claim #13 WC 5492 is denied and the claim is dismissed.

FINDING REGARDING WHETHER THE MEDICAL SERVICES PROVIDED TO PETITIONER ARE REASONABLE AND NECESSARY:

The medical care rendered the petitioner for his lumbar spine through June 4, 2012, was reasonable and necessary and is awarded. The medical care rendered the petitioner for his cervical spine and bilateral carpal tunnel syndrome after June 4, 2012, was not reasonable or necessary and is denied.

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 his condition of ill-being with his lumbar spine through June 4, 2012, was causally related to the work injury on May 21, 2012. The petitioner failed to prove that his condition of ill-being with his cervical spine and bilateral carpal tunnel syndrome was causally related to the work injury on May 21, 2012.

Contrary to his testimony, the petitioner did not report or complain of hand or cervical symptoms after the injury on May 21, 2012. In fact, the petitioner was very specific as to only a lumbar spine injury in his description of his condition to the medical providers and in the two reports of injury he signed on the day of his injury and in a third report he signed on May 24, 2012. Moreover, the petitioner reported being completely asymptomatic on June 4, 2012. Also of note is that the petitioner sought medical care for his lumbar and cervical spine a month before starting work with the respondent in April 2012 and had only worked a month when he strained his lumbar spine. The petitioner's testimony is contradicted by the medical records and his reports of injury. The petitioner is not believable or credible. The opinions of Dr. Fisher are not consistent with the

evidence and are of no probative value. The petitioner's request for benefits after June 4, 2012, is denied.

FINDING REGARDING THE AMOUNT OF COMPENSATION DUE FOR TEMPORARY TOTAL DISABILITY:

The petitioner failed to prove that he is entitled to any temporary total disability benefits after June 4, 2012.

FINDING REGARDING PROSPECTIVE MEDICAL:

Based upon the testimony, the evidence submitted and lack of any causal relationship of the injury with the petitioner's condition with his cervical spine and bilateral carpal tunnel syndrome, the petitioner's request for prospective medical care is denied.

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

Jerry Trhlik,
Petitioner,
vs.
Illinois State University,
Respondent,

NO: 10WC 9864

15IWCC0818

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, 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 January 12, 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.

NOV 3 - 2015

DATED:
MJB/bm
o-10/26/15
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

TRHLIK, JERRY
Employee/Petitioner

Case# 10WC009864

ILLINOIS STATE UNIVERSITY
Employer/Respondent

15IWCC0818

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:

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

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 6M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

4138 ASSISTANT ATTORNEY GENERAL
WARREN WILKE
500 S SECOND ST
SPRINGFIELD, IL 62702

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

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 12 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

JERRY TRHLIK
Employee/Petitioner

v.

ILLINOIS STATE UNIVERSITY
Employer/Respondent

Case # 10 WC 0009864

Consolidated cases: _____

15IWCC0818

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 **Bloomington, Illinois**, on **11/21/14**. 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 **1/4/10**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**35,275.24**; the average weekly wage was $**678.37**.

On the date of accident, Petitioner was **45** years of age, ***single*** with **2** dependent children.

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

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

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

Respondent is entitled to a credit **for all medical paid for by Petitioner's group health carrier** under Section 8(j) of the Act.

ORDER

Having found that Petitioner failed to prove to that his subtalar joint athrodesis nonunion and ankle replacement was the result of an accidental injury that arose out of and in the course of his employment with Respondent on January 4, 2010, his 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

1/9/15
Date

JAN 12 2015

Findings of Fact:

Petitioner testified that while working at Illinois State University, he was injured on January 4, 2010. Petitioner's job on the date of the injury was truck driver. His job consisted of collecting all recycled materials on the campus. Based on his testimony it would appear that cardboard was the primary recycled material. Petitioner claimed that the route included walking 10 miles per day. Petitioner claimed that he removed 5 to 6 tons of cardboard a day. Petitioner testified that in the process of collecting recyclables, he would jump off of a dock approximately 100 times per day. Petitioner indicated that the height of the jump was about 4 to 5 feet. At other points in his testimony, Petitioner provided that the loading docks were six feet high.

Petitioner also described having to move "toters" in a hand-truck-like fashion, meaning that the "toters" had two wheels and had to be tipped back to move. According to Petitioner's testimony, the recycled material he collected each day would be found in these "toters." Petitioner stated that these "toters" would weigh between 250 and 500 pounds. Petitioner stated that he removed between 400 and 650 "toters" per day. Petitioner testified that after loading the cardboard onto the truck, he would unload it by kicking it out. Petitioner provided that he was going to each floor and retrieving the "toters" which would be then be brought and unloaded at the docks.

Petitioner testified that on or around January 4, 2010, he began experiencing sharp pains in his ankle, and that due to these pains he arranged to see Dr. Grambart, whom he had seen on multiple prior occasions for ankle injuries. The evidence submitted at trial shows that Petitioner has treated with Dr. Grambart for ankle injuries and complications since 2005.

On May 27, 2005, Petitioner underwent an ankle fusion performed by Dr. Grambart. (RX. 5) Petitioner continued to experience pain after this surgery. The ankle fusion was declared stable on December 5, 2005. Petitioner's issues in the ankle area of his foot appeared to be somewhat stable until November 9, 2006 at which time Petitioner's pain in his right foot began to increase. The records indicate that the subtalar joint was found to be the sources of Petitioner's pain and a subtalar fusion was performed to rectify the issue. The remaining records show slow, but good healing until November 9, 2009 when Petitioner injured his foot at work. That injury however, appeared to be of little consequence since Petitioner was returned to work shortly thereafter. *Id.* The records submitted at trial indicate that Petitioner brought a workers' compensation claim related to the 2005 injuries, which was found by the Illinois Workers' Compensation Commission to be not related to Petitioner's employment. (RX 4)

Petitioner presented to Dr. Grambart on January 21, 2010. Records show he presented with new complaints of pain. Petitioner provided that he was having difficulties with extended walking as well as on uneven surfaces. An examination of the right lower extremity showed minimal swelling and tenderness within the sinus tarsi region. X-rays taken showed the right ankle fusion had healed. The doctor noted that at the "[s]ubtalar joint fusion, there does appear to be a line through the posterior facet and subtalar joint still. There does look like some loosening around some of the screws, but they have not changed position." The doctor assessed possible nonunion, right subtalar joint, and recommended a CT scan. (PX 2)

The CT scan was carried out on February 3, 2010 and Petitioner returned to Dr. Grambert that same day. Dr. Grambart reviewed the CT scan indicating same showed a nonunion of the subtalar joint. Dr. Grambart recommended a takedown of the ankle fusion with an ankle implant and revision subtalar joint fusion with possible lateralized calcaneal osteotomy. (PX 2)

On April 2, 2010, Dr. Grambart performed surgery consisting of a total ankle replacement, revision of subtular joint arhtrodesis, and deep hardware removal. The pre-operative and post-operative diagnosis was 1.) ankle joint fusion; 2.) subtalar joint athrodesis nonunion; and 3.) retained internal fixation of the right ankle (PX 2)

Dr. Grambart's deposition was taken on August 24, 2010. Dr. Grambart confirmed the non-union. (PX 1 pg. 6-7) Dr. Grmabart discussed movement of the joint as a possible cause of a non-union. The doctor indicated that motion at an attempted fusion site can lead to a non-union. He added the most reported reason is nicotine use. (PX 1, pg. 8) Dr. Grambart provided the opinion that Petitioner's work activities of jumping, walking, dumping large containers and kicking materials aggravated his right foot condition and contributed to his need for surgery. Dr. Gramber stated that "...the higher impact, the jumping and the kicking, can definitely aggravate it just because it can create micro motion across the fusion site. And the jumping with basically an ankle fusion and essentially a subtalar fusion, he wouldn't be able to do normal motion and normal activities with that. So any type of higher impact activity can aggravate it." The doctor added, that "...[e]ventually the bony fusion can break apart if it's not completely solid at that time." (PX 1, pgs. 12,13) Lastly, Dr. Grambart testified that the ankle replacement performed in 2010 was an elective procedure adding that it was performed to give Petitioner "a little bit more of his motion back." (PX 1, pgs 24,25)

Post-operatively, Petitioner continued to treatment with Dr. Grambart which included physical therapy. On October 18, 2010, Dr. Grambart noted Petitioner had transitioned into walking in shoes. Petitioner reported that he still had some pain and swelling. An examination revealed the subtalar joint looked liked it was healing with good alignment. Dr. Grambart felt Petitioner had to maintain low impact activities which would be "life-long." On May 27, 2011, Petitioner returned complaining of uncomfortable nerve type pain. X-rays taken showed good alignment of the implant with fixation in place. The arthrodesis site looked fine as well. The doctor ordered a CT scan of the right foot and ankle. He also discussed the possibility of an EMG/NCV study. The CT scan when carried out on May 31, 2011, showed the arthroplasty hardware appeared well anchored and in anatomic alignment. Bony fusion was demonstrated across the majority of the subtalar joint with one small open focus medially extending to the medial margin of the joint space. (PX 2)

Records show Dr. Grambart performed a deep hardware removal, right foot, on July 7, 2011. The indication for same was painful hardware. The post-operative diagnosis was 1.) painful internal fixation, right foot; and, 2.) tarsal tunnel pain, right foot. (PX 2)

Petitioner continued with complaints of right ankle compaints. On August 21, 2012, he underwent a exostectomy, right ankle and cascade injection, right ankle. The post operative diagnosis was exostosis, right ankle and superficial peroneal nerve neuritis, right ankle. (RX 5)

On July 16, 2013, Petitioner saw Dr. Grambart. The doctor noted Petitioner was continuing to experience nerve pain along the lateral aspect of the right ankle as well as pain and catching within the ankle joint. X-rays taken that day showed stable alignment of the ankle components. Also noted was quite a bit of extraosseous formation around the anterior ankle in the medial and lateral gutters. Dr. Grambart assessed 1.) status post total right ankle replacement; 2.) nerve pain; and, 3.) ankle impingement, osseous. The doctor

ordered a CT scan and recommended manipulation of the right ankle with common peroneal nerve block and scar tissue. (RX 5)

The prescribed CT scan was completed on July 23, 2013 showing an anteriorly located bone spur off the dorsal surface of the talus. There was a possible impingement on the anterior aspect of the joint space which was felt to be a new finding when compared to the stable appearing spurring off the posterior joint line. Also noted was that laterally the tib-fib relationship was fused. That same day, Dr. Grambart performed 1.) manipulation of the ankle under sedation; and, 2.) common peroneal nerve injection. (RX 5)

Petitioner testified that he notified Dee Beverly and Ben Ryburn, his supervisors, on the same day, (January 5, 2010) that he was having problems with his right foot because of his work activities. Petitioner provided that thereafter he received a call from Loretta Beech in Human Resource who sent his "some information" on January 12, 2011. He provided that he stopped working for Respondent thereafter. He now works for ADT as a sales representative.

On December 17, 2013, Dr. George Holmes, by the request of Respondent completed an independent medical examination and issued a report based on his review of the medical records and examination of Petitioner. Dr. Holmes opined that Petitioner "...did not sustain specific repetitive trauma injury to the right foot or ankle as a result of his employment [with Respondent] on January 5, 2010. Dr. Holmes wrote that "[i]t has been hypothesized that his repetitive activities, performing his duties as a recycling driver caused him to develop a nonunion of the subtalar joint. It has been my experience that it is not really possible to develop a nonunion with a fused ankle and a fused subtalar joint. Therefore, it is more likely true than not true that he probably did not have a fully fused subtalar joint prior to his re-embarking on his employment activities at [Respondent]." Dr. Holmes went on to state that "[i]n terms of causality . . . it would appear that he did not have a solid fusion, and therefore, any weight bearing activities such as walking, working activities, or even recreational activities, anything that involves any walking for activities of daily living would have been the cause of his injury..." (RX 1)

Dr. Holmes opined that the treatment after January 5, 2010 was reasonable and necessary. However, he stated that "[t]here are other avenues that could have been taken at the time he was diagnosed with a subtalar nonunion other than a subtalar fusion and revision to an ankle revision to an ankle replacement. That is to say, after the ankle replacement, this patient was placed on restrictions. However, if the patient had undergone a revision of the subtalar joint alone, it is possible he could have returned back to his regular duties without any weight bearing restrictions." RX 1)

Dr. Holmes was also deposed in this matter. The doctor confirmed his findings and expanded on his reasoning of those findings. Dr. Holmes stated that "[i]t is impossible if a joint is fused to have it become unfused...it really can't happen if it's fused." Dr. Holmes stated that "...[i]f you get a nonunion later on, then you have to assume that it wasn't fused..." (RX 3, pg. 12) Dr. Holmes added that "...[i]f it's solidly fused, it will stay fused unless he jumps off a bridge or gets in a car accident, but if that were to occur he as likely to have a fracture around the joint as through the subtalar joint. So it's at no greater risk of fracture than the bone would be originally." (RX 3 pg. 16) According to Dr. Holmes, "[s]ome non-unions can be tremendously symptomatic, some can be almost relatively asymptomatic." Dr. Holmes also clarified that asymptomatic non-unions can become symptomatic due to trauma, while not being causally connected to the formation of a non-union. (RX 3, pg. 17)

Dr. Holmes testified that the ankle replacement was totally unrelated to the subtalar revision. He also felt the ankle replacement was illogical. Dr. Holmes stated that "[o]ne, if you're going to do that, you would have done it initially when you did the first subtalar arthrodesis. Two, it has been shown that ankle replacements do not work very well if someone had a fusion. So this is a person who's had his ankle fused, his subtalar joint fused, and when you fuse a joint, the muscles around that joint generally stop working, [whether] it be your knee or your hip. So some – we've known for years, decades that it's very difficult to convert a – a fused joint to a functional joint after it's been fused . . . So I'm not sure why it was done, but it had nothing to do with the subtalar nonunion. (RX 3 pg. 19). Moreover, Dr. Holmes stated that that an ankle fusion followed by a replacement is a complete reversal of the typical and recommended course of action. He stated, "...If you do an ankle replacement and it fails in the future, your bailout procedure is an ankle fusion. If you do an ankle fusion, that is your committed procedure and it is very, very difficult to do an ankle replacement after an ankle fusion. If that were the case, we'd all be doing ankle replacements now for the people that were fused five and ten years ago as ankle replacements became more popular." (RX 3, pg 21) Dr. Holmes added that even if Petitioner did not have a prior fusion, he would not recommend an ankle replacement. Dr. Holmes noted that Petitioner appeared to be involved in high impact activities stating that "...most of my colleagues that do this in major institutions would say that these are the exact activities that you would not want do an ankle replacement for because it's not designed for high impact activities...High impact activities are activities that create a higher incidence of failure in a total ankle replacement." (RX 3, pgs 23-25) Dr. Holmes also clarified that neither Petitioner's job nor his recreational activities would cause a subtalar non-union. (RX 3, pgs. 25-26)

Dr. Holmes testified that a subtular fusion is done to eliminate pain. Same also eliminates motion as well. Dr. Holmes further testified that an ankle replacement addresses pain also. (RX 3, pgs. 30-31)

With respect to issues (C.) Did an accident occur that arose out of and in the course of Petitioner's employment byRespondent and (F.) Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds as follows:

Petitioner testified that on or around January 4, 2010, he began experiencing sharp pains in his ankle, and that due to these pains he arranged to see Dr. Grambart, whom he had seen on multiple prior occasions for ankle injuries. The evidence submitted at trial shows that Petitioner has treated with Dr. Grambart for ankle injuries and complications since 2005.

On May 27, 2005, Petitioner underwent an ankle fusion performed by Dr. Grambart. The ankle fusion was declared stable on December 5, 2005. Petitioner's issues in the ankle area of his foot appeared to be somewhat stable until November 9, 2006 at which time Petitioner's pain in his right foot began to increase. Petitioner's subtalar joint was found to be the sources of his pain. As a result a subtalar fusion was performed to rectify the issue. Petitioner brought a workers' compensation claim related to the 2005 injuries, which was found by the Illinois Workers' Compensation Commission to be not related to Petitioner's employment.

On January 21, 2010, Petitioner presented to Dr. Grambart with new complaints of pain. Petitioner provided that he was having difficulties with extended walking as well as on uneven surfaces. X-rays were taken showing the right ankle fusion had healed. Dr Grambert noted that at the "[s]ubtalar joint fusion, there does appear to be a line through the posterior facet and subtalar joint still. There does look like some loosening around some of the screws, but they have not changed position." The doctor assessed possible nonunion, right subtalar joint, and recommended a CT scan. The CT scan was carried out on February 3, 2010 and Dr.

Grambart reviewed same indicating the study showed a nonunion of the subtalar joint. Dr. Grambart recommended a takedown of the ankle fusion with an ankle implant and revision subtalar joint fusion with possible lateralized calcaneal osteotomy.

On April 2, 2010, Dr. Grambart performed surgery consisting of a total ankle replacement, revision of subtular joint arhtrodesis, and deep hardware removal. The pre-operative and post-operative diagnosis was 1.) ankle joint fusion; 2.) subtalar joint athrodesis nonunion; and 3.) retained internal fixation of the right ankle (PX 2)

Dr. Grambart testified and provided the opinion that Petitioner's work activities of jumping, walking, dumping large containers and kicking materials aggravated his right foot condition and contributed to his need for surgery. Dr. Gramber stated that "...the higher impact, the jumping and the kicking, can definitely aggravate it just because it can create micro motion across the fusion site. And the jumping with basically an ankle fusion and essentially a subtalar fusion, he wouldn't be able to do normal motion and normal activities with that. So any type of higher impact activity can aggravate it." The doctor added, that "...[e]ventually the bony fusion can break apart if it's not completely solid at that time." The doctor indicated that motion at an attempted fusion site can lead to a non-union. He added the most reported reason is nicotine use. Dr. Grambart also testified that the ankle replacement performed in 2010 was an elective procedure adding that it was performed to give Petitioner "a little bit more of his motion back."

Contrary to Dr. Grambarts opinion, Respondent's Section 12 examiner, Dr. Holmes, opined Petitioner "...did not sustain specific repetitive trauma injury to the right foot or ankle as a result of his employment [with Respondent] on January 5, 2010. Dr. Holmes indicated that "[i]t has been hypothesized that his repetitive activities, performing his duties as a recycling driver caused him to develop a nonunion of the subtalar joint. It has been my experience that it is not really possible to develop a nonunion with a fused ankle and a fused subtalar joint. Therefore, it is more likely true than not true that he probably did not have a fully fused subtalar joint prior to his re-embarking on his employment activities at [Respondent]." Dr. Holmes felt the prior fusions were either successful and resulted in unions, or were unsuccessful and resulted in non-unions. Dr. Holmes went on to state that "[i]n terms of causality . . . it would appear that he did not have a solid fusion, and therefore, any weight bearing activities such as walking, working activities, or even recreational activities, anything that involves any walking for activities of daily living would have been the cause of his injury..." Dr. Holmes stated that "[i]t is impossible if a joint is fused to have it become [un-fused]...it really can't happen if it's fused...[i]f you get a nonunion later on, then you have to assume that it wasn't fused..." Dr. Holmes added that "...[i]f it's solidly fused, it will stay fused unless he jumps off a bridge or gets in a car accident, but if that were to occur he as likely to have a fracture around the joint as through the subtalar joint. So it's at no greater risk of fracture than the bone would be originally." According to Dr. Holmes, "[s]ome non-unions can be tremendously symptomatic, some can be almost relatively asymptomatic." Dr. Holmes also clarified that asymptomatic non-unions can become symptomatic due to trauma, while not being causally connected to the formation of a non-union. In other words, trauma could cause someone to realize they have a non-union, but not actually cause the non-union. Dr. Holmes also clarified that neither Petitioner's job nor his recreational activities would cause a subtalar non-union. He indicated that the need for same was present prior, as the cause of a non-union is an ineffective attempt at a prior union. Dr. Holmes also felt the ankle replacement was totally unrelated to the subtalar revision.

As noted above, Dr. Holmes opines that a non-union is a failed union – meaning, that the prior union never took. Anything else would be a fracture or some sort of degradation of the bone such as a stress fracture. According to Dr. Holmes, there was no such evidence in any of Petitioner's medical history. Thus according to

Dr. Holmes Petitioner's subtalar condition was a non-union related to a surgery that the Illinois Workers' Compensation Commission already found not to be work related. In so finding the Commission stated: "[i]t is reasonable to expect that a worker with this condition would experience symptoms while working; however, that is not the same as concluding that the work activities actually cause or aggravate the condition. The doctor's opinion in that case, that any activity would cause symptomology is the same as Dr. Holmes'.

Relying on the opinions of Dr. Holmes, the Arbitrator finds that Petitioner failed to prove that his subtalar joint athrodesis nonunion and ankle replacement was the result of an accidental injury that arose out of and in the course of his employment with Respondent.

In addition to the medical evidence which the Arbitrator relies on, the Arbitrator is also troubled by Petitioner's testimony regarding his work related risks. While it was not disputed that Petitioner was performing the job duties in question on the date of the alleged accident, the Arbitrator questions the duration, intensity, and variety of Petitioner's work activities along with questions related to quantifying the weight of recycling materials he moved in a day.

Petitioner testified that his job was a truck driver. His job consisted of collecting all recycled materials on the campus. It appears that cardboard was the primary recycled material. Petitioner claimed that the route included walking 10 miles per day; removing 5 to 6 tons of cardboard a day; and jumping off of a dock, anywhere from 4 to 6 feet, approximately 100 times per day. Petitioner also described having to move "toters" in a hand-truck-like fashion. According to Petitioner these "toters," with materials, would weigh between 250 and 500 pounds. He allegedly removed between 400 and 650 "toters" per day.

If Petitioner's estimates are remotely accurate, it means he removed between 10,000 and 12,000 pounds of cardboard a day. Under Petitioner's "toters" assessment, he would remove between 100,000 and 325,000 pounds, or between 50 and 162.5 tons. That's an increase between 10 and 27 fold. Petitioner testified that after loading the cardboard onto the truck, he would unload it by kicking it out. This means that he would kick out up to 325,000 pounds of cardboard a day. These numbers are implausible.

The numbers Petitioner described are further questioned. For example, Petitioner claimed that he jumped off of docks at least 100 times per day. Petitioner's shift was eight hours per day. If you provide for breaks and a lunch, Petitioner would be jumping off a dock every 3.9 minutes. While that might not seem like a lot if Petitioner was just working on the docks; however, Petitioner was doing quite a bit more than that. Petitioner was going to each floor and retrieving the "toters" which would be then be brought and unloaded at the docks. Furthermore, Petitioner would then unload the truck, as he testified, by kicking the materials out. The daily total weight of the materials Petitioner claimed to unload ranged between 100,000 and 325,000 pounds. The time frame and the weight moved by hand alone is unfathomable. Adding the ten miles of walking, and a hundred instances of jumping from a height ranging between four and six feet, Petitioner's account is difficult to comprehend. While the inconsistencies of Petitioner's numerical allegations do not call into question the credibility of the totality of his testimony, his credibility with regard to his numerical allegations is certainly suspicious.

With respect to issue (E.) Was timely notice given to Respondent, the Arbitrator finds as follows:

Petitioner testified that he finished his job on the day in question and provided he showed his supervisor his ankle on the day in question. Petitioner indicated that he related to his supervisor that his ankle issues were due to his job duties.

On March 15, 2010, Petitioner filed an Application for Adjustment of Claim alleging he sustained a compensable accident on January 5, 2010. At trial the "Application" was amended to show an accident date of January 4, 2010. Respondent disputed notice at trial and submitted an Illinois Form 45 completed on September 17, 2013 to support of its position.

According to the evidence submitted, March 15, 2010, is the latest Respondent became aware Petitioner was claiming he sustained a January 2010 work related accident. While this notice is 24 days beyond the 45 day notice period, Respondent has not shown it was prejudice by said defective notice.

All remaining issues are rendered moot.

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

Edwin Doty,
Petitioner,
vs.
State of Illinois, Big Muddy River Correctional Center,
Respondent,

NO: 10WC 48499
15IWCC0817

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 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 26, 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:

MJB/bm NOV 3 – 2015
o-10/26/15
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

DOTY, EDWIN Case# **10WC048499**

Employee/Petitioner

SOI BIG MUDDY CORRECTIONAL CENTER

Employer/Respondent

15IWCC0817

On 1/26/2015, 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:

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

4948 ASSISTANT ATTORNEY GENERAL
WILLIAM H PHILLIPS
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

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

JAN 26 2015

RANDY A. PASCIA, 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)

Edwin Doty
Employee/Petitioner

v.

State of Illinois, Big Muddy River Correctional Center
Employer/Respondent

Case # **10** WC **48499**

Consolidated cases: _____

14IWCC0817

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael K. Nowak**, Arbitrator of the Commission, in the city of **Collinsville**, on **November 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. ☒ 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 _____

15IWCC0817

FINDINGS

On the date of accident, **October 13, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**56,483.96**; the average weekly wage was $**1,086.23**.

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

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

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

Respondent is entitled to a credit of $**any benefits paid through group** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, as set forth in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall authorize and pay for any medical treatment recommended by Dr. Young and Dr. MacKinnon, including but not limited to surgery pursuant to the fee schedule, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $$724.15/week for 1 week, commencing 1/5/11 through 1/12/11, 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.

Signature of Arbitrator

1/19/15
Date

ICArbDec19(b)

JAN 26 2015

FINDINGS OF FACT

The Petitioner has worked for the State of Illinois Department of Corrections since 1992. From 1992-1998 he worked at the Respondent's Robinson facility. In 1998 he transferred to Big Muddy River Correctional Center. He was a Correctional Officer (CO) at both locations. The Petitioner has no comorbid factors for the development of carpal tunnel syndrome. He does not have diabetes, gout, or hypothyroidism. His weight has been fairly consistent, although he has gained weight since April of 2010 because his exercise activity has been curtailed as a result of his arm symptoms. Petitioner testified that he had the opportunity to review all material prepared by Respondent, including the DVD's, the job site analysis, and the demands of the job form. With regard to the video, Petitioner testified that it did not show the frequency and pace at which he works, and the video was not even done on his shift. Petitioner worked his entire career on the 7-3 shift, where there is the most movement, and the video was taken on the 3-11 shift.

Petitioner testified that 20 percent of the COs were to be rotated every 90 days, but that did not happen for him. As a result, 75- 85 percent of his time was spent as a wing officer or segregation officer. As a wing officer he opens cell doors using a 3 inch key. The doors he opens are made of heavy metal and require grip and force to move. He testified that in the first 90 minutes alone he keys doors at least 120 times. After he opens the door he checks for violations and searches the property boxes. This involves lifting the property box and using his arms and hands to search them. This also involves moving and lifting furniture and moving and lifting mattresses, and requires grip and force. As a wing officer he conducts wing checks every half hour which requires him to walk up and down the top and bottom of both wings pulling on each door to ensure security. He also cuffs and uncuffs inmates. On occasion inmates resist requiring Petitioner to exert pressure using his arms and hands to restrain them.

While working in the segregation unit all inmate services are rendered through a chuckhole. Petitioner testified that to open the chuckhole he uses a large Folger Adams key which is not easy to turn. The key itself is five inches long and heavy. The key does not turn easily nor does the chuckhole open easily because they are blocked with dirt and food. When moving inmates in segregation they must be handcuffed. When cuffing and uncuffing them he would first have to open the chuckhole. The inmate then stands in front of the opening facing away from the door with his hands behind him. The CO then has to reach in and out of the chuckhole to put cuffs on them. If inmates resist this requires greater grip and force. When the chuckholes stick, he has to slam them shut. The doors in segregation have a strip of rubber bolted onto the bottom which make it harder to pull the doors open and closed. When working in segregation Petitioner was also required to do bar rapping. This involves using a mallet to strike steel bars on the shower cell which causes vibration to his arms and hands and it's done on each cell.

During the course of his employment at Big Muddy Correctional Center Petitioner began developing symptoms of numbness and tingling in his right hand. The Petitioner testified that over 95 percent of his activity the keying, the pulling on doors, the opening of chuckholes, the cuffing and uncuffing of inmates was done with his right hand. He has no symptoms in his left hand. The symptoms the Petitioner had been experiencing in his right arm and hand were described as "a tingling in my digits, pain in the wrist and it goes to the back of my arm to my elbow. It's sometimes burning pain, and it's just—like now—like now, numbness in the tips of the fingers."

Petitioner sought treatment from his family physician, Dr. McFadden, and was referred for electro diagnostic studies. These occurred on September 3, 2010, after which he filled out an incident report at work indicating his condition was work-related. Following the electro diagnostic studies Petitioner was referred to Dr. Steven Young, a board certified hand specialist. Dr. Young's records indicate Petitioner is a 52-year-old, right-hand dominant male with a history that since June 2010, he has had pain and numbness in the right upper

extremity which has slowly gotten worse. He states he does have pain from his shoulder all the way down into his hand, and his pain level is a between an 8 and a 10. He states that he has decreased grip strength and constant pain. On examination he noted Petitioner had full range of motion of the shoulder in all planes, as did the elbow and wrist. He was noted to have decreased grip strength. He had a positive Tinel's and a positive median nerve compression test at the right wrist as well as a positive Tinel's over the right radial tunnel. (PX. #2, 10/26/10)

Dr. Young diagnosed right carpal tunnel syndrome and right radial tunnel syndrome. (PX. #8 p. 9). Dr. Young testified that he had reviewed the DVD and Petitioner's job description of the position of Correctional Officer at Big Muddy. Based on his review of the DVD and job description, as well as his conversation with Petitioner, the history, examinations, and the diagnostic study, Dr. Young believed that Petitioner's employment at Big Muddy Correctional Center would be a contributing factor to his symptoms and a need for surgery. (PX. #8 p. 10-12). He also believed that Petitioner's condition was work related because of the majority of work utilizing his dominant right upper extremity. (PX. #8 p.12).

As of the Petitioner's last visit on March 24, 2011, his radial tunnel symptoms had improved somewhat, but still persisted. (PX. #8 p.12). There had been no improvement in his carpal tunnel syndrome and Dr. Young continued to recommend the same surgical procedure (PX. #8 p.12, 13).

Petitioner also saw Dr. Susan MacKinnon, Chief of Reconstructive and Plastic Surgery at Washington University. (PX. # 9 p. 4). Dr. MacKinnon reviewed materials supplied by both Respondent and Petitioner in conjunction with seeing Mr. Doty and giving her deposition. (PX. # 9 p. 6, 7). Dr. MacKinnon examined Petitioner, took his history, reviewed all materials that were sent, reviewed the diagnostic study and believed that petitioner had right carpal tunnel syndrome with radial tunnel syndrome or compression of the posterior interosseous nerve in the proximal forearm along with some inflammatory at the base of the right thumb/CMC joint. (PX. # 9 p. 8). Her impression was that Petitioner's symptoms/issues of radial tunnel and carpal tunnel would be aggravated by his work duties. (PX. # 9 p.8). She noted Petitioner had already tried conservative treatment for the carpal tunnel, but there is no conservative treatment available for radial tunnel. *Id.* at 9-10. She believed that Petitioner needed surgery on both his radial tunnel and carpal tunnel which could be done at the same time. (PX. # 9 p. 11). She believed the need for the surgeries would be associated with Mr. Doty's work activities. (PX. # 9 p.13). When ask to opine specifically on the issue of causation she stated:

> A. My conclusion is, based on what he told me, that the work that he did would have a higher association with the developing of the radial tunnel than if he hadn't been doing that work.
>
> Q. Would you be of the same opinion in terms of an aggravating factor, not a causative or—well, not a causative, but an aggravating factor-with regard to this gentlemen's symptoms necessitating the need for treatment, splinting, bracing, et cetera?
>
> A. Yes. (PX. # 9 p. 16).

Respondent had petitioner's records reviewed by Dr. Anthony Sudekum, but no Section 12 examination took place. Dr. Sudekum testified that he did not feel Petitioner's work as a Correctional Officer contributed "significantly" to the etiology or exacerbation of this carpal tunnel syndrome or radial tunnel syndrome. On cross examination, however he indicated Petitioner's carpal tunnel and radial tunnel syndromes had "nothing whatsoever" to do with work. Dr. Sudekum believed that the manual activity performed by Correctional Officers was performed at "a relaxed and unhurried pace" and "throughout the video there does not appear to be any significant sustained or repetitive heavy pinching, gripping, grasping, pushing, or pulling." (RX. # 1 Depo

X. #2 p.6). He also believed that the maximum number of times a CO would use a key to open a door on any of the jobs would be a maximum of forty times per shift. (RX. # 1 Depo X. #2 p.8). Petitioner, however, testified that he turns keys 120 times in the first 90 minutes alone of his day. Dr. Sudekum did, however believe that surgery was a reasonable alternative for Petitioner (T.25, 74).

Respondent had a Job Site Analysis prepared by Melanie Welch. The Job Analysis indicates that Petitioner does frequent lifting of up to 50 lbs. and frequent carrying of up to 25 lbs. (frequent being defined as up to 5 ½ hours per day); frequent finger manipulation up to 5 ½ hours per day; pinching up to 2 ½ hours per day; grasping up to 2 ½ hours per day; pulling up to 2 ½ hours per day; pushing up to 2 ½ hours per day, and wrist turning up to 2 ½ hours per day. (RX #2 p.65-67).

CONCLUSIONS OF LAW

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

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

An injury is accidental within the meaning of the Act if "a workman's existing physical structure, whatever it may be, gives way under the stress of his usual labor." *Laclede Steel. Co. v. Industrial Commission*, 128 N.E.2d 718, 720 (Ill. 1955); *General Electric Co. v. Industrial Commission*, 433 N.E.2d 671, 672 (Ill. 1982). In a repetitive trauma case, issues of accident and causation are intertwined. *Elizabeth Boettcher v. Spectrum Property Group and First Merit Venture,* 99 I.I.C. 0961 (1999). Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it is a causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672-73 (Ill. 2003) (emphasis added). As in establishing accident, to show causal connection Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury. *Fierke v. Industrial Commission*, 723 N.E.2d 846 (3rd Dist. 2000).

In *Edward Hines Precision Components v. Indus. Comm'n,* 825 N.E.2d 773, (2nd Dist. 2005). the Court expressly stated, "There is no legal requirement that a certain percentage of the workday be spent on a task in order to support a finding of repetitive trauma." *Id.* at N.E.2d 780. Similarly, the Commission recently noted in *Dorhesca Randell v. St. Alexius Medical Center*, 13 I.W.C.C. 0135 (2013), a repetitive trauma claim, a claimant must show that work activities are a cause of his or her condition; the claimant does not have to establish that the work activities are the sole or primary cause, and there is no requirement that a claimant must spend a certain amount of time each day on a specific task before a finding of repetitive trauma can be made. *Randell* citing *All Steel, Inc. v. Indus. Comm'n*, 582 N.E.2d 240 (2nd Dist. 1991) and *Edward Hines supra.*

The Appellate Court in *City of Springfield v. Illinois Workers' Comp. Comm'n*, 901 N.E.2d 1066 (4th Dist., 2009) issued a favorable decision in a repetitive trauma case to a claimant whose work was "varied" but also "repetitive" or "intensive" in that he used his hands, albeit for different task, for at least five (5) hours out of an eight (8) hour work day. *Id.* "While [claimant's] duties may not have been 'repetitive' in a sense that the same thing was done over and over again as on an assembly line, the Commission finds that his duties required an intensive use of his hands and arms and his injuries were certainly cumulative." *Id.*

In this case, the evidence shows that Petitioner used his hands for at least 5 hours out of an 8 hour work day. Respondent's Analysis, indicates that Petitioner does frequent lifting of up to 50 lbs. and frequent carrying of up to 25 lbs. (frequent being defined as up to 5 ½ hours per day); frequent finger manipulation up to 5 ½

hours per day; pinching up to 2 ½ hours per day; grasping up to 2 ½ hours per day; pulling up to 2 ½ hours per day; pushing up to 2 ½ hours per day, and wrist turning up to 2 ½ hours per day. (RX #2 p.65-67).

The Arbitrator finds the matter of *Branden Schrader v. SOI/Big Muddy Corr. Ctr.*, 13 I.W.C.C. 0089 (2013) to be instructive. In *Schrader*, the claimant worked as a gallery and wing officer during the day shift, and his job duties included counting inmates, performing wing checks, cuffing and uncuffing inmates, turning prison keys, performing shakedowns and performing bar rapping. *Id.* It was noted that Petitioner experienced difficulty while opening the doors and locks because the locks often stuck. *Id.* During the course of these duties, the claimant developed carpal tunnel syndrome and cubital tunnel syndrome. *Id.* The claimant also suffered from diabetes. *Id.* Dr. Sudekum, who is also the expert in the instant claim, concluded that Petitioner's job duties did not contribute to his conditions. *Id.* In that case the Commission found that Petitioner's repetitive injuries were causally connected to the claimant's employment as a Correctional Officer at Big Muddy Correctional Center. The job duties of Petitioner in the instant claim are very similar to the claimant's job duties in *Branden Schrader*. Like the claimant in *Schrader*, Petitioner worked the first shift.

With respect to the issue of causal relationship, the Arbitrator finds the opinions of Dr. Young and Dr. MacKinnon, who had the benefit of taking a personal history from Petitioner and performing physical examination in addition to reviewing the evidence in the record pertaining to Petitioner's job duties very persuasive. Both Dr. Young and Dr. MacKinnon were of the opinion that Petitioner's job duties played a direct role in the development and/or progression of his conditions. (PX. #8 p. 10-12; PX. # 9 p. 16). The medical evidence supports their opinion.

Based upon the foregoing, and the entirety of the evidence in the record, the Arbitrator finds that Petitioner met his burden of proof in establishing that he sustained accidental injuries which arose out of and in the course of his employment with Respondent, which are causally connected to his current condition(s) of ill-being.

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

Respondent only disputed liability for medical expenses in tandem with its dispute of causal connection. Respondent does not dispute the reasonableness or necessity of Petitioner's medical care.

Based upon the above findings regarding causal connection, Respondent is hereby ordered to pay the medical expenses contained in Petitioner's group exhibit 1, and is further ordered to authorize and pay for the treatment recommended by Dr. Young and Dr. MacKinnon, including but not limited to surgery pursuant to the fee schedule. Respondent shall have credit for any medical expenses paid by its group carrier, but shall indemnify and hold Petitioner harmless from any claims arising from any of the medical expenses for which it claims credit, pursuant to §8(j) of the Act.

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

Respondent shall pay temporary total disability benefits of $724.15/week for Petitioner's claimed period of 1 week, beginning on January 5, 2011, through January 12, 2011.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

- ☐ 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

GRISELDA MARTINEZ,

Petitioner,

vs. NO: 12 WC 05882

LTD COMMODITIES, LLC,

Respondent.

ORDER

This matter comes before the Commission on Petitioner's Petition for Penalties and Attorney's Fees and/or to Vacate the Settlement Contract, filed on May 27, 2015. Prior to hearing being held before Commissioner Tyrrell, and following pre-hearing discussions, the parties have come to agreement on resolution of the issues related to the Petition at bar.

The Commission having jurisdiction over the persons and subject matter, and being advised in the premises, finds as follows:

Based on the language in the approved (on March 4, 2015) Settlement Contract Lump Sum Petition and Order, Respondent is not liable for the payment of additional medical expenses. Notwithstanding the foregoing, Respondent agrees to pay $1,000.00 to Petitioner as a purchase of the peace and to avoid further litigation related to this claim.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Respondent pay to Petitioner additional compensation of $1,000.00 as a purchase of the peace and to avoid further litigation.

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: NOV 2 - 2015
TJT: pc
R: 7/17/15
51

Thomas J. Tyrrell

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

- ☐ 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

GRISELDA MARTINEZ,

Petitioner,

vs. NO: 12 WC 05882

LTD COMMODITIES, LLC,

Respondent.

ORDER

This matter comes before the Commission on Petitioner's Petition for Penalties and Attorney's Fees and/or to Vacate the Settlement Contract, filed on May 27, 2015. Prior to hearing being held before Commissioner Tyrrell, and following pre-hearing discussions, the parties have come to agreement on resolution of the issues related to the Petition at bar.

The Commission having jurisdiction over the persons and subject matter, and being advised in the premises, finds as follows:

Based on the language in the approved (on March 4, 2015) Settlement Contract Lump Sum Petition and Order, Respondent is not liable for the payment of additional medical expenses. Notwithstanding the foregoing, Respondent agrees to pay $1,000.00 to Petitioner as a purchase of the peace and to avoid further litigation related to this claim.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Respondent pay to Petitioner additional compensation of $1,000.00 as a purchase of the peace and to avoid further litigation.

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: NOV 2 - 2015
TJT: pc
R: 7/17/15
51

Thomas J. Tyrrell

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

Innocencio Carrasco,
Petitioner,

vs.

Service Drywall and Decorating,
Respondent,

NO: 13 WC 17786

15IWCC0843

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 14, 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 $19,150.00. 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: NOV 2 0 2015

MB/mam
o:9/24/15
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CARRASCO, INNOCENCIO
Employee/Petitioner

Case# **13WC017786**

15IWCC0843

SERVICE DRYWALL AND DECORATING
Employer/Respondent

On 1/14/2015, 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:

2731 SALVATO & O'TOOLE
DAVID FROYLAN
53 W JACKSON BLVD SUITE 1750
CHICAGO, IL 60604

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Innocencio Carrasco
Employee/Petitioner

v.

Service Drywall and Decorating
Employer/Respondent

Case # **13** WC **17786**

Consolidated cases: **N/A**

15IWCC0843

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 **Hegarty**, Arbitrator of the Commission, in the city of **Chicago**, on **October 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 **10/10/14**, 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 $**20,700.00 over 14 pay periods**; the average weekly wage was $**1,478.57**.

On the date of accident, Petitioner was **38** years of age, ***single*** with **2** dependent children.

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

Respondent ***has 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 $**N/A** for other benefits, for a total credit of $**0.00**.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $**712.55**/week for **5** weeks, because the injuries sustained caused the loss of **1%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $**985.71**/week for **15.71** weeks, commencing **5/29/13** through **9/16/13**, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of Mount Sinai Hospital, Marque Medicos, Medicos Pain and Surgical Specialists, Specialized radiology, Archer Open MRI, Midwest Orthopaedics at Rush and ATI, as provided in Sections 8(a) and 8.2 of the Act.

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

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

Signature of Arbitrator

1/13/15
Date

JAN 14 2015

15IWCC0843

STATE OF ILLINOIS)
) ss.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Innocencio Carrasco, Petitioner,	)	
vs.	)	Case No.: 13 WC 17786
Service Drywall and Decorating Respondent.	)	

ADDENDUM TO ARBITRATION DECISION

I. Background

On October 10, 2014, this matter proceeded to hearing pursuant to Section 19(b) of the Illinois Workers' Compensation Act (the "Act") before Arbitrator Jessica A. Hegarty in the City of Chicago, County of Cook.

The parties agree that on May 13, 2013, the Petitioner and Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and their relationship was that of employee and employer.

The parties dispute the following issues:

1. Whether timely notice of the accident was given to the Respondent;
2. Whether Petitioner's current condition of ill-being is causally related to the alleged injury;
3. Whether Respondent is liable for Petitioner's unpaid medical bills;
4. Whether Petitioner is entitled to TTD;
5. The nature and extent of the injury. (Arb. 1.)

An interpreter was qualified by the Arbitrator before being sworn in to provide interpretation services for the Petitioner. (T. 7-8.)

II. Findings of Fact

Petitioner testified he was employed as a "taper" for Respondent's drywall/decorating business. (T. at 12.) Taping drywall consists of using a compound to cover any lines, nails, screws, etc. that remain on drywall after installation. (Id.) Petitioner testified that he employed various tools of the trade to perform his job duties, including an angle box and stilts. Petitioner testified that stilts are employed in the trade in order to work on walls and ceilings beyond one's normal reach. (T. 13-14.)

Petitioner testified that on May 13, 2013, he started his shift at 6:30 a.m. Petitioner was assigned to "run the angle box"[1] in an apartment that was part of a larger project. The height of the ceiling in the apartment was approximately 9 feet high. Petitioner strapped stilts to his legs and was carrying his angle box containing joint compound[2] as he began his work. Petitioner testified that as he worked, he backed into an industrial fan causing his stilts to hit the fan. Apparently, Petitioner lost his balance and in order to prevent himself from falling, he grabbed the wall with his left hand while holding the angle box in his right hand. Petitioner testified that after this maneuver he began experiencing pain in his back. Petitioner continued to work but as the pain increased, at approximately 8:00 a.m., he reported that his back was hurting to co-worker Mario Peña, and supervisor Lorenzo Delarosa who assisted Petitioner off the stilts.

At approximately 11:30 a.m. that day Petitioner's wife picked him up and drove him home where he took some Tylenol. At 1:35 p.m. Mount Sinai Hospital ("Mt. Sinai") nursing triage records note Petitioner's complaints of "low back pain starting at 9 am today after bending over to pick up heavy object while at work." The records indicate that Petitioner was unable to bend over and that his pain was non-radiating. A lumber x-ray was unremarkable. Petitioner was discharged with light duty work restrictions and advised to follow-up with his primary care physician. (Px. 2.)

On May 16, 2013, Petitioner presented to Dr. Jairo Mejia at Access Community Health Network. (Rx. 3.) Petitioner received a note from Dr. Jairo Mejia to return to work on May 22, 2013. (Id.; T. at 53.)

Petitioner returned to work on May 22, 2013, and worked through May 24, 2013. The following Monday, May 27, 2013, Petitioner did not return to work.

On May 29, 2013, Petitioner presented to Daniel Johnson, D.C. at Marque Medicos with low back pain. (Px.3.) The history notes that Petitioner was working as a taper and was applying tape and joint compound to drywall corners when he felt pain in his low back. Petitioner indicated he was working for approximately eight hours this day when he felt pain. (Id.)

On May 30, 2013, Petitioner followed up at Marque Medicos with elevated pain levels in his low back with pain into his right leg and into his right foot which increased with movement. (Px. 3.) X-rays revealed decreased lumbar lordosis with apparent mild muscle spasms. Petitioner was to begin physical therapy, three times a week for one week. Petitioner was taken off of all work for one week. He was referred to Dr. Andrew Engel. (Id.)

On June 6, 2013, Petitioner presented to Dr. Andrew Engel at Medicos Pain complaining of pain in both sides of his low back. (Px. 5, at 25.) The pain radiated into both of his buttocks. He reported right sided greater than left sided numbness into his ankles. He also felt numbness in his knees. The recorded medical history indicates Petitioner was holding a 15 pound angle box full of joint compound on May 13, 2013. Petitioner was prescribed medication and referred to Archer Open MRI for an MRI of the lumbar spine. (Id.)

On June 24, 2013, Petitioner presented for an MRI of the lumbar spine which indicated a focal right 6 mm paracentral disc protrusion at L4-5 with mild central canal stenosis. (Px. 3.)

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[1] Petitioner explained "run the angle box" or "run the angle" is a term of art used in his trade to refer to the use of an angle box to seal seams between drywall. (T. at 18.)

[2] Petitioner testified joint compound is material used to seal the seams between drywall. (T. at 17.)

On July 25, 2013, Petitioner returned to Dr. Mejia. Dr. Mejia diagnosed Petitioner with low back pain and a disc herniation. Dr. Mejia gave Petitioner a referral to see Dr. Kern Singh ("Dr. Singh") of Midwest Orthopaedics at Rush.

On August 12, 2013, Dr. Singh examined and diagnosed Petitioner with a disc herniation and related the injury to the May 13, 2013, work accident. Dr.Singh referred Petitioner to ATI for physical therapy and work conditioning. Dr. Singh took Petitioner off work from August 12, 2013, through September 16, 2013.

On August 13, 2013, Petitioner started physical therapy at ATI. Petitioner participated in work conditioning from August 20, 2013 through September 13, 2013.

On September 16, 2013, Petitioner returned to see Dr. Singh. Dr. Singh placed Petitioner at maximum medical improvement, discharged him from treatment and released him to work full duty.

Witnesses called by Respondent

Lorenzo Delarosa testified he has been employed by the Respondent for eighteen (18) years. On the alleged date of injury he was a supervisor at the jobsite where Petitioner was working. On that date, at around 8:00 a.m., Petitioner approached him stating that he was feeling pain in his back. (T. at 89.) Mr. Delarosa testified that Petitioner did not tell him how he hurt his back. (Id). Mr. Delarosa asked Petitioner how the pain began to which Petitioner responded he did not know. (T. at 96.) Mr. Delarosa testified he did not report a work related injury to any of his supervisors because there was no accident or injury reported. (T. at 104). He further testified that Petitioner worked three full eight hour days following the alleged accident from May 22, 2013 through May 24, 2013 without complaint or issue. (T. at 91). Mr. Delarosa testified that he expected Petitioner to continue working the following week starting Monday, May 27, 2013, but he did not see Petitioner until Thursday, May 30, 2013 when Petitioner picked up his tools at 5:30 a.m. (T. at 91-92.) Mr. Delarosa further testified that there was no fan located in the room where Petitioner was working on the alleged accident date. (T. at 92.)

Respondent witness Ruben Loera testified that he has been employed by the Respondent for ten to eleven (10-11) years. On the date of accident alleged by Petitioner, Mr. Loera was employed as a Foreman whose duties included directing and supervising projects. On the alleged accident date, Petitioner approached Mr. Loera and advised that he was feeling pain and probably would not continue with his work for the day. (T. at 108.) According to Mr. Loera, Petitioner did mention not being on stilts or backing up into a fan. (T. at 108, 113, 115.) Petitioner did not mention that his pain was caused by lifting work materials. (T. at 108.) Mr. Loera explained that when a worker reports a work injury, paperwork is filled out and, if necessary, the worker is sent to the hospital. (T. at 109.) According to Mr. Loera, none of those procedures were carried out on the alleged accident date. (Id.)

Respondent witness Scott Mathews testified as to the policies procedures related to workplace injury reporting. Mr. Mathews stated that Petitioner never contacted him to report a work related injury. (T. at 122.) Mr. Mathews testified Petitioner attempted to return to work on Monday, May 20, 2014, and that Respondent did not allowed his return. Mr. Mathews stated the reason for the denial was that Dan Bloom (employed by Respondent in the employee Safety department) informed him that Respondent was in receipt of a doctor's note keeping Petitioner off work until May 22, 2013. (T. at

122.) On May 24, 2013, Mr. Matthews received a phone call from Petitioner's daughter who advised that Petitioner was sick with the flu. (T. at 123.) Mr. Mathews further testified that he understood that Petitioner was going to return to work on Monday, May 27, 2013, but Petitioner did not. (T. at 123-124.) As Petitioner did not show up for work on May 27, 2014, Mr. Mathews took this to mean Petitioner quit or abandoned his position. (T. at 126.) Mr. Mathews testified the job was coming to an end at the end of May 2013 and layoffs were about to occur. (T. at 124.)

II. LEGAL CONCLUSIONS

C. Whether an accident arose out of and in the course of Petitioner's employment with Respondent.

The Arbitrator finds that Petitioner presented sufficient evidence to support a finding that he did sustain an injury that arose out of and in the course of his employment. This conclusion is premised on the medical records and the testimonial evidence presented at trial.

In this case, Petitioner gave extensive testimonial evidence regarding his job duties. Specifically, Petitioner testified he is employed as a taper for Respondent. (T. at 12.) As a taper, he is required to cover lines, nails, corners and metal. (Id.) Petitioner employs various trade tools to perform his job duties, including an angle box and stilts. (T. at 13.) Testimonial evidence suggests the angle box, filled with joint compound, weighs between 5 pounds to 20 pounds. (T. at 17 & 92.) Petitioner utilizes stilts strapped onto his legs to increase his height in order to run the angle box on ceilings beyond his normal reach. (T. 13-14). On the alleged date of injury, Petitioner was taping ceilings 9 feet in height. (T. at 113). Petitioner was wearing his stilts, elevated above the floor and operating the angle box with both hands. (T. at 20.) As Petitioner ran the angle, he claims he sustained an injury to his back when he almost fell, after losing his balance. (T. at 24.)

Although there is some conflicting evidence as to how Petitioner injured himself, the evidence strongly supports an injury in the workplace. Lorenzo DeLarosa testified Petitioner told him he had back pain. (T. at 89.) Mr. DeLarosa stated he was told this as Petitioner stood on stilts. (Id.) Mr. DeLarosa further testified that "Mario" and he had to help Petitioner off the stilts. (T. at 97.) Ruben Loera testified he understood Petitioner was using a tool for making angles when he complained of back pain. (T. at 108). The Arbitrator concludes that testimony of both men supports Petitioner's allegation that he injured his lower back while on his stilts.

Following the injury, Petitioner testified he was sent home which is corroborated by Mr. DeLarosa's testimony. (T. at 27, 90.)

According to Petitioner he left the job site at 11:30 a.m., went home and took some Tylenol before presenting to the hospital emergency room approximately two hours after leaving work. (T. at 29.)

The Arbitrator notes that while the hospital emergency room records do not reflect a history of being injured while on stilts, the records do note that Petitioner reported "low back pain starting at 9 am today after bending over to pick up heavy object while at work." (Px. 2). According to Mt. Sinai records, Petitioner was triaged around 1:28 p.m. on May 13, 2013. (Id.) Petitioner was treated for lower back pain. Although the triage note describes low back pain after Petitioner bent down to

pick up an object at work, nevertheless, it describes an injury resulting from work. Petitioner testified the history in this medical record is not what he told the medical providers at this facility. (T. at 32, 48.)

The Arbitrator notes that Petitioner does not speak English. Petitioner's wife was the only family member that accompanied him to Mt. Sinai. (T. 30). Petitioner's wife does not speak English either. Although an interpreter was provided, Petitioner testified he explained many times while at Mt. Sinai as to the nature of the injury but he was not understood. (T. 35.) The Arbitrator notes that during Petitioner's testimony at hearing, the interpreter had a somewhat difficult time, at first, in translating Petitioner's testimony with respect to the mechanism of injury. The Arbitrator also notes that Petitioner performs a specific trade with tools tailored to that trade. Throughout Petitioner's testimony, Petitioner referred to his trade and the tools of the trade by their known names within the industry. Without prior knowledge of the trade or an extensive explanation by the Petitioner, it is foreseeable that a layperson would have difficulty understanding the nature of Petitioner's injury. What is evident from the records is that Petitioner arrived at Mt. Sinai, in severe pain,[3] seeking medical attention for low back pain that developed while in the course of his work duties. (Px. 2.)

The medical reports from Midwest Orthopaedics at Rush reflect that Petitioner sought treatment with Dr. Singh for low back pain. (Px. 7) The records document an injury that occurred on May 13, 2013, while working as a taper. (Id.) The description of injury reflects that Petitioner was on top of steel, taping and backed into an industrial sized fan and twisted. (Id.) Petitioner claimed he injured himself as he stood on his stilts, backed into an industrial fan and almost lost his balance. (T. 24) The stilts are made of metal. (Px. 1) Petitioner testified as he stood on the stilts, he backed into a fan. (T. 24) Petitioner claimed that as his stilt hit the fan, he lost his balance and struggled to regain it. (Id.)

The medical reports from ATI are also consistent with Petitioner's testimony. According to the records, on August 13, 2013, Petitioner began physical therapy for a low back injury. (Px. 8.) The records reflect an injury occurring on May 13, 2013. (Id.) A note from ATI, titled "Nature of Injury" states Petitioner stepped backwards while wearing stilts, running into a fan, losing his balance and falling into a wall. (Id.)

Medical records from Marque Medicos describe Petitioner's job duties and state he developed pain after an eight-hour workday. (Px. 3.) Although the record's history of injury differs from Petitioner's description, they do support a back injury that developed while working on May 13, 2013. (Id.) Petitioner testified the history with respect to the accident recorded at Marque Medicos was incorrect. (T. 40) Petitioner testified he started his shift around 6:30 a.m. on May 13, 2013. (Id.) Petitioner testified, prior to his wife picking him up at 11:30 a.m., he was waiting for her at the job site. (Id.) Mr. DeLarosa testified that Petitioner complained of back pain around 8:00 a.m. (T. 90.) By both accounts, it is impossible that Petitioner to have worked an eight (8) hour shift on May 13, 2013, prior to feeling pain.

The medical records from Medicos Pain and Surgical Specialists also describe a low back injury while Petitioner was applying joint compound. Petitioner testified he was running the angle box when he almost lost his balance. (T. 24) Petitioner testified the angle box is a tool that is used to apply coats of joint compound. (T. 16-17) This description is fairly consistent with Petitioner's

[3] A triage note from Mt. Sinai documents Petitioner's pain a 10 on a 0 – 10 pain scale.

testimony at trial as to the mechanism of injury, and therefore, the Arbitrator is inclined to consider this evidence in favor of Petitioner.

The Arbitrator notes that Petitioner and the witnesses called by Respondent gave conflicting testimony regarding whether an industrial fan was present at the time of the alleged injury. The Petitioner testified he backed into an industrial fan with his stilts. (T. 24.) The records from ATI and Midwest Orthopaedics at Rush describe an injury involving an industrial fan. (Px. 7 & 8.) Mr. Loera testified Respondent did not use industrial fans "on this occasion." (T. 119.) Scott Mathews testified fans were not used at the job site. (T. 125.) According to all three witnesses called by Respondent, having a fan present would not be out of the ordinary. All three witnesses testified a fan could be used to dry the joint compound faster. (T. 103, 119 & 128.) Based on the testimonial evidence, the Arbitrator concludes that a fan may have been present in Petitioner's work area without Respondent's knowledge.

After careful consideration of the medical records and testimonial evidence presented at trial, the Arbitrator finds that Petitioner's did sustain an injury that arose out of and in the course of his employment.

D. What was the date of the accident?

The Arbitrator concludes the date of accident is May 13, 2013. The Arbitrator's conclusion is based on the medical records documenting Petitioner's injuring occurring on May 13, 2013. Also, testimonial evidence from all witnesses refers to Petitioner's complaints of pain initiating on May 13, 2013. Based on the medical records and testimonial evidence, the Arbitrator determines the date of accident is May 13, 2013.

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

In this claim, Petitioner alleged that he sustained injury on May 13, 2013. (T. 17-24) On May 29, 2013, Petitioner filed an Application for Adjustment of Claim through his legal representative, Law Offices of James P. McHargue. (Rx. 1) On May 31, 2013, Petitioner filed a second Application for Adjustment of Claim through his second legal representative, Dworkin & Maciariello. (Rx. 2) Both applications were filed within the required 45 days of the alleged injury. Both applications provided sufficient information to allow Respondent to investigate the alleged injury. Therefore, Petitioner satisfied the notice requirement.

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

Medical evidence presented demonstrates that Petitioner's condition of ill-being is causally related to the injury.

On August 19, 2013, Dr. Singh examined Petitioner's lower back. (Px. 8.) Petitioner complained of low back pain, right buttock pain, lower left extremity numbness and tingling that radiated into his left foot. (*Id.*) Dr. Singh reviewed the June, 2013, MRI of Petitioner's lumbar spine and diagnosed Petitioner with degenerative disk disease and a right-sided herniated nucleus pulposus at L4-L5. (*Id.*) Petitioner explained to Dr. Singh that he worked for Service Drywall as a taper. (*Id.*) Petitioner reported that he was on top of steel, taping and backed into an industrial-sized fan and twisted. (*Id.*)

Dr. Singh's examination report concludes "The diagnosis/treatment is causally related to the alleged industrial accident: Yes." (*Id.*)

On June 6, 2013, Dr. Andrew J. Engel, of Medicos Pain & Surgical Specialists examined Petitioner. (Px. 5.) Petitioner complained of low back pain and pain radiating down his buttocks. (*Id.*) Petitioner also complained of numbness in his legs. (*Id.*) According to the history in the medical report, Petitioner stated he injured his lower back while standing on some metal and applying joint compound. (*Id.*) Dr. Engel stated, "Since the mechanism of action of his work-related accident is consistent with his current pain complaints, the work work-related accident on 05/13/2013 is the direct cause of his current pain complaints." (*Id.*)

The Arbitrator notes that no independent medical examination or any other medical opinion was offered to contradict Dr. Singh, Dr. Engel or any other of Petitioner's treating physicians.

Considering all of the evidence, the Arbitrator agrees with the only medical opinions offered, and concludes that Petitioner's condition of ill-being is causally 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?

The Arbitrator finds that the medical services that were provided to Petitioner at Mount Sinai Hospital; Marque Medicos; Medicos Pain and Surgical Specialists; Specialized Radiology; Archer Open MRI; Midwest Orthopaedics at Rush; and ATI; were reasonable and necessary and that Respondent has not paid all appropriate charges for all reasonable and necessary medical services.

The Arbitrator notes that there was no contradictory evidence on this issue presented.

Therefore, the Arbitrator finds that Respondent is liable for the outstanding balances from the following providers, subject to the fee schedule: Mount Sinai Hospital; Marque Medicos; Medicos Pain and Surgical Specialists; Specialized Radiology; Archer Open MRI; Midwest Orthopaedics at Rush; and ATI.

K. What temporary benefits are in dispute?

The Arbitrator finds that Petitioner was temporarily totally disabled from May 29, 2013 through September 16, 2013.

The Arbitrator notes that Dr. Engel placed Petitioner off work from May 29, 2013 thru August 21, 2013. (Px. 3) Dr. Singh placed Petitioner off work from August 12, 2013 through September 16, 2013. (Px. 7.) Petitioner testified that although he did not personally send Respondent off work notes, his understanding was that his physicians would send them to Respondent. (T. 43)) Scott Mathews testified that Respondent was aware of the medical note from Mt. Sinai placing Petitioner on light duty. (T. 122.) According to Mr. Mathew's testimony, that was the basis for turning Petitioner away when he called asking to return to work. Mr. Loera also testified that he was aware of the medical note from Mt. Sinai, placing Petitioner on light duty. Mr. Loera testified that Petitioner wanted to work, but he was unable to do so because of the doctor's note. (T. 109-110.)

According to the records from Mt. Sinai, Petitioner was placed on light duty after he was discharged. (Rx. 3.) The Arbitrator notes the testimony from Respondent that economic layoffs, not Petitioner's disability, precluded Petitioner returning to work.

In this claim, whether Respondent laid-off Petitioner for economic reason or not has no bearing on his TTD benefits. As the Arbitrator notes, Petitioner's treating physician's removed Petitioner *completely* off work until September 16, 2013. Furthermore, up until September 16, 2013, Petitioner's medical condition had not stabilized. A job search would not have been possible with Petitioner's off work status, and therefore, whether Respondent laid off Petitioner or not has no bearing on his TTD benefits.

After considering all evidence, the Arbitrator finds that Petitioner was temporary totally disabled from May 29, 2013 thru September 16, 2013.

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

Given the fact that Petitioner's injury occurred after the 2011 amendments to the Illinois Worker's Compensation Act ("the Act") which applies to accidents that occur on or after September 1, 2011, the Arbitrator must consider Section 8.1(b) of the Act in her determination of Petitioner's permanent partial disability for which the following criteria was weighed:

In determining the level of permanent partial disability, the Commission shall base its determination on the following factors:

i. the reported level of impairment as assessed pursuant to subsection (a) (the AMA "Guides to the Evaluation of Permanent Impairment);
ii. the occupation of the injured employee;
iii. the age of the employee at the time of the injury;
iv. the employee's future earning capacity; and
v. evidence of disability corroborated by the treating medical records.

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

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a taper at the time of the accident. As a taper, Petitioner was required to cover lines, nails, corners and metal that was leftover on drywall after its installation. Petitioner utilized stilts strapped onto his legs to increase his height in order to work on walls and ceilings beyond his normal reach. The evidence at hearing and in the record reveals Petitioner's occupation as a taper is a heavy physical job, the Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was thirty-eight (38) years old at the time of the accident. Because of the Petitioner's relatively young age, the Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that there was no evidence presented as to whether the accident had any bearing on his future earnings capacity. The Arbitrator therefore gives *no* weight to this factor as Petitioner has not suffered a loss of earning capacity.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes On August 19, 2013, Dr. Singh examined Petitioner's lower back. (Px. 8.) Petitioner complained of low back pain, right buttock pain, lower left extremity numbness and tingling that radiated into his left foot. (*Id.*) Dr. Singh reviewed the June, 2013 MRI of Petitioner's lumbar spine and diagnosed Petitioner with degenerative disk disease and a right-sided herniated nucleus pulposus at L4-L5. (*Id.*) The Arbitrator gives *greater* weight to this factor as the above-mentioned medical records are corroborative of Petitioner's claimed disability relating to this accident.

Based on all the above factors, and the record taken as a whole, the Arbitrator awards permanency equivalent to 1% loss of use of the person as a whole, under Section 8(d)2 of the Act. In making this award, the Arbitrator relies upon the above-mentioned findings of fact.

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

David Younan,

Petitioner,

vs. NO: 13WC 24789

15IWCC0840

A Emergency Fire Board Up, Inc.,
Musick Loss Management,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b-1) 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, penalties, fees and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 29, 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 $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: NOV 19 2015
o112115
DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19 (b-1) ARBITRATOR DECISION

YOUNAN, DAVID
Employee/Petitioner

Case# **13WC024789**

A EMERGENCY FIRE BOARD UP INC MUSICK LOSS MANAGEMENT
Employer/Respondent

15IWCC0840

On 7/29/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

Unless a party does the following, this decision shall be entered as the decision of the Commission:

1) Files a Petition for Review within 30 days after receipt of this decision; and

2) Certifies that he or she has paid the court reporter $ 400.00 for the final cost of the arbitration transcript and attaches a copy of the check to the Petition; and
3) Perfects a review in accordance with the Act and Rules.

If the Commission reviews this award, interest of 0.14% 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:

1938 ALEKSY BELCHER
GIANNINA ALONSO
350 N LASALLE ST SUITE 750
CHICAGO, IL 60654

0507 RUSIN & MACIOROWSKI LTD
JEFFREY RUSIN
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

15IWCC0840

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b-1)

David Younan
Employee/Petitioner

v.

A Emergency Fire Board Up, Inc.
Musick Loss Management,
Employer/Respondent

Case # **13** WC **24789**

Consolidated cases: **n/a**

15IWCC0840

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. Petitioner filed a *Petition for an Immediate Hearing Under Section 19(b-1) of the Act* on **May 27, 2015.** Respondent filed a *Response* on **June 9, 2015.** The Honorable **Deboarh L. Simpson**, Arbitrator of the Commission, held a pretrial conference on **June 29, 2015**, and a trial on **July 13, 2015**, in the city of **Chicago.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **June 21, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**65,200.20**; the average weekly wage was $**1,253.85**.

On the date of accident, Petitioner was **33** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of $**3,343.60** for TTD, $**0** for TPD, $**0** for maintenance, and $**3,000.00** for other benefits, for a total credit of $**6,343.60**.

ORDER

The Petitioner was involved in a work-related motor vehicle accident and sustained minor injuries to his left shoulder. The Petitioner gave defective notice to the Respondent of the injuries from the accident. The Respondent is liable for payment for the costs of the necessary and reasonable medical treatment that Petitioner incurred from the date of accident of June 21, 2011 through July 11, 2011, for Petitioner's left shoulder, pursuant to the fee schedule or prior agreement, whichever is less, as provided in the Act.

The Petitioner failed to prove that his current condition of ill-being pertaining to his left shoulder and his cervical spine is causally related to the accident on June 21, 2011. Any and all medical treatment and medication received for the cervical spine is not causally related to the incident on June 21, 2011 and Respondent is not liable for payment.

Petitioner's claim for TTD and TPD benefits is denied as Petitioner did not present sufficient evidence to establish a claim for TTD or TPD benefits.

The Respondent did not act vexatiously or frivolously in their termination of benefits. Therefore, the Petitioner's petition for penalties and fees against the Respondent is denied.

The parties agreed that the Respondent has paid $3,343.60 in TTD and $3,000 for other benefits. The Respondent is entitled to credit for a total of $6,343.60.

The Petitioner failed to prove that his current condition of ill-being as it relates to his left shoulder and neck is causally related to the motor vehicle accident on June 21, 2011. The Respondent is not liable for any prospective medical care or treatment relating to the left shoulder or cervical spine.

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

RULES REGARDING APPEALS Unless a party 1) files a *Petition for Review* within 30 days after receipt of this decision; and 2) certifies that he or she has paid the court reporter $ or the ***final*** cost of the arbitration transcript and attaches a copy of the check to the *Petition*; and 3) perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

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

Richard L. Simpson
Signature of Arbitrator

July 29, 2015
Date

ICArbDec19(b-1) p. 2

JUL 29 2015

15IWCC0840

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

David Younan,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 13 WC 24789**
	)	
A Emergency Fire Board Up, Inc, Musick Loss Management,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on June 21, 2011, 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.

At issue in this hearing is as follows: (1) Did the Petitioner sustain accidental injuries that arose out of and in the course of employment; (2) Did the Petitioner give timely notice of the accident to the Respondent; (3) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (4) What were the Petitioner's earnings; (5) Were the medical services that were provided to the Petitioner reasonable and necessary and has the Respondent paid for all reasonable and necessary medical services; (6) Is Petitioner entitled to TTD or TPD; (7) Should penalties or fees be imposed upon Respondent; (8) Is Respondent due any credit; and (9) Is Petitioner entitled to prospective medical care.

STATEMENT OF FACTS

Petitioner testified that currently he is 37 years of age, married and employed by Real Restoration Group. According to Petitioner he has been employed there for over a year and is doing the same type of work that he did when he worked for Respondent. He testified that he is a project manager/sales manager which requires him to manage the day to day activities and deal with employees and contractors on behalf of the company. Petitioner stated that his job was sedentary and that he is earning approximately the same amount of money working for Real Restoration Group as he was when working for Respondent.

Petitioner testified that at the time of his accident he was employed at A Emergency Fire Board Up, Inc., also known as Musick Loss Management. Petitioner testified that he had been employed by Respondent for approximately 8 years prior to the date of the accident. At the time

of his accident, he was employed as a manager for the Respondent. As the manager, he would generally report to the warehouse which is the main location for the employer, located at 3101 North Western Avenue. Petitioner testified that his general job activities required him to travel on a regular basis. His traveling would consist of driving to various locations of varying distances.

Petitioner testified that he even though he was a manager; he performed some of the physical aspects of the job, this varied from job site to job site and depended upon the size of the crew that was available as well as the nature of the job. Petitioner testified that he was not required to perform the physical aspects of the job and could designate the crew members to perform those tasks. The physical aspects of the job included carrying the supplies needed to board up or restore a location, including tools and boards of varying sizes and weights. The buildings they worked on could be one story or more. Petitioner testified that his main job duties consisted of supervising employees and organizing the various tasks at hand, making sure they had the supplies to do the job. Petitioner admitted that his job duties never changed during the entire time that he worked for Respondent. Petitioner testified that his salary remained the same at approximately $1,200.00 a week. Petitioner further testified that he worked overtime hours, but that overtime was not mandatory and/or consistent. Basically, the business was an emergency business and they could get called out at any time of the day or night.

Petitioner testified that he was given a company car and was also given a company credit card. Petitioner admitted to using the company car and company credit card for personal uses on occasion.

Petitioner also testified that he owned a motorcycle. When Petitioner was asked if he performed any jobs other than his job for the employer, Petitioner denied doing any work on the side. When asked if he performed motorcycle repairs he admitted that he did repair motorcycles for other people. Petitioner admitted that he would repair motorcycles a couple times a week and would be paid cash for those repair jobs.

Petitioner testified that at the time of the accident he was not married, he got married after the accident and has a two year old child. Petitioner admitted to drinking alcohol occasionally. Petitioner testified that he smokes marijuana on a regular basis, 2-3 times a week. Petitioner denied having a prescription for medical marijuana although he testified that his doctor, Dr. Padron was working on getting him a prescription for medical marijuana. Petitioner acknowledged that he was aware that consuming marijuana without a prescription is illegal in the State of Illinois. Petitioner also admitted that he used cocaine.

Petitioner had been in car accidents prior to June 21, 2011, but could not remember any details relating to those accidents.

On June 21, 2011, Petitioner testified that he was working and had traveled to a job site. Petitioner testified that he did not remember any details about the job that he was involved in on June 21, 2011, including where it was located, how long he had been there, what the job consisted of or what type of facility it was. Petitioner did not remember who directed him to travel to the job site, what time he arrived, what was performed or when they finished.

Petitioner testified that after the job was complete he was traveling westbound on I-94, returning to the office. According to Petitioner there was moderate stop and go traffic on the expressway at the time. Petitioner was driving the company car, a Chevrolet Silverado, at the time of the accident. Petitioner stated that he was involved in a rear end collision wherein he was struck by another driver. Petitioner stated that he did not know how fast the car was going that rear ended him, but he guessed it was in the range of 30-40 miles an hour. Petitioner admitted that he was not wearing his seatbelt. The airbags did not deploy. Petitioner testified that he was not under the influence of drugs or alcohol at the time of the accident. Petitioner was shown color pictures at trial of the damages sustained to the vehicle he was driving at the time of the accident. Petitioner testified that the pictures accurately represented the car he was driving and the damage sustained to the rear bumper of the vehicle (RX. 1, 2).

Petitioner denied that any co-workers were in his vehicle at the time of the accident.

Petitioner testified that after the collision, he exited the vehicle to make sure everyone was okay. Petitioner testified that the police arrived on scene. Petitioner testified that he denied the need for an ambulance or any medical treatment at the accident scene. Petitioner testified that once the officer released him from the scene, Petitioner contacted the owner of the company, Mark, and advised him of the motor vehicle accident. Petitioner did not fill out any paperwork regarding the accident nor did he fill out any paper work for a workers' compensation injury/claim at that time.

Petitioner then testified that he also called his wife (later identified as his fiancé at the time) and told her about being involved in a motor vehicle accident. She insisted that he should go to the emergency room to be checked out. Petitioner left the scene of the accident and headed home to pick up his fiancé on his way to the hospital. Petitioner and his fiancé traveled in his own personal vehicle to the emergency room at Lutheran General Hospital on June 21, 2011.

At Lutheran General Hospital on June 21, 2011, Petitioner testified that he presented with complaints of left shoulder pain following a motor vehicle accident. Petitioner denied any neck pain. Petitioner did admit to smoking marijuana at the hospital. No testing was done to assess Petitioner's THC levels on the date of the accident. Petitioner admitted undergoing x-rays of the left shoulder but did not seek any treatment for his neck. Petitioner agreed that he was discharged and authorized to return to full duty work. (PX. 1).

Petitioner testified that he followed up with an orthopedic specialist, Dr. Ali, after his emergency room visit. Petitioner treated with Dr. Ali on two occasions on June 24, 2011 and July 8, 2011 (PX. 2). Petitioner was seen by Dr. Ali for his left shoulder. Petitioner did not complain of any neck pain to Dr. Ali. Petitioner testified that he underwent an MRI of the left shoulder. The MRI showed no evidence of a rotator cuff injury or tear. Petitioner agreed that there was no evidence of a rotator cuff tear on the MRI; he insisted it was because they did not use contrast when they performed the MRI.

Petitioner was able to return to work after the accident. He testified that he worked with limitations. Petitioner testified that he was not able to perform the same physical job requirements that he did prior to the accident. Petitioner testified that his employer knew about

the limitations and accommodated those restrictions. Petitioner did not have any restrictions ordered or recommended by medical treaters.

Petitioner testified that he did not seek any medical treatment for his left shoulder or neck from July 11, 2011 until August 7, 2012, a period of approximately 13 months. Petitioner admitted to working for Respondent during this entire period of time.

Petitioner testified to undergoing treatment with his primary care physician, Dr. Pales in March and June of 2012. Petitioner agreed that he presented for complaints of intermittent rapid heart rate at that time. Petitioner testified that he believed he did advise Dr. Pales of his shoulder complaints. However, the medical records do not indicate any complaints of shoulder pain or problems. There are no complaints of neck pain during that period of time recorded by Dr. Pales either. (PX. 4)

Petitioner testified that he was involved in two motor vehicle accidents after his work accident on June 21, 2011. These accidents were not work related in any way. Petitioner denied filing any law suits relating to those motor vehicle accidents.

Petitioner admitted that the two additional motor vehicle accidents occurred on July 5, 2012 and again on July 26, 2014. Petitioner denied that the air bags deployed in either of these two accidents either.

Petitioner testified that on August 7, 2012, after approximately one year of working full duty without treatment for his left shoulder or neck, and one month after the second accident, Petitioner sought treatment with a new orthopedic surgeon, Dr. Visotsky. (PX. 5). Petitioner testified that his wife who is "in the medical field" recommended he seek treatment with Dr. Visotsky because he was "the best."

Petitioner testified that he presented to Dr. Visotsky on August 7, 2012 with complaints of left shoulder pain, but no neck pain. Petitioner testified that he advised Dr. Visotsky of his June 21, 2011 accident, but did not mention his July 5, 2012 accident. Petitioner testified that following his initial visit with Dr. Visotsky, he underwent a new MRI of the left shoulder. Petitioner testified that Dr. Visotsky diagnosed him with a rotator cuff tear and recommended that Petitioner undergo surgery. Petitioner testified that he underwent a rotator cuff repair on December 10, 2012 (PX 5, 6).

Petitioner testified that he participated in physical therapy for about three months following the surgery. Petitioner admitted that he was discharged from physical therapy on March 27, 2013 and authorized to return to full duty work as a construction worker and part time mechanic with no restrictions. (PX 5)

Petitioner testified that during therapy for his shoulder, he began to develop radiating pain down the left arm. (PX 5) Petitioner stated that the radiating pain occurred during the strength type exercises. Petitioner stated that the pain occurred a couple months after the surgery. Petitioner testified that Dr. Visotsky referred him to treat with a spinal surgeon, Dr. Siemionow at Illinois Bone & Joint. (PX 5)

Petitioner testified that he was examined by Dr. Siemionow for the first time in June of 2013 and was told that he had protruding or herniated discs. (PX 5) Petitioner admitted that Dr. Siemionow was the first physician he treated with relating to neck pain which he maintains stems from his motor vehicle accident on June 21, 2011. Petitioner also failed to advise Dr. Siemionow that he was involved in a second motor vehicle accident on July 5, 2012.

Petitioner testified that Dr. Siemionow recommended he undergo pain management. Petitioner testified that he treated with Dr. Padron for pain management. Petitioner testified that he treated with Dr. Padron on a monthly basis from June of 2013 through the present. Petitioner admitted to working full duty during this period of time.

Petitioner testified that he underwent multiple epidural steroid injections for the radiating pain. (PX 7) Petitioner testified that he was diagnosed with cervical radiculopathy. Petitioner reported that he had five epidural steroid injections. Petitioner testified that the epidural steroid injections were supposed to relieve his radicular pain. Petitioner testified that the injections did not provide any long lasting relief. (PX 7)

Petitioner testified that he underwent an MRI of the cervical spine in April of 2013. (PX 3) after reviewing the MRI results, Dr. Siemionow recommended a two level fusion from C4-5 to C5-6 on September 24, 2013. (PX. 12) Petitioner continued working full duty during this period of time.

Petitioner testified that he underwent a medical examination at the Respondent's request with Dr. Vitello, an orthopedic surgeon, on February 26, 2014, pursuant to Section 12 of the Act. (RX 3) Dr. Vitello noted that Petitioner provided a history of a motor vehicle accident on June 21, 2011. Dr. Vitello reviewed Petitioner's medical records from the date of the accident through February 2014. Dr. Vitello performed a physical examination on Petitioner's left shoulder. The examination revealed full strength and almost full range of motion. (RX 3)

After his review of the medical records and his physical examination of the Petitioner, Dr. Vitello questioned the causal connection of Petitioner's left shoulder rotator cuff condition and the MRI suspected labral tear due to the 13 month gap between the injury and the date which he presented to treat with Dr. Visotsky, August 7, 2012. (RX 3, PX 5) Dr. Vitello opined that the documented AC joint separation was causally related to the car accident. Dr. Vitello noted that that condition was properly diagnosed and treated in the immediate post-accident period. Dr. Vitello opined that the extensive gap in Petitioner's left shoulder treatment does not establish a causal connection between Petitioner's rotator cuff tear and labral tear as being related to the June 21, 2011 accident. (RX 3) Dr. Vitello opined that as of February 26, 2014, Petitioner had reached MMI with regards to his left shoulder and does not require any additional medical care. Dr. Vitello opined that Petitioner was able to return to full duty work as well. (RX 3)

Petitioner also testified to undergoing a medical examination with Dr. Avi Bernstein, a spinal orthopedic surgeon, on May 8, 2014, pursuant to Section 12 of the Act, also at the request of the Respondent. Dr. Bernstein noted the history he obtained from the Petitioner as he was involved in a "huge collision" wherein he was fully stopped and was rear-ended by a car traveling 50 MPH. (RX. 4) Petitioner alleged that he suffered an acute whiplash. (RX 4) Dr.

Bernstein noted that Petitioner treated for his left shoulder and later began to complain of left peri-scapular pain. Petitioner described symptoms radiating down the left arm with achiness, numbness and tingling in the elbow, and ulnar digits of the hands bilaterally. (RX 4) Dr. Bernstein reviewed Petitioner's medical records and diagnostic scans. Dr. Bernstein did note the gap in treatment from July, 2011 through August 7, 2012. Dr. Bernstein did opine that Petitioner's neck complaints are reasonably related to the disc abnormalities found on the MRI. Dr. Bernstein also opined that Petitioner's elbow symptoms and/or ulnar numbness and tingling is not related to his cervical condition. (RX 4) Dr. Bernstein indicated that neck and shoulder complaints can overlap. Dr. Bernstein reserved his final opinion on causation until he obtained an updated MRI of the cervical spine.

Dr. Bernstein drafted an addendum report on August 20, 2014 related to the causation issue of Petitioner's cervical spine condition. (RX 5) Dr. Bernstein reviewed additional medical records and updated MRI scans and opined that the extensive gap in treatment from July 2011 through August 2012 strongly suggests that Petitioner's clinical syndrome and complaints are not causally related to the motor vehicle accident on June of 2011. (RX. 5)

On July 26, 2014, Petitioner was involved in his second motor vehicle accident since the work related motor vehicle accident. Petitioner testified he received medical treatment in the Emergency Room at Lutheran General Hospital on July 26, 2014. Petitioner admitted that he was involved in a motor vehicle accident on that date. Petitioner stated that the motor vehicle accident occurred in his personal automobile. Petitioner admitted that he underwent x-rays of the chest and left shoulder as well as a CT scan of the cervical spine and brain. Petitioner admitted that this accident was significant enough to force him to seek follow up treatment at the emergency room.

Petitioner testified that he followed up with Dr. Siemionow on July 30, 2014 and advised him of the motor vehicle accident on July 26, 2014. (PX. 11) Petitioner agreed that after the recent motor vehicle accident Dr. Siemionow recommended a new MRI. Petitioner did undergo a new MRI. Petitioner admitted that after the July 26, 2014 car accident and the subsequent MRI, Dr. Siemionow changed his recommendation from a two level cervical fusion to a three level fusion. Petitioner underwent a three level cervical fusion on February 12, 2015. (PX. 11, 12)

Following the surgery, Petitioner began physical therapy in April which he continues to attend through the present time, at Illinois Bone & Joint. (PX. 5). Petitioner agreed that he is showing improvements with his therapy. Petitioner testified that he also continued to treat with Dr. Padron following the surgery. (PX. 7)

Petitioner testified that he underwent lab tests as part of his treatment with Dr. Padron. Petitioner testified that he had lab tests in January, March, April and May of 2015. Petitioner agreed that his laboratory tests showed high levels of narcotics, marijuana and cocaine in his system. Petitioner also admitted to taking narcotic pain medicine. Petitioner testified that he only used cocaine on one occasion while on vacation, that was purportedly on February of 2015. That testimony is contradicted by the medical records. Petitioner did admit to being a chronic

user of marijuana which is supported by the medical records. (PX. 7) Petitioner testified that Dr. Padron is trying to get him approved for medical marijuana; he stated that it is a long process.

Petitioner testified that after the cervical fusion he was off of work for 3-4 weeks and eventually returned to work light duty. Petitioner testified that he was working for his current employer at the time of his surgery.

Petitioner's work restrictions were accommodated by his employer. Petitioner is earning approximately the same amount of money for the new employer as he was when working for Respondent.

Petitioner returned for a follow up examination with Dr. Bernstein on June 15, 2015 following his surgery. (RX. 6) Dr. Bernstein noted that Petitioner was recovering well following the surgery and was capable of continuing to work. Dr. Bernstein reiterated that the updated medical records and surgical intervention did not change his prior opinions that Petitioner's cervical condition and current condition of ill-being is not causally related to the car accident on June 21, 2011. (RX. 6)

Petitioner testified that he was terminated from Respondent in April of 2014. Petitioner testified that he was terminated due to lack of physical performance. However, when questioned as to what was said to him when he was terminated by the employer, Petitioner testified that the employer told him that "he needed to get his head right." Petitioner admitted that he was never informed that he was being terminated due to his lack of physical capabilities.

Petitioner testified that he is currently feeling better and progressing every week. Petitioner testified that he is scheduled to proceed with physical therapy through the end of July and to follow up with Dr. Siemionow afterwards.

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).

On the issue of an intervening cause, the courts have consistently held that for an employer to be relieved of liability by virtue of an intervening cause, the intervening cause must completely break the causal chain between the original work-related injury and the ensuing condition. *Boatman v. Industrial Commission,* 256 Ill.App.3d 1070, 628 N.E.2d 829, 195 Ill.Dec. 365 (1st Dist. 1993).

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).

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.

While it is true than an employee's uncorroborated testimony will not bar a recovery under the Act, it does not mean that the employee's testimony will always support an award of benefits when considering all the testimony and circumstances shown by the totality of the evidence. *Caterpillar Tractor Co. v. Industrial Commission,* 83 Ill. 2d. 213, 46 Ill. Dec. 687, 414 N.E. 2d 740 (1980).

The employee bears the burden of proving by a preponderance of the evidence all of the elements of his claim. *R & D Thiel v. Workers' Compensation Comm'n*, 398 Ill. App. 3d 858, 867 (2010).

Among the elements that the employee must establish is that his condition of ill-being is causally connected to his employment. *Elgin Board of Education U-46 v. Workers' Compensation Comm'n*, 409 Ill. App. 3d 943, 948 (2011).

Credibility is the quality of a witness which renders his evidence worthy of belief. The Arbitrator, whose province it is to evaluate witness credibility, evaluates the witness' demeanor and any external inconsistencies with testimony. Where a claimant's testimony is inconsistent with his actual behavior and conduct, the Commission has held that an award cannot stand. *McDonald v. Industrial Commission*, 39 Ill. 2d 396 (1968); *Swift v. Industrial Commission*, 52 Ill. 2d 490 (1972).

In support of the Arbitrator's decision with regard to whether Petitioner sustained accidental injuries that arose out of and in the course of his employment with Respondent and whether Petitioner gave Respondent proper notice of the accident, the Arbitrator makes the following conclusions of law:

Although the Petitioner could not recall any information about the job he had left prior to the motor vehicle accident, including the time, location or job that was performed on June 21, 2011, Respondent did not provide any evidence that he was not on the job to contradict the testimony of the Petitioner. The Petitioner did testify that he occasionally used the company vehicle for personal reasons; he also testified that at the time of the accident he was returning to the office from a job site. The suggestion that Petitioner has used the company vehicle for personal reasons on occasion, by itself, is not sufficient to prove he was not using it for work purposes on the date of the accident.

Petitioner's testimony that he was traveling westbound on I-94 is questionable based upon the police accident report that was admitted as Petitioner's exhibit # 14. A review of the police report indicates that Petitioner was traveling northbound on I-90/I-94, 4.1 miles north of Grand Avenue, and that Petitioner (unit 2) had slowed in traffic; Unit 1 was following too close and failed to reduce speed to avoid the accident. (PX. 14) Petitioner testified that he was completely stopped in traffic and while he was stopped his vehicle was struck by the other vehicle. The Petitioner first testified that he did not know how fast the vehicle was travelling, and then he stated it was going 30-40 miles per hour. He told the doctors that he was involved in a "huge crash" stopped in traffic and was struck by a vehicle travelling 50 miles per hour. Additionally, Petitioner referred to the vehicle as a company car, however, the police report and the photographs of the damage to his vehicle indicate that the vehicle is a Chevrolet Silverado, which is actually a pick-up truck and not a car. The pictures of the damages to Petitioner's pick-up truck do not appear to be as extensive as one would expect from a "huge crash."

The Petitioner, on the advice of his then fiancé went to Lutheran General Hospital on June 21, 2011, after the accident. The Petitioner drove to his home, picked up his fiancé and then drove his personal vehicle to the hospital. Petitioner reported to emergency room personnel that he had left shoulder pain following a motor vehicle accident. Petitioner denied any neck pain. At the hospital Petitioner admitted to smoking marijuana, however no testing was done to assess Petitioner's THC levels on the date of the accident. Petitioner underwent x-rays of the left shoulder. He did not seek any treatment for the neck and no treatment or testing was done with respect to Petitioner's neck. Petitioner was discharged and authorized to return to full duty work. (PX 1)

Petitioner followed up with an orthopedic specialist, Dr. Ali, after his emergency room visit. Petitioner treated with Dr. Ali on two occasions on June 24, 2011 and July 8, 2011 (PX. 2). Petitioner was seen by Dr. Ali for his left shoulder. Petitioner did not complain of any neck pain when being treated by Dr. Ali. Petitioner underwent an MRI of the left shoulder. The MRI showed no evidence of a rotator cuff injury. Petitioner continued to work his regular job for the Respondent; no restrictions were placed upon Petitioner's job duties by Dr. Ali. After July 8, 2011, Petitioner did not seek any medical treatment for his shoulder until August 7, 2012 when he saw Dr. Visotsky. This was after his second motor vehicle accident, which was not work related, on July 5, 2012. The Petitioner admitted that he advised Dr. Visotsky that he was in a motor vehicle accident on June 21, 2011, and attributed the pain he was experiencing to that accident. He admitted that he did not advise Dr. Visotsky that he was also involved in a motor vehicle accident on July 5, 2012. Following his initial visit with Dr. Visotsky Petitioner underwent a new MRI of the left shoulder. It was at this time that Petitioner was diagnosed with a rotator cuff tear and Dr. Visotsky recommended that Petitioner undergo surgery.

The Petitioner did notify his employer of the car accident and advised him of the damages to the company car. Petitioner has met his burden of proof that he was involved in a motor vehicle accident on June 21, 2011, that arose out of and in the course of his employment.

The Petitioner testified that he called Mark Musick, the owner of the company as well as the supervisor of the Petitioner, and told him that he was involved in the accident and that he was going to the hospital. He did not testify to what if any details he provided to Mr. Musick at the time or later. Petitioner never testified that he completed a work injury report or that he claimed

a workers' compensation injury at the time. Given the circumstances under which the limited information was provided, this information would qualify as defective notice at best. Respondent did not offer any evidence that he was prejudiced in any way by the lack of specificity as to why the Petitioner was going to the hospital to be treated after the accident or what part of his body was injured.

In support of the Arbitrator's decision with regard to whether Petitioner's current condition of ill-being is causally connected to this injury, the Arbitrator makes the following conclusions of law:

The Arbitrator notes that Petitioner's testimony was not credible. In addition to the contradictions regarding where he was going, the direction of travel and speed of his pick-up truck and the speed of the Ford Explorer that struck his vehicle, the Arbitrator finds Petitioner's testimony to lack credibility as he lied at trial regarding his use of cocaine as well. Petitioner testified at trial that he had only used cocaine on one occasion when he was on vacation in February of 2015. However, a review of the laboratory tests from January of 2015 documents cocaine found in Petitioner's system before his accident. (PX. 7) The January 2015 and March 2015, lab tests prove that Petitioner lied about using cocaine on only one occasion; He tested positive for cocaine in both January and March of 2015, before and after his vacation in February. He also testified that he smokes marijuana regularly.

Additionally, with respect to the Petitioner's lack of credibility, during the hearing when Petitioner was asked about whether he performed a second job or any side jobs other than his job as a manager for Respondent the Petitioner at first denied having any side jobs, but later after being questioned about ownership and interest in motor cycles and repairing them, Petitioner admitted that he did perform side jobs working as a mechanic on motorcycles. Petitioner testified that he did that as a hobby, but he agreed that he performed the side jobs on motorcycles a couple times a week and was paid cash for his work. Moreover, his physical therapy discharge note from March 27, 2013 indicated that he was capable of returning to full duty work as both a construction worker and part-time motorcycle mechanic. (PX. 5)

Based on Petitioner's lack of credibility, the Arbitrator questions Petitioner's testimony regarding his condition of ill-being relating to the left shoulder and cervical spine as it causally relates to the June 21, 2011 accident. The Arbitrator does not dispute that Petitioner was involved in a motor vehicle accident on June 21, 2011. However, the Arbitrator questions the severity of the accident and injury as alleged by the petitioner.

Petitioner testified that he was rear-ended by a vehicle traveling between 30-50 miles per hour. The Arbitrator initially questions Petitioner's testimony as to the speed of the vehicle that rear-ended him based on Petitioner's testimony that he was in moderate stop-and-go traffic. The Petitioner testified that he was not wearing a seat-belt and the airbags did not deploy. Petitioner testified that he was stopped and told the doctors that he was stopped, however he told the Illinois State Trooper at the scene of the accident that he had slowed down and the car behind him was following too close and could not slow down enough and struck his vehicle.

Considering the Petitioner was driving a pick-up truck and was struck by a Ford Explorer the Arbitrator questions whether Petitioner sustained an impact at the rate of speed he testified to when the airbags did not deploy.

Lastly, the Arbitrator questions Petitioner's testimony of the severity of the accident based on Respondent's Exhibits One and Two, which were colored photos of the rear bumper of Petitioner's work vehicle. The Arbitrator notes that there was damage to the rear bumper, but not the type of damage one would expect if rear-ended by a vehicle traveling 30-50 miles per hour. (RX. 1 and 2).

The Petitioner testified that after the accident, he exited his vehicle to make sure everyone was okay. Petitioner refused medical care at the scene and was eventually released from the scene. It was after he drove away from the scene of the accident and he spoke to his fiancée, now his wife, that Petitioner decided he had been injured and should go to the emergency room to be examined.

Left Shoulder Injury:

The Arbitrator finds that Petitioner failed to prove that his left shoulder condition was causally related to the motor vehicle accident on June 21, 2011. The Arbitrator relies on the medical evidence, the testimony of Petitioner and the exhibits entered into evidence as well as the expert opinion from Dr. Vitello to support her decision.

Following the accident, the Petitioner traveled back to his home in Skokie, IL. Petitioner testified that his fiancée, now his wife, recommended that he go to the Emergency Room. Petitioner traveled to the ER at Lutheran General via his own personal car. Petitioner provided a history of a car accident, with no indication that it was a work-related injury, and complained of pain to the left shoulder. Petitioner admitted to hospital personnel that he used marijuana; however, no lab tests were performed at that time to assess the level of marijuana in Petitioner's system on the date of the accident. Petitioner underwent x-rays of the left shoulder and was recommended to follow up with an orthopedic physician for further care. Petitioner was discharged and authorized to return to work the next day. (PX. 1)

The Petitioner did follow up with an orthopedic physician, Dr. Ali on June 24, 2011 and again on July 8, 2011. Petitioner complained of left shoulder pain and discomfort over clavicle and AC joint. (PX. 2) Petitioner was diagnosed with a shoulder sprain and possible AC joint separation. Petitioner denied any neck pain or treatment at that time. Petitioner was recommended to undergo an MRI and authorized to continue working without restrictions. (PX 2)

The Petitioner did undergo an MRI of the left shoulder on July 11, 2011. (PX. 3) The MRI revealed that the "subscapularis, supraspinatus, infraspinatus and teres minor tendons were intact." (PX. 3) The MRI documented widening of the AC joint with no significant surrounding capsular or bone marrow edema, representative of grade 1 sprain of the AC joint. The MRI report specifically denied any evidence of rotator cuff tear. There was increased signal between the posterior glenoid labrum and adjacent glenoid articular cartilage. (PX 3)

The MRI performed a few weeks after the June 21, 2011 is the best indicator of Petitioner's objective pathology status post the motor vehicle accident on June 21, 2011.

Following the July 11, 2011 MRI of the left shoulder, Petitioner continued to work full duty for the Respondent. Petitioner did not receive any medical care relating to the left shoulder or cervical spine for approximately thirteen (13) months, until Petitioner eventually sought treatment with Dr. Visotsky on August 7, 2012. (PX 5) By that time, the Petitioner had been involved in his first of two accidents that were not work related and occurred after the June 21, 2011 accident.

Petitioner did not seek medical care for his left shoulder or neck from July 11, 2011 until August 7, 2012. However, the Petitioner did treat with his primary care physician, Dr. Pales on March 20, 2012 and June 26, 2012. (PX. 4) Petitioner testified at trial that he informed Dr. Pales of his left shoulder and neck symptoms, but the records do not support the testimony. (PX 4)

On March 20, 2012, Petitioner presented with complaints of intermittent rapid heart rate. (PX 4) There is no indication in the medical record that Petitioner complained of any left shoulder or neck pain.

Petitioner followed up with Dr. Pales on June 26, 2012. At that visit, Petitioner advised Dr. Pales that he was trying to "channel his energy into more exercise, work around the house and work on his motorcycle." (PX 4) Petitioner advised the doctor, according to the medical record that he was exercising every day for 90 minutes. His exercise consisted of running, biking and swimming. (PX 4) Petitioner did not report any complaints of pain to the left shoulder or neck at that time.

Based on the March and June 2012 records from Dr. Pales, the Petitioner was exercising regularly and working full duty with no complaints of left shoulder or neck pain. His admission of regularly swimming is inconsistent with a rotator cuff tear.

The Petitioner eventually sought treatment with Dr. Visotsky with complaints of left shoulder pain on August 7, 2012, which is the first date of treatment relating to the left shoulder in over one year. Petitioner complained of left shoulder pain to Dr. Visotsky attributing the pain to his motor vehicle accident on June 21, 2011 (PX 5) and ignoring the motor vehicle accident of July 5, 2012.

The Arbitrator questions the causal relationship of Petitioner's left shoulder complaints on August 7, 2012 to the car accident in June of 2011 considering that Petitioner had not treated or made any complaints of pain in over a year and was working full duty and exercising regularly. The Petitioner had opportunities to complain of pain and seek treatment for his left shoulder, if he really had them, when he treated with Dr. Pales in March and June of 2012.

The logical explanation for Petitioner needing to seek treatment on August 7, 2012 for the left shoulder was the personal motor vehicle accident that Petitioner testified to occurring on July 5, 2012. This explanation is supported by the medical evidence and diagnostic testing as

well. The Petitioner did undergo a new MRI on the left shoulder on August 14, 2012. The MRI from August of 2012 revealed changes in the left shoulder as compared to the prior MRI performed on July 11, 2011. (PX. 3) All of Petitioner's rotator cuff tendons were intact in July of 2011, but the August 2012 MRI showed changes in the rotator cuff tendons suggestive of changes to Petitioner's left shoulder condition unrelated to the June 21, 2011 car accident. The MRI from August of 2012 documents an intact glenoid labrum, which was the location which demonstrated an increased signal on the July 11, 2011 MRI. (PX 3)

Based on the MRI findings in August of 2012, Dr. Visotsky recommended surgery which was performed on December 10, 2012 consisting of a rotator cuff repair and debridement of calcific tendinosis. The procedures performed were related to the findings on the August 14, 2012 MRI, not the July 11, 2011 MRI. (PX 3, 5, 6). Therefore, the Arbitrator finds that the surgical procedure performed on December 10, 2012 was to cure findings in the left shoulder documented after Petitioner's second motor vehicle accident on July 5, 2012, and were findings unrelated to Petitioner's June 21, 2011 motor vehicle accident. The Arbitrator finds that Petitioner's rotator cuff tear and subsequent surgery was not causally related to the motor vehicle accident on June 21, 2011. The changes found on the MRI's from 2011 to 2012 establish a change in Petitioner's left shoulder condition that could not be related to the June 21, 2011 incident.

The Arbitrator's findings are supported not only by the medical records, but they are also supported by the expert opinions rendered by Dr. Vitello on February 26, 2014. The Arbitrator agrees with Dr. Vitello's analysis that Petitioner did sustain a sprain/strain to the left shoulder with some AC joint separation as a result of the accident on June 21, 2011. Dr. Vitello noted that Petitioner received appropriate treatment for that condition and returned to full duty work. The Arbitrator further relies on Dr. Vitello's opinion that Petitioner's rotator cuff tear and subsequent surgery are in no way causally related to the motor vehicle accident that occurred on June 21, 2011. Dr. Vitello's supported his opinion that Petitioner's condition of ill-being as of August 7, 2012 was not causally related to the June 21, 2011 work accident, by considering the facts that: Petitioner sought no medical treatment for 13 months, worked full duty, exercised regularly and was involved in a subsequent motor vehicle accident on July 5, 2012 which caused diagnostic/objective changes in Petitioner's left shoulder condition as well.

Cervical Spine Injury:

The Petitioner began to complain of cervical spine pain following his left shoulder surgery, which the Arbitrator has determined was not causally related to the motor vehicle accident on June 21, 2011. Therefore, the Arbitrator denies a causal connection between Petitioner's cervical spine symptoms and the motor vehicle accident on June 21, 2011.

According to the medical records, Petitioner began to complain of paracervical and trapezial pain in March of 2013. (PX 5) The Petitioner was working full duty with no restrictions during this period of time.

To support this opinion, the Arbitrator relies on the medical records of the Petitioner and the opinions of Dr. Avi Bernstein. The Petitioner did not make any complaints of cervical spine,

paracervical or trapezial pain following the motor vehicle accident in June of 2011. The Petitioner did not allege any complaints relating to the paracervical or trapezial region until Petitioner sought treatment for his unrelated left shoulder condition. The Petitioner's first complaint of neck pain was two years after the accident of June, 2011.

According to Dr. Bernstein's opinion, it is sometimes hard to determine causation in claims involving neck and shoulder complaints as they tend to overlap. (RX 3) The Arbitrator does not dispute the overall validity of Dr. Bernstein's statement. However, in the present case, the extensive gap in treatment with no complaints of pain to either the shoulder or neck for over a year strongly suggests that Petitioner's condition of ill-being relating to both the shoulder and cervical spine are not causally related to the motor vehicle accident on June 21, 2011. There cannot be an overlapping in pain when Petitioner did not complain of pain or seek treatment for pain for either the left shoulder or cervical spine for an entire year following his initial treatment.

The fact that Petitioner had minor diagnostic findings in the left shoulder following the motor vehicle accident and was able to work full duty without any complaints or treatment for 13 months establishes that Petitioner did not have significant enough left shoulder pain for it to "mask" his cervical condition.

The more logical and reasonable explanation for the cause of Petitioner's cervical complaints, is the July 5, 2012 motor vehicle accident, which led to Petitioner seeking treatment for his left shoulder's condition after that accident.

In terms of the medical records relating to the cervical spine, the Petitioner did undergo an MRI of the cervical spine on April 23, 2013 which did not reveal any significant, acute or traumatic findings. The MRI revealed some straightening of the normal lordosis, but otherwise normal cervical alignment with intact cervical vertebral heights, a small paracentral disc protrusion at C4-5 and small left disc protrusion at C5-6 with mild stenosis at both levels. The C6-7 level showed minimal diffuse disc bulge. The rest of the cervical spine revealed mild degenerative changes with no significant spinal stenosis. (PX 3)

The MRI from April 23, 2013 does not illustrate any acute or traumatic disc herniation stemming from the June 21, 2011 motor vehicle accident. The MRI findings in April of 2013 are degenerative in nature. (PX 3) The Arbitrator rejects the conclusion that Petitioner could have sustained multiple herniated discs stemming from a single car accident and did not make any complaints of pain for two years, while working his full duty job for that entire period and exercising on a regular basis as he described.

Dr. Visotsky found that Petitioner's cervical spine revealed disk degeneration but no focal or acute disk herniation. (PX 5)

The first treatment record with Dr. Siemionow, a spinal specialist, relating to Petitioner's cervical spine is on June 26, 2013, almost two years after the motor vehicle accident in June of 2011. (PX 5) The Petitioner provided a history to Dr. Siemionow alleging neck pain stemming from his June 21, 2011 car accident. Dr. Siemionow diagnosed Petitioner with left upper extremity radiculopathy and possible cubital tunnel syndrome. Petitioner was recommended to

undergo an EMG of the upper extremities to differentiate between cervical radiculopathy and cubital tunnel. No evidence that Petitioner had the EMG study was offered in evidence.

Dr. Siemionow's opinion noted in the medical record on June 26, 2013 that Petitioner's "current condition is a direct result of the motor vehicle collision that he was involved in 2011,since he had no prior symptoms to speak of before that," (PX 5), is questionable. The information given to Dr. Siemionow is incomplete. Dr. Siemionow's record is void of any mention that Petitioner continued to work his full duty job since June of 2011, both for Respondent and repairing motorcycles, or that he exercised daily for 90 minutes, including running, swimming and biking. Dr. Siemionow's reasoning for causally connecting Petitioner's current condition of ill-being is because he claimed to have no symptoms prior to June of 2011.

The Petitioner began treating with a pain management physician, Dr. Padron in June of 2013. The Petitioner underwent extensive pain management treatment without any improvement, including five cervical epidural injections. The diagnosis of cervical radiculopathy and the reasonableness and necessity of those injections considering they provided zero relief for Petitioner's symptoms is also questionable.

The Petitioner's alleged cervical spine condition worsened in July of 2014 after Petitioner was involved in another personal motor vehicle accident this time on July 26, 2014. The Petitioner sought treatment at Lutheran General Hospital on that date and underwent diagnostic scans including x-rays of the chest and left shoulder, as well as CT scans of the cervical spine and brain.

The Petitioner followed up with Dr. Siemionow on July 30, 2014 and advised him of the accident on July 26, 2014. (PX 11) The Petitioner complained of an increase in the intensity of his symptoms following that accident. After July 30, 2014, the Petitioner's prior recommendation for a two level cervical fusion changed to a three level fusion from C4-C7. (PX 11, 12) The Petitioner's MRI from April of 2013 which revealed minimal disk bulging at C6-7 had transformed into a full blown herniation impinging on the spinal cord.

The Petitioner's cervical condition, which worsened from 2013 to 2014, is not causally related to the June 21, 2011 car accident.

Based on the totality of the evidence, including testimony, medical records and expert physician reports, the Arbitrator finds that Petitioner failed to prove that his condition of ill-being relating to the left shoulder and his cervical spine is causally related to the motor vehicle accident on June 21, 2011.

In support of the Arbitrator's decision with regard to whether the medical services that were provided to the Petitioner were reasonable and necessary and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator makes the following conclusions of law:

The Petitioner proved that he sustained a work related accident on June 21, 2011. He did sustain a sprain/strain to the left shoulder with some AC joint separation as a result of the

accident on June 21, 2011. Dr. Vitello noted that Petitioner received appropriate treatment for that condition and returned to full duty work.

The Petitioner failed to prove that his current condition of ill-being relating to his cervical spine and his left shoulder are causally related to the motor vehicle accident on June 21, 2011. The Arbitrator finds that the treatment Petitioner received for his left shoulder, including the MRI and the x-rays, from the date of the accident on June 21, 2011 through July 11, 2011 was reasonable and necessary. The Respondent is responsible for the costs of this care and treatment.

The Petitioner's treatment for his neck and left shoulder beginning on August 7, 2012 was not causally related to the June 21, 2011 accident. The Arbitrator finds that Petitioner's cervical condition is not causally related to the car accident on June 21, 2011. The Arbitrator finds that any and all medical treatment and medication received for the cervical spine is not causally related to the incident on June 21, 2011 and Respondent is not liable for payment.

In support of the Arbitrator's decision with regard to whether Petitioner is entitled to TTD or TPD and what Petitioner's earnings were, the Arbitrator makes the following conclusions of law:

After consideration of all of the evidence, the Arbitrator finds that Petitioner failed to prove that he was entitled to TTD benefits or TPD benefits.

The Petitioner did not present any evidence of reduced payments to establish a claim for TPD. Submitting Petitioner's tax records does not sufficiently prove a claim for TPD benefits (PX 15). The Petitioner claimed that he was earning less from the Respondent after his motor vehicle accident. However, Petitioner's testimony claimed that his work duties after the accident never changed and he continued to earn approximately $1,200.00 per week.

Petitioner testified that he received payment in cash for the motor cycle repairs that he performed on an average of two or three times per week. There was no testimony that the Respondent was aware of the Petitioners other job or that Petitioner lost earnings due to an inability to perform motorcycle repairs either.

Petitioner returned to full duty work the day after the accident, June 22, 2011. Any lost time from work or temporary partial disability claim alleged after August 7, 2012 is denied as the Arbitrator found that Petitioner failed to prove that his condition of ill-being relating to the shoulder and neck after August 7, 2012 was causally related to the motor vehicle accident on June 21, 2011.

Petitioner testified that after his termination from the Respondent in April of 2014, he obtained a job performing essentially the same job functions as his prior job, also earning approximately $1,200.00 per week. He stated that he believed that there was a difference in his income basically because at the new job he has to pay for his health insurance and he did not have to do that when working for the Respondent.

The Petitioner testified that he continued working his regular job for the Respondent from June 22, 2011 until his discharge in April of 2014. The only claim for TTD alleged by Petitioner is the three to four week period he was off of work following an unrelated cervical fusion in February of 2015.

Petitioner's claim for TTD and TPD benefits is denied as Petitioner did not present sufficient evidence to establish a claim for TTD or TPD benefits.

In support of the Arbitrator's decision with regard to whether Petitioner is entitled to Fees and Penalties, the Arbitrator makes the following conclusions of law:

The Arbitrator denies Petitioner's claim for penalties pursuant to Section 19(k) or 19(l) of the Act, and accordingly, does not award attorneys' fees pursuant to Section 16 of the Act. The Arbitrator found that Petitioner failed to prove that his condition of ill-being relating to the left shoulder and cervical spine were causally related to the work accident on June 21, 2011.

It is undisputed that Respondent paid temporary total disability benefits and medical benefits. Payment of temporary total disability benefits is not an admission of liability. TTD benefits and medical benefits were terminated after Respondent relied upon its Section 12 examination reports. The Arbitrator finds that Respondent did not act vexatiously or frivolously in their termination of benefits.

Therefore, the Petitioner's petition for penalties and fees against the Respondent is denied.

In support of the Arbitrator's decision with regard to whether Respondent is due any credit, the Arbitrator makes the following conclusions of law:

The parties agreed that the Respondent has paid $3,343.60 in TTD and $3,000 for other benefits. The Respondent is entitled to credit for a total of $6,343.60.

In support of the Arbitrator's decision with regard to whether Petitioner is entitled to Prospective medical care, the Arbitrator makes the following conclusions of law:

The Arbitrator found that Petitioner failed to prove that his current condition of ill-being as it relates to his left shoulder and neck is causally related to the motor vehicle accident on June 21, 2011. The Arbitrator finds that the Respondent is not liable for any prospective medical care or treatment relating to the left shoulder or cervical spine.

ORDER OF THE ARBITRATOR

The Petitioner was involved in a work-related motor vehicle accident and sustained minor injuries to his left shoulder. The Petitioner gave defective notice to the Respondent of the injuries from the accident. The Respondent is liable for payment for the costs of the necessary

and reasonable medical treatment that Petitioner incurred from the date of accident of June 21, 2011 through July 11, 2011, for Petitioner's left shoulder, pursuant to the fee schedule or prior agreement, whichever is less, as provided in the Act.

The Petitioner failed to prove that his current condition of ill-being pertaining to his left shoulder and his cervical spine is causally related to the accident on June 21, 2011. Any and all medical treatment and medication received for the cervical spine is not causally related to the incident on June 21, 2011 and Respondent is not liable for payment.

Petitioner's claim for TTD and TPD benefits is denied as Petitioner did not present sufficient evidence to establish a claim for TTD or TPD benefits.

The Respondent did not act vexatiously or frivolously in their termination of benefits. Therefore, the Petitioner's petition for penalties and fees against the Respondent is denied.

The parties agreed that the Respondent has paid $3,343.60 in TTD and $3,000 for other benefits. The Respondent is entitled to credit for a total of $6,343.60.

The Petitioner failed to prove that his current condition of ill-being as it relates to his left shoulder and neck is causally related to the motor vehicle accident on June 21, 2011. The Respondent is not liable for any prospective medical care or treatment relating to the left shoulder or cervical spine.

Deborah L. Simpson — July 29, 2015

Signature of Arbitrator — 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 MADISON)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jo Ellen Wilson,

Petitioner,

vs. NO: 13WC 39034

Big Muddy River Correctional Center,

Respondent,

15IWCC0842

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 17, 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: NOV 1 9 2015
o110515
DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILSON, JO ELLEN
Employee/Petitioner

Case# **13WC039034**

15IWCC0842

BIG MUDDY RIVER CORRECTIONAL CENTER
Employer/Respondent

On 4/17/2015, 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 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

4948 ASSISTANT ATTORNEY GENERAL
WILLIAM H PHILLIPS
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

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

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

APR 17 2015

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

15IWCC0842

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

Jo Ellen Wilson
Employee/Petitioner

v.

Big Muddy River Correctional Center
Employer/Respondent

Case # **13** WC **39034**

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**, on **3/23/15**. 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 **Future Medical and Future TTD**

FINDINGS

On **3/19/13**, 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* sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned $**73,380.00**; the average weekly wage was $**1,411.15**.

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

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

ORDER

Claims for TTD and for future medical care after May 6, 2013 are denied. See attached order.

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

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

Signature of Arbitrator

4/13/15
Date

APR 17 2015

Jo Ellen Wilson v. Big Muddy River Correctional Center

IWCC No. 13 WC 039034

The Arbitrator finds the following facts:

On March 19, 2013 Petitioner was employed as a Certified Food Supervisor III at Big Muddy River Correctional Center. On that date, Petitioner reported to work and parked in in a lot specifically designated for employees and visitors to Big Muddy River Correctional Center. While walking through the parking lot Petitioner slipped on a patch of ice and fell on her left knee. (Px 9, Rx 1, 2, 3)

On the date of her accident Petitioner reported to Marshall Browning Hospital in DuQuoin with complaints of left hip and left knee pain. (Px 3) X-rays of Petitioner's knee revealed a knee joint effusion and degenerative changes without evidence of a fracture. (Id) X-rays of her left hip revealed arthritis without a fracture. (Id) Petitioner next reported to Dr. Craig Furry who treated her injuries conservatively. (Px 4) MRI imaging of Petitioner's left knee was obtained on April 12, 2013. (PX 5) The MRI revealed mild patellar tendinopathy, likely acute, edema in the superior lateral aspect of Hoffa's fat suggesting fat impingement, and moderate to severe chondromalacia of the patellofemoral joint. (Id) The MRI report noted that edema in the Hoffa's fat is frequently caused by a maltracking abnormality although an acute injury was possible. (Id)

Petitioner first reported to Mark Miller MD on May 7, 2013. (Px 6) Dr. Miller diagnosed Petitioner with a patellofemoral contusion and cautioned against surgical intervention. (Id) Dr. Miller wrote, "There is a causal relationship between the fall and the MRI findings, current symptoms. The patient does have preexisting/coexisting patellofemoral compartment DJD. I trust this is simply an exacerbating incident rather than an aggravating incident." (Id) Petitioner continued to treat with Dr. Miller over the following months. (Id) On July 8, 2013 he noted "The patient has made some nice improvement since the injury. She has been back at work. At this point the primary struggle is with the preexisting/coexisting degenerative joint disease of the patella. This is the reason for the feel of rough movement of the patellofemoral joint. The fall has probably aggravated this situation." (Id) At that time, Dr. Miller recommended cortisone injection or viscosupplementation. (Id) Despite initially declining the viscosupplementation, Petitioner underwent the injection on November 18, 2013. (Id) Dr. Miller never wavered in his opinion that Petitioner was not a surgical candidate. (Id)

Petitioner first reported to Bonutti Orthopedic Services on February 14, 2014 and was assessed by Nickolas Williams PA-C. (Px 7) On that date, Mr. Williams diagnosed "knee pain" and recommended that Petitioner undergo arthroscopic surgery with chondroplasty and possible lateral release. (Id) Mr. Williams' note states, "She brought a MRI report with her. We could not get the MRI disk to work, but the report stated advanced patellofemoral disease." (Id) On March 26, 2014 Petitioner underwent an arthroscopic chondraplasty of the lateral facet of the patella and a removal of 25-30% of her medial meniscus. (Px 7, 8) Petitioner testified that the surgery provided her relief for "maybe two weeks". When Petitioner failed to show improvement postoperatively Dr. Bonutti ordered a repeat MRI which revealed post-meniscectomy changes of the medial meniscus without evidence of a new meniscal tear,

a leaking Baker cyst, and minimal tricompartment osteoarthritic changes. (Px 7) Postoperatively, Dr. Bonutti unsuccessfully treated Petitioner with injections, physical therapy, and a TENS unit. (Id)

Dr. Bonutti testified that, if Petitioner's account of her injury was valid, her preexisting degenerative changes to her patellofemoral joint were aggravated by a direct fall on her patella. (Px 10, p. 9) Dr. Bonutti stated that he has not formally recommended a revision surgery, but another arthroscopic intervention or a realignment of the patella could be considered. (Id, p. 11) Dr. Bonutti confirmed that he did not examine Petitioner on February 14, 2014. (Id, p. 16) Dr. Bonutti further confirmed that the recommendation to proceed with surgery was completed based solely on Petitioner's MRI report, as he was unable to review the studies themselves. (Id, p. 17) Dr. Bonutti also acknowledged that he never reviewed the records of Dr. Miller or Petitioner's family physician. (Id, p. 18) Dr. Bonutti testified that he originally found Petitioner's presentation to be credible but postoperatively he felt that her subjective symptoms were more substantial than her objective findings. (Id, p. 19)

Petitioner was assessed by Dr. Richard Lehman at Respondent's request. (Rx 4) Dr. Lehman reviewed all of Petitioner's imaging as well as the records of Dr. Miller and Dr. Bonutti. (Id, p. 5) Dr. Lehman opined that Petitioner sustained a soft tissue bruise as a result of her fall which did not affect her arthritis or chondromalacia. (Id, p. 8-9) Dr. Lehman opined that Petitioner reached maximum medical improvement from her fall approximately six to eight weeks after it occurred. (Id, p. 9) Dr. Lehman pointed out that Petitioner's MRI was taken one month after her fall and showed exclusively degenerative processes within the knee. (Id, p. 10) Dr. Lehman testified that Petitioner's meniscal tear, which was repaired during her March 26, 2014 surgical intervention, was degenerative in nature and was not yet present when the May 7, 2013 MRI was obtained. (Id, p. 10-12) Dr. Lehman found that the arthroscopic procedure performed by Dr. Bonutti was not an effective treatment for degenerative arthritis and was unrelated to her fall in 2013. (Id, p. 9, 12) Furthermore, Dr. Lehman explained that Petitioner's symptoms originated from her patellofemoral arthritis and not her meniscus, which is why her symptoms failed to improve after Dr. Bonutti's surgical intervention. (Id, p. 36-37)

Petitioner retired on December 30, 2014. Petitioner acknowledged that her knee symptoms have abated to some extent since her retirement. Petitioner denied any occupational objectives and indicated that it is her intention to remain retired.

When asked if she was confident whether a repeat surgical procedure with Dr. Bonutti would provide her with a better result than his prior attempt, Petitioner said, "No, I'm not confident, I just – that's what he suggested so I was just going with my doctor."

Therefore, the Arbitrator concludes:

1. Petitioner sustained an accidental injury on March 19, 2013 when she slipped on ice while crossing a parking lot controlled and maintained by Respondent.

2. Petitioner's treatment at Marshall Browning Hospital and her treatment with Dr. Furry was reasonable, necessary, and causally connected to her March 19, 2013 fall. Petitioner's May

7, 2013 MRI was similarly reasonable, necessary, and related. However, once Petitioner reached Dr. Miller her traumatic findings had resolved and his treatment focused on her degenerative findings. While Dr. Miller's treatment was reasonable and necessary, it was not causally connected to her fall. It is important to note that Dr. Miller's initial statement regarding causal connection is equivocal at best, and his later statement indicating that Petitioner's degenerative conditions were aggravated were not explained with the specificity found in Dr. Lehman's deposition. Specifically, Dr. Lehman's analysis of Petitioner's MRI is compelling evidence that her acute findings had resolved by the time she reported to Dr. Miller. Petitioner is found to have reached maximum medical improvement as of May 6, 2013 and therefore no medical benefits or temporary total disability after that date is hereby awarded.

3. The treatment offered by Dr. Bonutti's office is not reasonable or necessary to alleviate Petitioner's medical condition. Dr. Bonutti neglected to review Petitioner's medical records and imaging and failed to examine her personally until the date of her surgery. Petitioner's poor results are not surprising since the surgical intervention performed by Dr. Bonutti focused on her asymptomatic degenerative meniscal tear instead of the patellofemoral arthritis which was generating her symptoms. The opinions of Dr. Miller and Dr. Lehman combine for far more weight than the opinion of Dr. Bonutti regarding the necessity or wisdom of surgical intervention. Therefore, Petitioner's surgery is neither reasonable nor necessary.

4. It is important to note that Dr. Bonutti and Petitioner appear to have an issue with communication and trust; as he has indicated that her subjective complaints are excessive postoperatively and she expressed a lack of confidence in Dr. Bonutti's ability to resolve her symptoms via additional surgery. Furthermore, Dr. Bonutti's notes and deposition do not indicate that he has made a second surgical recommendation, however Petitioner's testimony indicates that she believes such a recommendation exists. Therefore, even if Dr. Bonutti's past treatment had been found to be reasonable, necessary, and causally connected, further medical treatment with Dr. Bonutti would not be awarded.

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)
JEFFERSON		☐ PTD/Fatal denied
	☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kelli A. Standley,
Petitioner,

vs. NO: 14WC 7174

15IWCC0839

Cooper B-Line,
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, 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 January 7, 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: NOV 19 2015
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CJD/jrc
049

Joshua D. Luskin

Ruth W. White

DISSENT

I must respectfully dissent from the majority's decision that the Petitioner failed to prove that she sustained accidental injuries on December 15, 2012 and that her current condition of ill-being was not causally connected to that accident.

I would find that Petitioner did sustain a traumatic repetitive injury to her left side resulting in carpal tunnel syndrome. I would order the Respondent to pay for the carpal tunnel release and any resulting temporary total disability. I would find that the left thumb degenerative arthritis was not related to this accident.

The Petitioner credibly testified that she was employed by the Respondent as a "lead" of the rivet department. Although she does not run the machines, her job is to make sure the machines are able to run. Her job also required her to fold up and tape in the area of 1,208 boxes a day. This testimony represents what she does the whole time she was employed by the Respondent. She also helps the line person at the end of the conveyor belt in folding or taping up boxes and does inspections. (Transcript Pgs. 29-31)

The boxes she deals with range from 3 to 4 inches long and 2 inches wide. She also folds 12 inch by 12 inch boxes and 14 inch by 14 inch boxes. At times she will fold 40-60 boxes in an hour. She will also label the boxes from 400-800 a day. She has to fold the flap closest to her and utilizes her thumbs. She then will fold the side flaps with her index fingers and the back flaps with her thumbs. (Transcript Pgs. 24-29)

Respondent did not offer any rebuttal to Petitioner's explanation of her job duties.

I find Dr. Morgan's opinions as to her carpal tunnel syndrome much more persuasive than those of Dr. Rotman. Morgan opined that Petitioner's work activities was an accumulative trauma and was a likely cause of her carpel tunnel syndrome. (Petitioner Exhibit 2 Pg. 10) Therefore, the Respondent should pay for her carpal tunnel release on the left side.

As for the surgery that Morgan wants to do on Petitioner's left thumb, I would agree that surgery and the condition of the left thumb is not causally connected to that accident. I find Rotman's opinion in regard to the left thumb arthritis more persuasive than that of Morgan. When Petitioner first saw Dr. Fozard on December 30, 2013 she had complaints consistent with Carpal Tunnel Syndrome, but had no complaints regarding her left thumb. (Petitioner Exhibit 1) It was Rotman's opinion that Petitioner's job did not require extraordinary heavy pinching with her left thumb and there was nothing with regard to the making of those boxes that would put a major force on her left thumb. (Respondent Exhibit 5 Pgs. 12-13) The x-rays taken by Fozard on March 27, 2014 indicate no injury involving left thumb and very mild early degenerative changes of the left thumb with no acute findings.

Charles J. DeVriendt

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

STANDLEY, KELLI A
Employee/Petitioner

Case# **14WC007174**

COOPER B-LINE
Employer/Respondent

15IWCC0839

On 1/7/2015, 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:

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

5515 THOMAS MARGOLIS
862 E PLEASANT HILL RD
CARBONDALE, IL 62902

15IWCC0839

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

KELLI A. STANDLEY
Employee/Petitioner

v.

COOPER B-LINE,
Employer/Respondent

Case # **14** WC **007174**

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 **Mt. Vernon**, on **November 6, 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, December 15, 2012, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**46,098.00**; the average weekly wage was $**886.50**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **0** children under 18.

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

Petitioner ***has*** received 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 general credit for any medical bills paid through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove she sustained an accident on December 15, 2012 that arose out of and in the course of her employment or that her condition of ill-being in her hand and thumb was causally connected to her employment duties for Respondent. 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

January 2, 2015
Date

JAN 7 - 2015

ICArbDec19(b)

Findings of Fact and Conclusions of Law

Petitioner claims repetitive trauma injuries to her left hand that manifested on December 15, 2012. (AX 2) Disputed issues were accident, causal connection, prospective medical care, and medical expenses. Present at the hearing was Respondent's representative, Wayne Weshoinkey.

The Arbitrator finds:

On September 30, 2013 Respondent completed a First Report of Injury regarding Petitioner. Her job was noted to be that of a machine operator and she reported packing boxes was causing her thumb and index finger to become tingling. (RX 2, Res. Ex. 2, p. 3)

Petitioner was seen by her family doctor, Dr. Fozard, on December 30, 2013, for purposes of an annual exam. He noted she had a history of left carpal tunnel syndrome related to work and was "following through workers' compensation" and being referred to a surgeon in the near future. (PX 1)

Petitioner signed her Application for Adjustment of Claim in this matter on February 26, 2014. (AX 2)

Petitioner was again examined by Dr. Fozard on March 28, 2014; this time primarily for her left upper extremity complaints which she felt were related to her work duties. According to his office notes, workers' compensation was not covering her alleged injury. Petitioner needed a nerve conduction study. Petitioner reported a night splint was helping to some degree. She also complained of pain at the base of her left thumb. "Her job requires repetitive use of the thumb to push labels off of a roll of labels. She does this repetitively multiple times a day of the last 10 years." Dr. Fozard ordered a nerve conduction study, prescribed voltaren gel, and gave her work restrictions. His diagnoses were left carpal tunnel syndrome and left thumb osteoarthritis. (PX 1)

The EMG/NCS was performed on April 10, 2014. According to the history, Petitioner complained of numbness and tingling in her left hand. The conclusion from the EMG/Nerve Conduction Study was: 1) moderately severe left median mononeuropathy at the wrist (i.e., carpal tunnel syndrome) without active denervation; and, 2) mild right median mononeuropathy at the wrist (i.e., carpal tunnel syndrome) without active denervation. (PX 4) Thereafter, Dr. Fozard diagnosed Petitioner with left carpal tunnel syndrome and osteoarthritis of the first MP joint of the left hand. (PX 1 at 6)

Petitioner was then referred to Dr. Richard Morgan, an orthopedic surgeon. He initially examined her on May 15, 2014. As part of the examination Petitioner provided/completed a questionnaire. According to it, Petitioner's chief complaint was pain, numbness, and tingling in her left hand and thumb which had begun in December of 2012 at work. (PX 2, 5) Petitioner described her work as factory work where she handled boxes and labels. Petitioner has performed this work for about 10 years part-time and about 5 years full-time. Dr. Morgan noted Petitioner did not have any systemic issues that would lend itself to carpal tunnel. She had a history of hypertension, no thyroid problems, and no diabetic type problems. (PX 2) Dr. Morgan noted Petitioner's nerve conduction velocity studies which revealed moderate to severe carpal tunnel syndrome and x-rays of her hand that showed basilar thumb arthritis. (PX 2) Dr. Morgan's notes indicated her carpal tunnel symptoms were pretty significant so he recommended that she have a combined carpal tunnel decompression and resection of the trapezium and an FCR inner position arthroplasty of her thumb. (PX 2)

Petitioner was then seen by Dr. Mitchell Rotman for a Section 12 Examination on July 7, 2014 and a written report followed[1]. As part of the exam Petitioner completed a questionnaire in which she claimed a work-related injury to her left hand and thumb occurring in December of 2012. Petitioner described her job as "Packing parts. Folding boxes. Labeling boxes. First piece inspections. Applying screws to parts. Perform these all day every day. 5-10 lbs. off and on. Sometimes 20 lbs. or so (very intermittently). Small amount of data entry (1 hour) intermittent. Repetitive work day daily - constantly." (RX 2, Res. Ex. 3) Petitioner's complaints included carpal tunnel symptoms and pain at the base of her left thumb which she attributed to repetitive work and excessive finger and thumb use. Petitioner acknowledged previously undergoing a right carpal tunnel release from which she had done well. She denied any thumb symptoms on the right hand. Petitioner explained she was continuing to work full duty for Respondent, having begun her job with Respondent in 2003. Petitioner had been at her current facility for the last five years. Petitioner described her typical work day as 10 1/2 hours long or 50-59 hours per weeks. Her job activities included packing parts, folding boxes, labeling boxes, and performing "first piece inspections", and applying screws to parts. Petitioner told the doctor she might have to lift between 5 and 10 pounds off and on and up to twenty pounds intermittently. She also did a little data entry work but not for longer than an hour and it, too, was intermittent. Petitioner explained that box making was a two-handed job and she made boxes for parts ranging in size from 3-4 inches square to up to two feet. Petitioner described folding down the tabs of the boxes and thereafter placing them under a machine to be filled with parts. She might also help tape the boxes or fold the tops in. Occasionally, she would pack some of the small parts into boxes but that depended upon the demands of the day. Petitioner's job also required her to put labels on boxes. While she is right-handed, she explained that she used her left hand to feed the labels through. She then peeled the labels off a roll with her right hand while supporting the labels with her left hand. Petitioner also occasionally applies screws to parts which involved holding the parts with her left hand and applying the screw with her right. "First piece inspection" involved checking the tightness on parts. How many checks she performed varies by day but she thought it might be 10 - 30 parts. Petitioner explained that since it was difficult for her to pinch with her left hand and thumb, she used pliers. (RX 2, Res. ex. 2)

After taking a history from Petitioner, Dr. Rotman performed a physical examination and concluded that Petitioner did have left carpal tunnel syndrome and left thumb CMC arthritis. He considered her carpal tunnel syndrome to be idiopathic as the condition is generally bilateral in nature. He noted her prior history of right carpal tunnel syndrome in her dominant hand and felt it to be "no surprise" that she was now presenting with symptoms in her non-dominant hand. He also felt her thumb arthritis was not related to her work activities as the condition was very common in females, especially at her age of 51. He did not feel her pinching activities at work were excessive nor did her job involve heavy gripping or pinching or the use of power or vibratory tools. Any forces on her hands would be considered light with regard to her level of activity and varied in nature. Dr. Rotman did agree with the need for a carpal tunnel release but felt an injection to her thumb was the preferred method of treatment rather than proceeding to a fusion. He felt she needed some conservative care for her thumb first. He also felt she could work full duty. (RX 2, Res. ex. 2)

[1] Markings contained in the doctor's report were not done by the Arbitrator.

The deposition of Petitioner's physician, Dr. Morgan, was taken on September 25, 2014. Dr. Morgan, a board certified orthopedic surgeon, testified consistent with his office notes. He testified that Petitioner told him her problems began in December of 2012. He was asked to render a causation opinion based upon a hypothetical set of facts which centered around estimates Petitioner had kept at work over three days of work. (PX 5, pp. 9-10) He opined, based upon a reasonable degree of medical and surgical certainty, that Petitioner's "accumulative trauma" certainly was a likely cause of her carpal tunnel problems. (PX 5 at 10) Dr. Morgan continued stating that both carpal tunnel and her basilar thumb arthritis were certainly, even if they were not proximately caused by the work activities, both can be aggravated by that type of activity and this was more likely than not what happened in her case. (PX 5 at 10) Dr. Morgan testified the type of arthritis the Petitioner has, basilar thumb arthritis, is usually not work-related; however, it certainly could be aggravated by work activities but work is usually the proximate cause barring some type of injury. Dr. Morgan further testified the basilar thumb arthritis can be structurally changed with an activity which uses the thumbs significantly. If there is a degenerative process, the repetitive use of the thumb can certainly aggravate the arthritis and accelerate the degenerative changes, the wear, spurs, narrowing that you see. (PX 5 at 19) Dr. Morgan felt the carpal tunnel was the more severe problem of the two and felt Petitioner was a candidate for emergent surgery for the carpal tunnel with the nerve conduction velocity study being that bad. (PX 5 at 24) Dr. Morgan further stated if it were the thumb only, she might be able to put that off awhile but if she were to have the carpal tunnel procedure it would be better, or optimal, to do them both at one time in one setting. (PX 5 at 24)

Dr. Morgan acknowledged that he has only seen Petitioner on one occasion. He also acknowledged that he never saw a job description. He hasn't seen Petitioner's job being actually performed. (PX 5)

The deposition of Dr. Rotman was taken on October 6, 2014. (RX 2) Dr. Rotman, also a board certified orthopedic surgeon, testified that Petitioner provided him with a history and description of her job. Petitioner told Dr. Rotman she started working for Respondent in December of 2003 and had been working at the present facility in Pinckneyville for the last five years. (Id.) The plant in Pinckneyville makes small steel fasteners for tubing and wiring, it also makes steel gratings. (RX 2 at 1, 2) Petitioner reported working 10 ½ hour days, approximately 50-59 hours per week with job activities that included packing parts, folding boxes, labeling boxes, performing first piece inspections, blank screws to parts, performing those jobs daily. (PX 2 at 2) Petitioner further stated she might have to lift between 5-10 pounds off and on and sometimes up to 20 pounds that is intermittent. (Id.) Her job activities involved making small boxes for small parts. Petitioner was noted to be right-handed but she used her left hand to feed the labels through. Petitioner told him that she peeled the labels off, though, with her right hand while she supported the labels with her left. The labels came on a roll. According to Dr. Rotman, Petitioner told him that some cardboard boxes were 3-4 inches square and other could be up to two feet long. Petitioner folded down the tabs of the boxes and would place the boxes underneath one of the machines so that the parts could be placed in them. Petitioner also told him about taking the sides down and flipping front to back to put the boxes together. At the end of the line, she might help take the boxes or fold the tops in. She would sometimes pack some of these small parts into boxes. She would also apply screws to parts, holding the parts with her left hand and applying the screw with her right. The box making and folding of the tabs was a two-handed job. Petitioner also told Dr. Rotman about "first piece inspections" which involved checking the tightness of the parts. How often she did that depended on the day. She might check from 10 to 30 parts. Since it was difficult to pinch with her left hand with her thumb, Petitioner used pliers to complete some of the testing activities. (Id.)

Dr. Rotman agreed that there was no significant medical history. (RX 2 at 11) Dr. Rotman testified that Petitioner's work activities would not bother her thumb arthritis any more than other activities she might do either at home or at work, she did not do any extraordinary heavy pinching in her job, there was really nothing with regard to making boxes or putting labels on boxes, or twisting screws on, supporting the small parts with the left hand that was going to put major forces on the base of her left thumb. Dr. Rotman did not think that her type of work was going to be an aggravating factor for left thumb arthritis. (RX 2 at 13) Dr. Rotman further stated that as far as the left carpal tunnel syndrome Petitioner's work was not an aggravating factor for her idiopathic carpal tunnel condition because her work did not involve repetitively heavy gripping with the left hand. (RX 2 at 15, 16) Dr. Rotman further stated that light forces do not increase risk for carpal tunnel as they did not create enough pressure in the carpal tunnel to be an aggravating factor to the median nerve. He also testified that heavy gripping creates more forces into the hand and will cause increased stresses and pressures inside the carpal tunnel. (RX 2 at 16)

On cross-examination Dr. Rotman was asked questions about the numbness in Petitioner's hand and whether each episode of numbness represented an aggravation of her condition. Dr. Rotman replied that it was a triggering of symptoms from a temporary microscopic loss of blood flow which then reverses itself. (RX 2 at 20-21) Dr. Rotman went on to testify that when Petitioner was experiencing numbness in her left hand it was because the ligament going over the median nerve was thick and blocks some blood flow temporarily. (RX 2 at 19) If the blood flow is decreased time and time again, the carpal tunnel or the median nerve will go through progressive changes. At the beginning it might be completely reversible and then if you wait until it becomes very severe, there might be irreversible changes in the covering of the myelin sheath of the nerve. Dr. Rotman agreed that he might not be surprised if Petitioner's hands went numb with activity and the numbness meant the nerve was actually being deprived of oxygen. (RX 2 at 20) Dr. Rotman agreed that gripping increases the pressure of the median nerve. (RX 2 at 23) However, he went on to state that repetition alone is not considered a risk factor. It has to be heavy forceful activities with repetition and it does not matter to him how much repetition there is if there is not enough force. (RX 2 at 25, 26) Dr. Rotman indicated 20 pounds might be getting into the category of heavy gripping but you would need to be doing it repetitively all day long and one would need to consider the size of the person's hands as the bigger the hand the less troublesome gripping twenty pounds might be. He acknowledged that a smaller hand might require less grip force. (RX 2 at 27)

At the arbitration hearing Petitioner testified she was employed as a lead person in the riveting section at Respondent's plant. This section of the plant involved making parts and placing them in boxes. She further described her job duties as varied over a ten hour day, Monday through Friday. As the lead person Petitioner oversees the department and rotates the workers around the various machines (of which there are 11). She, herself, does not operate a rivet machine; however, it is her responsibility to make sure the machines are ready to run and she troubleshoots and resets them as necessary. She also helps with making and staging boxes to hold the parts as they come down the machine. Petitioner does not actually pack any boxes. Petitioner explained that making the boxes requires her to twist with her hands. She also uses hand tools, allen wrenches, and screw drivers when working on the machines. Petitioner testified she assembles boxes ranging in size from 3-4" long to 2" wide by 3" and 12" by 12" square to 14" square. Petitioner described having to use her thumbs to maneuver the first and back flaps as she made boxes. She estimated making between 40 and 60 boxes/hour depending upon how fast the machines were running. Petitioner also testified that she labels all the boxes intermittently but labels approximately 400 to 800 boxes altogether. Petitioner explained that the boxes come off a roll and she peels them off and applies them to the box. Petitioner denied taping any boxes. Petitioner explained that she keeps busy all day and doesn't spend any time just standing around. There is paperwork to be done, lead work to be done, and general helping out on the line.

At her attorney's request Petitioner was asked to keep track of the number of times she engaged in certain activities while at work. Petitioner did so and produced her notes at trial (PX 7). Petitioner testified that on one occasion, as part of her job, she would perform the following in a one hour time period: fold or tape up to 88 boxes; labeling up new orders for approximately 68 boxes; first piece inspections about 4 total; and helping the end of the assembly line either folding or taping boxes, approximately 24 boxes. On February 28, another day example would be: folding or taping up approximately 94 boxes; labeling up new orders, about 84 boxes; helping the end of the line either folding or taping boxes shut, about 27 boxes. Petitioner further testified on an additional one hour sampling she would tape up 160 boxes; labeling up of new orders of 570 boxes and helping the end of the line either folding or taping approximately 22 boxes. Petitioner also provided details as to the amount of folding, taping, labeling, first piece inspections, and end of line work she did on March 4, 2014, April 3, 2014, and April 30, 2014. Petitioner demonstrated folding boxes utilizing her hands and thumbs to fold cardboard boxes.

Petitioner identified RX 3-5 as photographs of the boxes and her job site. (RX 3-5)

Petitioner testified to the gradual development of pain in her thumb and hand. Petitioner stated as she was folding the boxes she would routinely have to shake out her hands because of numbness. Petitioner further testified that her thumb became extremely painful as she progressed throughout the day. the base of her thumb is often swollen. At the end of a week, Petitioner stated she had more pain and needed the time off from work to rest the thumb and hand. She notices a constant ache no matter what she is doing -- dressing, doing her hair, or working. At night, Petitioner wears a splint. She testified that her fingers are going numb. She notices them going numb and tingling while making boxes.

Petitioner would like to proceed with the surgery as proposed by Dr. Morgan.

The Arbitrator concludes:

1. Issues (C, F) - Accident and Causal Connection.

Petitioner failed to prove she sustained an accident on December 12, 2012 that arose out of and in the course of her employment or that her current condition of ill-being in her left hand and thumb is causally connected to her employment duties with Respondent.

Petitioner bears the burden of proving she sustained a repetitive trauma injury that arose out of her employment and that her conditions of ill-being in her left hand and thumb were caused by her employment duties. To do so, she relies primarily upon the opinions of Dr. Morgan.

Dr. Morgan's opinions as to causal connection are unpersuasive. It was his understanding (from his office notes) that Petitioner "handled boxes and labels all the time." At his deposition he was asked to assume some examples of Petitioner's tasks on various days but he never really addressed the relationship between those activities and her ailments. Furthermore, while he felt her type of work activity could aggravate both conditions, he acknowledged reviewing no outside medical records nor did he have any specific information regarding Petitioner's work duties. She did not demonstrate to him how she performed her job duties. He testified, "...at least in her mind, she said it started at work from her work activities in her questionnaire." (PX 5, p. 15) He acknowledged personal medical conditions can start at work and yet not be work-related. Dr. Morgan also

acknowledged never performing a pinch test or checking Petitioner's grip strength. He had no copy of her thumb x-rays. In sum, Dr. Morgan had very little, if any, actual knowledge of the details of Petitioner's job and how she performed the various tasks she did throughout the day. As such, his opinion is not persuasive. Dr. Rotman's opinion was more persuasive and based upon a more detailed understanding of Petitioner's physical job requirements.

The Arbitrator has also considered Dr. Fozard's records and the comments on causation as found in his office notes. They, too, are not felt to be persuasive as he also had very limited knowledge of Petitioner's job duties for Respondent.

In addition, the Arbitrator is troubled by the manifestation date. While Petitioner claims an accident date of December 15, 2012, she provided no testimony as to the significance of that date. There are some general references to an onset of symptoms in December of 2012 but without additional testimony or information it is difficult to conclude how Petitioner's symptoms and their perceived relationship to her work duties for Respondent manifested themselves at that time. The first medical record in evidence is dated December 30, 2013, over one year after the alleged manifestation date. What happened in that intervening period of time is not known.

Petitioner's claim for compensation is denied and no benefits are awarded. All other issues are moot.

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STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ 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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cortney Toppel,

Petitioner,

vs.

NO: 14 WC 8160

15IWCC0861

Alexian Brothers Health System,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, extent of temporary total disability, maintenance benefits and medical expenses 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 (1980). The Commission also grants Petitioner's Motion for Leave to File Statement of Exceptions.

The Commission affirms the Arbitrator's finding that Petitioner sustained accidental injuries arising out of and in the course her employment on October 26, 2013. Petitioner testified a patient rolled onto her left wrist up to her mid forearm on October 26, 2013. That same day, she was seen Alexian Brothers Emergency Room. Nurse Practitioner Steven Hammer noted that Petitioner chief complaint was traumatic left wrist pain and this was an initial encounter. The following history was noted: "The patient complains of left wrist pain from a workplace injury." The triage narrative noted: "while assisting a pt she bent left wrist now pain." The following was

also noted: "Patient arrived to the ED with complaint of left wrist pain X 2 days. Patient states she was pushing a patient at work when her left wrist hyperextended and she states she has been having pain since. Left wrist appears with minimal bruising." Normal range of motion of the left wrist was noted, although Petitioner complained of difficulty with flexion. She rated her left wrist pain at 4/10. She denied any treatment prior to arrival. It was noted there was no pertinent past medical history. Other emergency room records noted the following History of Present Illness: "The patient presents with an injury to the left wrist that occurred while at work yesterday when hyperextended same rolling pt. Able to work today, though still painful, sent here for evaluation." On examination there was mild diffuse dorsal tenderness of the left wrist with minimal swelling, mild dorsal bruising, no deformity, full range of motion with minimal pain, the joints above and below were non-tender with full range of motion, there was no snuff box tenderness and the neurovascular and skin examinations were otherwise normal. Left wrist x-rays were negative for a fracture or dislocation. Petitioner was diagnosed with a left wrist sprain. She was prescribed a wrist splint and medications and was to follow-up with the Occupational Health Clinic in 1 or 2 days. The October 26, 2013 Employer Discharge Summary by Dr. Oh noted the following: "Effective 10/26/2013, Cortney M. Toppel is released to work on a modified basis. Work restrictions: limit strong grip/grasp/pinch left hand." The Patient Injury Description indicated Petitioner stated she had left wrist pain. The diagnosis of left wrist sprain/strain was noted. The October 26, 2013 ER-Employee Status Report noted that Petitioner was to return to work with restrictions to limit left hand strong grip/grasp/pinch. (Rx2). The Commission notes that Petitioner did not mention her left arm, left shoulder or left upper back to the Alexian Brothers Emergency Room personnel.

Petitioner was seen at Alexian Brothers Employee Health on October 28, 2013 by Physician Assistant Kelly Licari, who noted the following history: "This 28-year-old female complains on 10/26/13 a patient weighing approximately 232 pounds rolled like deadweight onto her left wrist while she was changing the Depends. She states at that time she notified her supervisor. She did present to the ER and had a negative x-ray of her left wrist. They placed a wrist splint and she has been using ibuprofen for discomfort. At this point the discomfort is located only over the dorsum of the wrist at the ulnar area and there is some mild bruising that she has noticed that has developed there. She denies numbness or tingling to the area. She states that flexion mostly produces the pain for her. There is no elbow pathology and no radiation of the pain to the proximal forearm." Examination revealed a minor area of light brown ecchymosis over the dorsum of the left wrist at the distal ulnar area, mild tenderness to palpation, full range of motion to all 5 digits, full range of motion to the wrist, pain was reproduced with flexion of the wrist, pincer grasp to all 5 fingers was intact and sensation to all 5 digits was intact. Petitioner was diagnosed with a wrist sprain. The rigid black wrist splint was removed and replaced with a simple Ace wrap to give more flexibility. Petitioner was to take ibuprofen as needed and apply heat to the area. Work Status was noted as return to work with a 10 pound restriction. She was to follow-up on November 1, 2013. The October 28, 2013 Employee Status Report indicated Petitioner was diagnosed with an acute left wrist sprain. She was to return to work with restrictions of limited lift/carry to maximum of 10 pounds and limited push/pull to

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maximum of 10 pounds. She was to use Ace wrap at work. (Px1). The Commission notes that Petitioner gave a specific history of no radiation of the pain to the left proximal forearm.

Petitioner testified she presented the restrictions to Respondent, who accommodated the restrictions (Tr 25-26). She continued to work with those restrictions (Tr 26). Petitioner testified that when she returned to work with her light duty restrictions, she was physically able to perform her job duties without any problems (Tr 26). However, she then stated she had pain that radiated from her left wrist to her left shoulder while performing her job duties (Tr 26-27).

Petitioner was seen at Alexian Brothers Employee Health on November 1, 2013 by Physician Assistant Heather Venamore, who noted the following history: "She is currently without any pain or complaints in the left wrist. She is here today complaining of left upper back pain that occurred on Wednesday (10-30-13) while she was "making a bed at work." She now complains of achy-type pain in the left upper back, worse with movement of the neck. She denies any direct trauma. No numbness, tingling or weakness of the extremities. No shoulder pain. No throat pain. No history of a similar complaint in the past." Examination revealed left paraspinal and left trapezius tenderness with spasm, limited neck range of motion secondary to discomfort, bilateral upper extremities with full range of motion with 5/5 strength and neurovascular that was intact distally and her left shoulder was non-tender with full range of motion. Petitioner was diagnosed with a left trapezius strain. She was to use ice/heat locally and was prescribed Motrin 600 and Flexeril. Ms. Venamore noted, "I did speak with Sheryl Brandt regarding patient's work status and plan. She did approve evaluation of this injury, as this is a new injury." Work Status noted an additional restriction of no reaching above the shoulder on the left side. Petitioner was to follow-up on November 5, 2013. The November 1, 2013 Employee Status Report noted the following diagnosis: 1) left wrist sprain – resolved; 2) left trapezius strain and spasm. Petitioner was to return to work with restrictions of limited lift/carry to maximum of 10 pounds, limited push/pull to maximum of 10 pounds and no reaching/lifting with the left arm above shoulder level. In his Discharge Summary of November 1, 2013, Dr. Lyman noted the following under Work Status Summary: "Effective 11/1/2013, Cortney M. Toppel is cleared to perform all job functions associated with regular job duties." Petitioner was to return only as needed and was discharged from care. (Px1). Petitioner testified she had no explanation if they noted in those records that she had another or additional date of accident of October 30, 2013 (Tr 28-29). After that visit, she continued to work under light duty restrictions (Tr 29). The Commission notes that Petitioner's complaints were to her left upper back after making a bed at work on October 30, 2013, which is a separate injury from the left wrist injury she sustained on October 26, 2013.

Petitioner was seen at Alexian Brothers Employee Health on November 5, 2013 by Physician Assistant Kelly Licari, who noted Petitioner's main problem was pain in her left upper back with a date of onset of October 30, 2013. Petitioner reported she was much better, that her pain was resolved and she felt comfortable to return to work. Other notes indicated Petitioner reported left trapezius numbness and tingling to her neck and left shoulder. Petitioner was diagnosed with left wrist sprain/strain and left trapezius sprain/strain, both resolved. Ms. Licari

noted Petitioner was fit for duty without restrictions as of this day. In his November 5, 2013 Discharge Summary, Dr. Lyman noted the following Work Status Summary: "Effective 11/5/2013, Cortney M. Toppel is cleared to perform all job functions associated with regular job duties." Under Patient Injury Description, Dr. Lyman noted the following: "Patient states that she was making a bed then spasm began in left upper back area." The diagnosis was noted as thoracic sprain/strain. Petitioner was to return only as needed and was discharged from care. (Px1).

Petitioner testified she did not tell Alexian Brothers Employee Health personnel on November 5, 2013 that her left wrist pain had resolved (Tr 29). She also stated that she did not tell them that she felt she could return to work at full duty. Petitioner did not know why that would be in that record (Tr 29). She provided the full duty release to her employer and she was put back on the schedule at full duty (Tr 31). After that date, Petitioner started working back at her regular duties (Tr 31). In the mornings, it would be okay, but the more she used her left hand or left wrist, the more the pain would come to the left wrist (Tr 31). Petitioner was asked if she was having any problems with her arm or shoulder. She stated, "Arm, from the left wrist. The more I used the arm, the more pain – the worse the pain would get. It would go from my left wrist to my elbow to my shoulder." (Tr 31). Petitioner worked full duty through January 3, 2014.

Petitioner was seen at Presence St. Joseph Hospital emergency room on January 6, 2014. The stated complaint was shoulder pain and her chief complaint was shoulder injury. The Primary Impression was shoulder pain/injury. Petitioner rated he pain at 5/10. The following was noted: "C/o pain to left shoulder – increased pain with movement. Left hand warm to touch with good color, movement, sensation." Onset of Chief Complaint was noted as December 23, 2013. The following was noted: "Reason for seeking care: C/o pain to left shoulder – says approx. 2 weeks ago, pt was turning a resident at work and resident rolled back onto left hand, hyperextending wrist. Initially had pain up left arm into shoulder. Since, has had intermittent pain to shoulder, tonight increased pain." The Discharge Diagnosis was noted as shoulder pain/injury. No follow-up care was noted. Petitioner was prescribed medications. A slip noted, "The patient is unable to lift/push heavy objects with her left arm until cleared by doctor." (Px2). The Commission notes that there was no mention of an October 30, 2013 left upper back/trapezius injury while making a bed. It appears that the history of the October 26, 2013 event was reported by Petitioner to the emergency room as having occurred on December 23, 2013. Petitioner also reported that she initially had pain up her left arm into her left shoulder, which is not what the initial medical records show.

Petitioner was seen at Alexian Brothers Employee Health on January 9, 2014 by Dr. James, who noted a Date of Onset of October 26, 2013. Petitioner's main problem was noted as pain in her left wrist and left shoulder. She reported usage makes her pain worse and rest makes it better. Petitioner complained of wrist pain with flexion and extension. Her left shoulder pain worsened the past weekend. It was noted that Petitioner went to the emergency room at St. Joe's in Elgin. The following was noted: "Pt had been improving with respect to wrist pain, however,

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return of wrist pain radiating to upper arm/shoulder." X-rays were negative. Examination revealed full active and passive left wrist range of motion, good distal sensation, biceps/triceps reflexes within normal limits and a positive Tinel's sign. Left wrist x-rays showed no evidence of fracture or osseous lesion and the joint spaces were preserved. Dr. James noted that carpal tunnel syndrome must be considered in differential. Dr. James diagnosed Petitioner with a left wrist strain and possible carpal tunnel syndrome. Dr. James found Petitioner fit for duty with following restrictions: avoid strong gripping with left hand and limit repetitive motion with left hand, no lifting with left arm greater than 10 pounds over the shoulder, 10 pounds below the waist, 10 pounds from waist to shoulder and no pushing/pulling over 10 pounds. (Px1). Petitioner testified she brought the restrictions to Respondent, but they were not accommodated (Tr 35-36).

Petitioner was seen at Alexian Brothers Employee Health on January 14, 2014 by Dr. Sandoval, who noted a Date of Onset of October 26, 2013. Petitioner's main problem was noted as pain in her left wrist and left shoulder. Her pain was made worse with grip, grasp and certain movements and made better with rest. She had radiation up her left arm. Petitioner reported, "When using arm for long periods will have sharp shooting pains into left arm. At times with certain pressure arm will go numb." Petitioner reported no improvement in pain in her left wrist. On examination, her pain increased with flexion/extension, she had a positive Phalen's and a negative Tinel's. Dr. Sandoval diagnosed left wrist sprain/strain. Petitioner was given a wrist splint and she was advised to take over-the-counter Ibuprofen. She was given the following work restrictions: lift/carry limited to 10 pounds, push/pull limited to 10 pounds, limit repetitive motion, limit flexion/extension. She was to use the split at work and home. (Px1).

On January 21, 2014, Petitioner was seen at Alexian Brothers Employee Health by Physician Assistant Heather Venamore, who noted a Date of Onset of October 26, 2013 and the main problem as pain in her left wrist and left shoulder. Petitioner reported sharp pain was constant and radiating up her left arm. She reported using the splint and feeling the same. Ms. Venamore noted: "28 year old female here for F/U eval of persistent left wrist pain. Pt c/o decrease in her grip strength. Pt notes pain is constant with movement and better with rest. Radiation of the pain to the left shoulder." Petitioner was diagnosed with a left wrist sprain, rule out carpal tunnel syndrome. Petitioner was to continue wearing the splint and take Motrin as needed for pain. Her work restrictions were increased to limited lift/carry and push/pull to maximum of less than 5 pounds and limited left hand strong grip/grasp/pinch. Ms. Venamore referred Petitioner to Dr. Birman for wrist pain evaluation. (Px1).

Petitioner saw Dr. Birman on January 31, 2014. In his Occupational Health Continuation Record, Dr. Birman noted a Date of Injury of October 30, 2013. He noted the following Description of Injury: "28 year old sprained left wrist at work. She was rolling large patient, hyperextended left wrist. Seen at ER. Light duty. Also had left neck and shoulder pain. Returned to full duty. Increased pain with work duties. Over time, intermittent. Pain radiating up to shoulder." Dr. Birman noted her previous treatment with Employee Health. On examination, Dr. Birman found guarded left wrist, range of motion decreased by 40 degrees

from contralateral wrist, focal tenderness, non-tender and full elbow and shoulder range of motion. Dr. Birman's impression was a left wrist sprain. Dr. Birman ordered a left wrist MRI. Dr. Birman gave work restrictions of limited lift/carry, push/pull to 10 pounds with the left hand. She was to use the splint at work and home as needed. (Px1).

Petitioner saw Dr. Birman again on February 28, 2014. In his Occupational Health Continuation Record, Dr. Birman noted the following: "Wrist pain unchanged. Describes burning along ulnar side of thumb. Still awaiting approval for MRI." On examination, left wrist range of motion was minimally limited compared to the contralateral side. Dr. Birman's impression was left wrist sprain. He noted the left wrist MRI was pending approval. Petitioner was to continue the same restrictions. She was to follow-up on March 28, 2014. (Px1).

On March 17, 2014, Petitioner saw Dr. Wiesman, a surgeon. In his records, Px3, Dr. Wiesman noted the following history: "This is a 28-year-old female who is right-hand dominant, who works as a nurses' aide. She states that on 10/25/2013 she was rotating a stroke patient who weighed approximately 300 pounds and he fell, landing onto her extended left hand and caused a hyperextension injury. She was diagnosed with a sprain, but she has had persistent pain since then." On examination, there was no cervical spine tenderness, no anterior scalene tenderness, no upper shoulder girdle tenderness, no medial or lateral epicondylar tenderness. Right hand examination was unremarkable. Left hand examination revealed mild diffuse tenderness more on the radial aspect than on the ulnar aspect, negative Watson's test, negative Kienbock's test, negative shuck test, no DRUJ instability and the hands were vascularly intact. Fluoroscopic examination was performed which showed no bony or ligamentous instability patterns or fractures. Dr. Wiesman's assessment was left wrist pain. He ordered a MR arthrogram since it has been almost 5 months since her injury. Dr. Wiesman gave Petitioner light work restrictions of no lifting over 5 pounds with her left hand. He opined that the need for additional diagnostic testing was causally related to her work injury of October 25, 2013.

On March 26, 2014, Petitioner underwent a CT arthrogram of the left wrist. It was found that contrast was demonstrated in the left radiocarpal joint where the injection was performed. It was noted there was abnormal contrast extravasating into the distal radioulnar articulation, which was highly suspect for tear of the triangular fibrocartilage. A MR arthrogram of the left wrist was performed the same day and demonstrated contrast was seen in the left radiocarpal articulation. The radiologist's impression was 1) abnormal contrast extravasating into the dital radioulnar articulation, suspect for a tear of the triangular fibrocartilage (the tear is not readily visualized); 2) scapholunate and lunotriquetral ligaments appear intact without contrast extravasating into the midcarpal row region.

On April 4, 2014, Dr. Wiesman noted that the patient rolling over forced Petitioner's left hand into severe extreme dorsiflexion. She has been having pain ever since localized over the ulnar aspect of the left wrist and it radiates circumferentially. Petitioner also reported weakness with grip strength as well as pain with movement and it has been completely debilitating. Dr. Wiesman noted that Petitioner had undergone extensive conservative treatment, including

prolonged splinting, medications and work modification. Dr. Wiesman noted: "The patient was discharged by the company clinic to return back to work, however, returning back to work aggravated the patient's pain, increasing her disability and pain." Dr. Wiesman examined Petitioner's left wrist and reviewed the diagnostic studies, noting that the abnormal contrast extravasation into the distal radial-ulnar articulation was diagnostic of a TFCC tear. Dr. Wiesman's assessment was a left TFCC tear and his plan was to perform surgery to correct the TFCC tear. Petitioner was placed in a splint for immobilization. Dr. Wiesman authorized Petitioner off work. Dr. Wiesman opined a causal relationship existed between the accidental injuries Petitioner sustained on October 25, 2013 and the proposed surgery.

On May 12, 2014, Dr. Wiesman performed surgery on Petitioner's left wrist. In his Operative Report, Dr. Wiesman noted a pre-operative diagnosis of left wrist pain, possible triangular fibrocartilage complex tear. Dr. Wiesman performed: 1) proximal carpal row arthroscopy with synovectomy and debridement of TFC and slight debridement of frayed volar scapholunate ligament; 2) mid carpal row arthroscopy with synovectomy and partial debridement of scapholunate ligament.

Petitioner was continued off work until September 22, 2014 when Dr. Wiesman released her to return to work with restrictions of no left arm/hand use. On November 3, 2014, Dr. Wiesman gave restrictions of 5 pounds lift/carry/push/pull. On December 1, 2014, Dr. Wiesman found Petitioner at maximum medical improvement and ordered a functional capacity evaluation, which was performed on January 10, 2015. On January 14, 2015, Dr. Wiesman released Petitioner to return to work with restrictions of 20 pounds lift/carry/push/pull.

In his December 2, 2014 deposition, Px12, Dr. Wiesman opined that a causal relationship exists between Petitioner's hyperextension type injury she sustained on October 26, 2013 and the TFCC tear, as well as his treatment and surgery. At Respondent's request, Petitioner underwent a §12 evaluation with Dr. Neal on August 27, 2014. In his reports and in his deposition, Rx1, Dr. Neal initially opined causal connection for Petitioner's left wrist condition, but once he received medical records from December 2009 which showed Petitioner had sustained a left sprain, he opined no causal connection.

Petitioner testified she is right hand dominant (Tr 59). She has not started looking for work since January 14, 2015 as she does not know yet what she can do according to her restrictions (Tr 60). She is trying to figure out some alternative work that she can do and has been looking up various office jobs (Tr 60). She planned on applying for employment in the near future (Tr 61). Arbitration was held on January 22, 2015.

The Commission modifies the Arbitrator's finding that Petitioner failed to prove causal connection after November 5, 2013, finding that Petitioner proved that a causal relationship exists between the injuries she sustained to her left wrist on October 26, 2013 and her current condition of ill-being. The Commission finds causal connection for Petitioner's left wrist condition based on the medical records and Dr. Wiesman's opinions.

The Commission finds no causal connection for Petitioner's left shoulder condition to the October 26, 2013 left wrist injury. The contemporaneous medical records show only injury to Petitioner's left wrist. The medical records show Petitioner sustained a new injury for her left upper back after making a bed on October 30, 2013. There was no claim filed for that injury. The Commission notes that there is no causal connection opinion regarding Petitioner's left upper back of left shoulder.

The Commission finds Petitioner was temporarily totally disabled beginning on January 9, 2014. At that time, Petitioner was released to return to work with restrictions. Petitioner testified she gave those restrictions to Respondent and the restrictions were not accommodated. This testimony is unrebutted. The Commission finds that Petitioner was temporarily totally disabled through December 1, 2014, the date Dr. Wiesman determined that Petitioner had reached maximum medical improvement.

The Commission finds Petitioner failed to prove she was entitled to vocational rehabilitation and therefore Respondent is not liable for maintenance benefits. Petitioner gave vague testimony regarding a job search. The Commission also notes that Petitioner requested TTD benefits and maintenance benefits for some of the same period of time. The Commission finds that Petitioner is entitled to medical benefits for her treatment of the left wrist only. Credit to Respondent of $2,865.50 for an advance is carried to the next hearing since the advance was for permanency. The Commission affirms all else. Additionally, the Commission grants Petitioner's Motion for Leave to File Statement of Exceptions.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $310.66 per week for a period of 46-5/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner medical expenses for treatment of the left wrist only under §8(a) of the Act, subject to the Medical Fee Schedule under §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's Motion for Leave to File Statement of Exceptions is hereby granted.

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.

15IWCC0861

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 this case be remanded to the Arbitrator for further proceedings consistent with this Decision.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $14,600.00. 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: NOV 2 3 2015
MB/maw
o09/24/15
43

Mario Basurto

Stephen J. Mathis

David L. Gore

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

TOPPEL, CORTNEY
Employee/Petitioner

Case# **14WC008160**

15IWCC0861

ALEXIAN BROTHERS HEALTH SYSTEM
Employer/Respondent

On 3/16/2015, 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 0.09% 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:

4239 LAW OFFICES OF JOHN S ELIASIK
180 N LASALLE ST
SUITE 3700
CHICAGO, IL 60601

0075 POWER & CRONIN LTD
WILLIAM P DEWYER
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

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)

Cortney Toppel
Employee/Petitioner

v.

Alexian Brothers Health System
Employer/Respondent

Case # **14** WC **8160**

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 **January 22, 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, **October 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*** 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 $**14,911.78**; the average weekly wage was $**465.99**.

On the date of accident, Petitioner was **28** years of age, ***single*** with **4** 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, $**0** for TPD, $**0** for maintenance, and $**2,865.50** for other benefits, for a total credit of $**2,865.50**.

ORDER

Respondent shall pay reasonable and necessary medical expenses with respect to the testing and treatment that Petitioner received from October 26, 2013 through her release from treatment to return to work full duty on November 5, 2013, pursuant to the medical fee schedule or by prior agreement, whichever is less, pursuant to the Act.

All other benefits sought pursuant to Section 8 of the Act are denied as Petitioner failed to prove that her condition after November 5, 2013, was related to the accidental injury she suffered on October 26, 2013.

Pursuant to the stipulation entered into by the parties, the Respondent shall be given a credit of $2,865.50, for other benefits paid by the Respondent.

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

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

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

Deborah L. Simpson
Signature of Arbitrator

March 16, 2013
Date

MAR 16 2015

15IWCC0861

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cortney Toppel,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 14 WC 8160**
	)	
Alexian Brothers Health System,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on October 26, 2013, 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 gave the Respondent notice of the accident which is the subject matter of the dispute within the time limits stated in the Act. They further agree that in the year preceding the injuries, the Petitioner earned $14,911.78, and that her average weekly wage was $465.99; Petitioner was 28 years old, single with four dependent children.

At issue in this hearing is as follows: (1) Did the Petitioner sustain accidental injuries or was she last exposed to an occupational disease that arose out of and in the course of employment; (2) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (3) Were the medical services that were provided to the Petitioner reasonable and necessary and has Respondent paid all appropriate charges for all reasonable and necessary services; (4) Is Petitioner entitled to TTD from January 9, 2014 through January 22, 2015; (5) Is the Petitioner entitled to Maintenance from January 14, 2015 through January 22, 2015; and (6) Is Respondent due any credit.

STATEMENT OF FACTS

The Petitioner is employed by the Respondent as a patient care technician. She is responsible for helping patients with their activities of daily living such as showering, dressing, meals, fixing their hair, brushing their teeth and other everyday needs. She also draws blood from patients as well.

The Petitioner alleges that on October 26, 2013, while moving a 300 pound patient, she injured her left hand, left elbow, and left shoulder.

The Petitioner testified that the patient, who had recently had a stroke, was positioned in his bed on his right side. The Petitioner had her right hand on the patient's right shoulder with

her left hand on his back above his buttocks area. The patient was in the process of being washed and dressed by Petitioner, when he rolled over onto his back and the Petitioner's left hand, up to her left elbow became lodged under the patient. Petitioner testified that she was reaching for a wipe with her right hand at the time the patient rolled onto his back. Petitioner lifted him with her right arm just enough that she could pull her left arm out from underneath the patient. Petitioner is right hand dominant. Although the Petitioner testified this patient was 300 pounds at the hearing, she reported to numerous medical personnel that the patient weighed 232 pounds. (PX 1)

The Petitioner stated that about one half hour after the incident she felt pain in her left wrist up to her elbow especially when she bent her wrist up or down. She testified that she told Belinda Jordan, a nursing supervisor, about forty minutes after it happened that she had injured her left wrist. According to the Petitioner there was a bruise visible on her wrist which she showed to Ms. Jordan. The Petitioner testified that she was directed to seek medical treatment after her shift that day. The accident, according to the Petitioner, happened in the middle of her shift somewhere between 10:00 a.m. and 12:00 p.m.

The Petitioner testified that she sought treatment at the emergency room at Alexian Brothers Medical Center that evening and she was sent to occupational health which was about five minutes down the road. Medical records confirm that Petitioner reported injuring her left wrist. X-rays were taken which were negative for a fracture. She was given a wrist splint and pain medication and taken off of work and referred to occupational health. (PX 1)

The medical records from Alexian Brothers Medical Group from October 28, 2013, state that the Petitioner reported that she was changing the Depends of a patient weighing 232 pounds when he rolled like deadweight onto her left wrist. Petitioner reported pain located only over the dorsum of the wrist at the ulnar area and some mild bruising over the area. Petitioner denied numbness or tingling to the area and admitted that flexion mostly reproduces the pain for her. She denied any elbow pain or any radiation of pain to the forearm. The doctor's examination revealed a minor area of light brown ecchymosis over the dorsum of the left wrist at the distal ulnar area; mild tenderness to palpation; full range of motion to all five digits, full range of motion to the wrist. The doctor noted further that pain was reproduced with flexion of the wrist and her pincer grasp to all five fingers was intact, sensation to all 5 digits is intact. (PX 1, RX 2) Petitioner was released to return to work with a ten pound restriction, continue to take ibuprofen as needed and apply heat to the area if needed. (PX 1, RX 2)

On November 1, 2013, she reported to the Occupational Health Clinic for follow-up. At that time she reported her wrist feels better, she rated the pain as a two. The medical report indicates that she was currently without pain or complaints regarding her left wrist. She was complaining of some pain in her upper back on the left side that started on Wednesday while she was making a bed. She denied any direct trauma, numbness, tingling or weakness of the extremities. She denied any shoulder pain or throat pain. She also denied a similar history or complaints in the past. She had no other complaints at the time. She was released from treatment for her wrist to return as needed, and released to return to work full duty with no restrictions. (PX 1) With respect to the pain in the Trapezius, she was diagnosed with a sprain. She was restricted to light duty work, told to use ice/heat/stretch/ use Icy Hot and or Motrin. She was told to return for follow-up on November 5, 2013. (PX 1, RX 2) At the hearing, the Petitioner denied reporting to medical personnel that her wrist felt better.

On November 5, 2013, the Petitioner returned for follow-up as directed. At that time she reported that the pain was resolved, and she felt comfortable returning to work full duty. The Petitioner was permitted to return to work full duty with no restrictions beginning on November 5, 2013, per the medical records. (PX 1, RX 2)

At the hearing the Petitioner denied telling medical personnel that her pain was resolved and that she could go back to work full duty. Petitioner testified that she returned to work full duty, but she struggled performing her job duties because of pain in her left wrist.

The Petitioner did not seek out any further medical care or treatment until January 6, 2014, when she went to the emergency room at St. Joseph's Hospital in Elgin, Illinois.

The Petitioner testified that on January 6, 2014, her left shoulder pain increased to the point where she went to the emergency room at St. Joseph's Hospital. The record from the visit indicates that Petitioner reported pain in her left shoulder after a patient rolled back onto her left hand two weeks prior, causing bruising. The triage nurse listed the date of accident as 12/23/13. (PX2, RX3). Petitioner testified that she was given a shoulder splint and advised to return to the work clinic where she was previously receiving treatment for this injury.

The chart note from St. Joseph's Hospital on January 6, 2014 does not make mention of any left wrist pain with a history, upon presentation, of pain in the claimant's left shoulder.

The Petitioner returned to Alexian Brothers on January 9, 2014. (PX1, RX 2). She was seen Dr. Thomas James, and reported that she had been improving, but now had a return of her wrist pain, radiating into her shoulder. She was diagnosed with possible carpal tunnel syndrome, and released to return to work with light duty restrictions. She was also given another x-ray of the left wrist, which was negative. (PX1, RX 2). Petitioner testified that she presented these restrictions to Respondent, and they did not provide accommodation. She has not returned to work for Respondent since. Petitioner testified that her last day of work at Respondent was on Friday January 3, 2014.

Petitioner returned to Alexian Brothers on January 14, 2014. She was again seen by Dr. James. She complained of a sharp pain into her left arm when using for long periods, and that her arm would go numb. Dr. James recommended a wrist splint, over the counter Ibuprofen, and released her to return to work light duty. (PX 1, RX 2).

Petitioner retuned to Alexian Brothers for follow- up on January 21, 2014. She saw a physician's assistant, and reported that she was using the wrist splint, but had no improvement. She continued to have "achy" pain in the wrist, radiating into the shoulder and that she was losing grip strength in her left hand. Petitioner was referred to see Dr. Birman, a hand surgeon. She was also given light duty restrictions of no lifting/carrying/pushing/pulling greater than 5 lbs. (PX 1, RX 2).

Petitioner saw Dr. Birman at Alexian Brothers on January 31, 2014. Dr. Birman recommended an MRI of the left wrist, and continued the 5 lb. restrictions. Petitioner returned to Dr. Birman on February 28, 2014. He continued to recommend an MRI and continued the same restrictions. (PX1). Petitioner testified that she did not get the MRI because Respondent would not authorize it.

The Petitioner continued in conservative care and treatment eventually coming under the care of Dr. Irwin Wiesman at Illinois Orthopedic Network (ION) in downtown Chicago, Illinois, upon referral by her attorney.

Dr. Wiesman recommended a CT arthrogram of the wrist and kept her on light duty. (PX3). A CT scan and an MRI was performed on March 26, 2014 at Edgebrook Radiology, and revealed a suspected tear of the triangular fibrocartilage. (PX4).

Petitioner returned to see Dr. Wiesman on April 4, 2014. (PX3). Dr. Wiesman recommended arthroscopic surgery of the wrist and kept Petitioner off work. He performed the surgery on May 12, 2014. At the time of surgery, Dr. Wiesman discovered synovitis proximal and mid carpal row of the wrist, Geissler II scapholunate ligament tear and a small volar central perforation of the triangular fibrocartilage complex. Dr. Wiesman performed a synovectomy and debridement of the TFC and slight debridement of the frayed volar scapholunate ligament. (PX3).

According to the Petitioner, the surgical intervention did not make the pain in her left wrist subside until 2-3 months thereafter.

Petitioner followed up with Dr. Wiesman after surgery, and started on a course of post-surgical physical therapy at ATI, from June 24, 2014 through October 27, 2014. (PX3, 5). During this period, Petitioner continued to complain of significant pain in the wrist. (PX3). Dr. Wiesman released Petitioner to return to work on September 22, 2014 with no use of the left hand. (PX3). Petitioner testified that Respondent did not accommodate her restrictions.

In her first post-physical therapy visit with Dr. Wiesman on November 3, 2014, Petitioner complained of diffuse, persistent ongoing pain in her wrist. (PX3). Dr. Wiesman tried an injection, and recommended that Petitioner use a wrist splint and take Ibuprofen. He released her to return to work with 5 lbs. lifting/carrying/pushing/pulling restrictions.

Petitioner returned to Dr. Wiesman on December 1, 2014, where she complained of pain in the left hand of 5/10 that comes and goes and fatigue in the hand with use. Dr. Wiesman found that Petitioner was at maximum medical improvement, and sent Petitioner for a functional capacity evaluation.

The FCE was performed on December 15, 2014 at Athletico. The report indicated restrictions that would prevent her from returning to work as a nursing assistant. She saw Dr. Wiesman again on January 14, 2015, where she was discharged from care, with permanent light duty restrictions. (PX3).

Petitioner testified that in the eight days since being discharged, she has been trying to find an alternative line of employment, and has considered office-type work. She also testified that she checked Respondent's employment website for open positions within her restrictions, but that her employee password was expired.

Petitioner testified that she continues to have pain in her wrist on and off with use, that occasionally radiates into her elbow. Petitioner testified that she has difficulty with activities of daily living, and needs assistance with things like doing laundry and doing the dishes. She

testified that the fingers in her left hand get stiff when driving. She testified that her arm and shoulder/neck pain has resolved. She is currently not working.

Petitioner testified that at the time of the accident, her left hand, wrist arm and shoulder were in good physical condition. She could not recall having a prior incident in December of 2009 where she injured her left wrist lifting a patient.

Medical records from Advocate Sherman Outpatient Center indicate that Petitioner was seen on December 11, 2009 for a left wrist strain as a result of assisting a resident at work. (RX6). The records show that she was given an x-ray, which was normal. (RX6). She was also prescribed Ibuprofen and a hand splint and given work restrictions. (RX6).

Petitioner returned December 17, 2009, and was given the same treatment recommendations. (RX6). She was working within her restrictions. (RX6).

Petitioner returned again on December 24, 2009, 13 days from the original visit, when she was discharged from further treatment. (RX6).

On July 30, 2014, Petitioner was seen by Dr. Bryan Neal, a hand surgeon, at the Request of Respondent. Dr. Neal testified by way of evidence deposition on behalf of Respondent. (RX1). In addition to examining the Petitioner, Dr. Neal reviewed the records from Alexian Brothers and Dr. Wiesman, as well as the CT arthrogram and MR arthrogram, and issued a report on August 27, 2014. He opined that Petitioner's wrist condition and the need for surgery were related to the work incident of October 26, 2013. Despite her continued complaints of pain, Dr. Neal also felt she could return to work full duty. (RX1).

About two weeks later, on September 9, 2014, Dr. Neal issued an addendum report. He was provided with the records from Advocate Sherman Hospital. (RX6). Based upon these records, and the fact that Petitioner did not report this prior injury to him, Dr. Neal changed his opinions and found that Petitioner's left wrist condition was not related to the work injury.

At his deposition, Dr. Neal testified that Petitioner's failure to report the prior injury in 2009 affected her credibility, and also that her current complaints may be related to the prior incident. (RX1)

Dr. Wiesman testified on behalf of Petitioner by way of evidence deposition on December 2, 2014. (PX12). Dr. Wiesman testified that Petitioner's wrist injury and the need for medical treatment were related to the patient lifting incident Petitioner described. Dr. Wiesman testified that he did not find anything inconsistent about examination findings in any of the medical records. He also testified that the alleged prior injury to Petitioner's wrist in 2009 was insignificant to her current condition.

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).

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 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)

It is the burden of every Petitioner before the Worker's Compensation Commission to establish with evidence every disputed issue litigated at trial, including the issues establishing Respondent's liability for benefits. *Board of Trustees of the University of Illinois v. Industrial Commission,* (1969), 44 Ill.2d 207 at 214, 254 N.E.2d 522, *Edward Don v Industrial Commission,* (2003) 344 Ill.App.3d 643, 801 N.E.2d 18.

For an employee's workplace injury to be compensable under workers' compensation, Petitioner must establish the injury is due to a cause connected with the employment such that it arose out of the employment. *Hansel & Gretel Day Care Center v Industrial Commission*, (1991) 215 Ill.App.3d 284, 574 N.E.2d 1244.

In support of the Arbitrator's decision with regard to whether Petitioner sustained accidental injuries that arose out of and in the course of her employment with Respondent, the Arbitrator makes the following conclusions of law:

The Arbitrator notes that the Petitioner testified to an event on October 26, 2013 wherein she sustained injury to her left wrist while cleaning a patient who had recently undergone a stroke. The Arbitrator notes that the accident was not witnessed by anyone, however, no contrary testimony relative to the accident in and of itself was presented by Respondent. The Arbitrator finds that the Petitioner suffered an accident arising out of and in the course of her employment at Respondent's facility on October 26, 2013. The issue of whether her current condition is causally connected to this accident is less clear.

In support of the Arbitrator's decision with regard to whether Petitioner's present condition of ill-being is causally connected to the injury, the Arbitrator makes the following conclusions of law:

The Petitioner testified to an accidental injury to her left wrist with indication of ongoing pain under the initial diagnosis of a left wrist strain. The Petitioner sought care from the occupational health clinic on multiple occasions undergoing care and treatment and diagnostic studies through November 1, 2013. The medical records entered into evidence, coupled with the Petitioner's testimony establish that she was released to her regular work duties without any medical restrictions as of November 5, 2013, eleven days after her alleged work injury. The medical records indicate that Petitioner reported pain located only over the dorsum of the wrist at

the ulnar area and some mild bruising over the area. Petitioner denied numbness or tingling to the area and admitted that flexion mostly reproduces the pain for her. She denied any elbow pain or any radiation of pain to the forearm.

Likewise when Petitioner reported to the Occupational Health Clinic for follow-up on November 1, 2013, she reported that her wrist feels better and she rated the pain as a two. The medical report indicates that she was currently without pain or complaints regarding her left wrist. She was however, complaining of some pain in her upper back on the left side that started on Wednesday while she was making a bed. Petitioner denied any direct trauma, numbness, tingling or weakness of the extremities. She denied any shoulder pain or throat pain. She also denied a similar history or complaints in the past. She had no other complaints at the time. She was released from treatment for her wrist to return as needed, and released to return to work full duty with no restrictions. With respect to the pain in the Trapezius, she was diagnosed with a sprain. She was restricted to light duty work, told to use ice/heat/stretch/ use Icy Hot and or Motrin. She was told to return for follow-up on November 5, 2013.

On November 5, 2013, the Petitioner returned for follow-up as directed. At that time she reported that the pain was resolved, and she felt comfortable returning to work full duty. The Petitioner was permitted to return to work full duty with no restrictions beginning on November 5, 2013, per the medical records.

The Petitioner resumed her patient care tech duties without any medical restrictions or any care and treatment until she reported to the emergency room at St. Joseph's Hospital on January 6, 2014. The initial care and treatment on that date indicated left shoulder pain relating to an injury from 2 weeks prior, which is contrary to the Petitioner's testimony at trial. Petitioner testified she did not injure her left shoulder or left elbow at any point between her release to her regular duties on November 5, 2014 and her presentation to St. Joseph's Hospital emergency room on Sunday evening January 6, 2014. Petitioner also testified that she had no prior problems or any care and treatment to her left wrist, which is contrary to the evidence at trial, as well as cross examination regarding the December 2009, event from a different employer with an injury to her left wrist with an accident being claimed thereafter. Based upon all the evidence and testimony in this claim, coupled with the credibility of Petitioner in her testimony at trial, the Arbitrator finds that the Petitioner's current condition of ill-being is not causally related to her claim of injury on October 26, 2013.

As of November 5, 2013, the Petitioner was able to perform all of her regular work duties without any medical restrictions and thereafter no further care and treatment would be causally related to her initial claim of a left wrist strain.

In support of the Arbitrator's decision with regard to whether the medical services that were provided to Petitioner were reasonable and necessary and whether Respondent paid all appropriate charges for reasonable and necessary medical treatment, the Arbitrator makes the following conclusions of law:

Based upon the foregoing discussion, The Arbitrator finds that the treatment received by Petitioner from October 26, 2013 through November 5, 2103, was reasonable and necessary, and related to her work injury.

(4) Is Petitioner entitled to TTD from January 9, 2014 through January 22, 2015; (5) Is the Petitioner entitled to Maintenance from January 14, 2015 through January 22, 2015; and (6) Is Respondent due any credit?

The remaining issues are moot since Petitioner failed to prove that her current condition of ill-being is causally connected to the accidental injuries Petitioner suffered on October 26, 2013.

ORDER OF THE ARBITRATOR

Respondent shall pay reasonable and necessary medical expenses with respect to the testing and treatment that Petitioner received from October 26, 2013 through her release from treatment to return to work full duty on November 5, 2013, pursuant to the medical fee schedule or by prior agreement, whichever is less, pursuant to the Act.

All other benefits sought pursuant to Section 8 of the Act are denied as Petitioner failed to prove that her condition after November 5, 2013, was related to the accidental injury she suffered on October 26, 2013.

Pursuant to the stipulation entered into by the parties, the Respondent shall be given a credit of $2,865.50, for other benefits paid by the Respondent.

Deborah K. Simpson — March 16, 2015

Signature of Arbitrator — 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 WILL	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DOUGLAS YARGER,

Petitioner,

15IWCC0853

vs.

NO: 14 WC 21204

PERFTECH, 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, causation, temporary total disability, and medical expenses both current and prospective, and being advised of the facts and law, changes the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

As indicated above, this matter was arbitrated under §19(b) of the Act. The Arbitrator found that Petitioner failed to meet his burden of proving a compensable accident. The Commission affirms that finding. However, in the "ORDER" section of the decision, the Arbitrator included the language that "in no instance shall this award be a bar to subsequent hearing and determination of any additional amount of medical benefits or compensation for a temporary or permanent disability, if any." Because the claim was denied in its entirety, the matter will not be remanded for determination of any additional benefits and therefore the decision does bar subsequent awards. Therefore, the Commission strikes the above quoted language from the "ORDER" section of the Decision of the Arbitrator.

15IWCC0853

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 4, 2015 is hereby affirmed and adopted with the changes noted above.

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

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: NOV 2 0 2015
o10/27/15
RWW/dw
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

15IWCC0851

YARGER, DOUGLAS
Employee/Petitioner

Case# **14WC021204**

PERFTECH INC
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:

2988 CUDA LAAW OFFICES
ANTHONY CUDA
6525 W NORTH AVE SUITE 204
OAK PARK, IL 60302

0560 WIEDNER & McAULIFFE LTD
NICOLE SCHNOOR
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60605

15IWCC0853

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)

Douglas Yarger
Employee/Petitioner

v.

Perftech, Inc.
Employer/Respondent

Case # **14** WC **21204**

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

15IWCC0853

FINDINGS

On the date of accident, **September 24, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**33,416.24**; the average weekly wage was $**642.62**.

On the date of accident, Petitioner was **40** years of age, ***married*** with **1** dependent child.

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

Respondent shall be given a credit of $**37,455.27** for TTD, $**0** for TPD, $**0** for maintenance, and $**43,795.80** for other benefits (i.e., medical bills paid as stipulated by the parties), for a total credit of $**81,251.07**. *See* AX1 & Tr. at 5-8.

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

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner failed to establish that he sustained a compensable accident at work on September 24, 2012. By extension, all remaining issues are rendered moot and all requested benefits and compensation are denied.

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

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

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

Signature of Arbitrator

January 22, 2015
Date

ICArbDec19(b) p.2

FEB 4 - 2015

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*
19(b) & 8(a)

Douglas Yarger
Employee/Petitioner

v.

Perftech, Inc.
Employer/Respondent

Case # **14** WC **21204**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues in dispute are accident, causal connection, Respondent's liability for certain unpaid medical bills, Petitioner's entitlement to temporary total disability benefits from September 25, 2012 through October 7, 2012 and from November 7, 2012 through December 10, 2014, and whether he is entitled to prospective medical care in the form of surgery as ordered by Dr. Rabin. Arbitrator's Exhibit[1] ("AX") 1.

Background

Petitioner testified that he was employed with Respondent on the claimed date of accident of September 24, 2012. Tr. at 11. He had been so employed for approximately a year and a half in a full-time position as a slitter operator. Tr. at 11-12. Petitioner testified that his job duties were to load and unload the machine, operate it, handle material from the racks to the machine, and lay out the finished products. Tr. at 12.

Petitioner submitted a job description that he created at Dr. Rabin's request in November of 2012. PX11 (Exh. 5); Tr. at 13-14, 26. Petitioner testified that he used his on the job experience to create this document. *Id.*

As a slitter operator, Petitioner testified that he operated the "bemis" machine, which slits and perforates various materials, like plastic. Tr. at 14-15. First, Petitioner explained that he would find the roll of material on the racks, put it on the forklift, remove the shrink wrap with a knife, and slide the forklift into the hollow core of the material to drive it over to a roll cart. Tr. at 16. Petitioner would then reverse the forklift to remove it from the center of the roll, and maneuver the roll cart with the roll to the back of the machine. Tr. at 16-18.

Petitioner explained that he had to manually push the roll on the cart forward and side to side so that it rested in the appropriate place in the back of the machine. Tr. at 17-18. He would then get behind the machine and lift a metal shaft weighing about 35 pounds and measuring approximately 7 feet in length into the center of the roll and line it up so that he could move the roll forward into the machine and drop it into place. Tr. at 18. The machine would then lock the roll and he would place a collar on each and which grabbed the shaft. Tr. at 18-19. Petitioner would then web the roll through a series of rollers. Tr. at 19-20.

Petitioner estimated that the rolls weighed approximately 1100 pounds and measured 5' x 30" in diameter. Tr. at 17. He testified that he does not lift the roll. Tr. at 19. He explained that the process of placing these rolls of

[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. Exhibits attached to depositions will be further denominated with "(Dep. Exh. _)." The December 10, 2014 Arbitration Hearing Transcript is denominated as "Tr." with corresponding page numbers.

paper or plastic onto the bemis machine required repetitive pushing, pulling, bending, and heavy lifting of the machine shaft which weighed approximately 35 pounds. Tr. at 18-19. He also testified that a roll would pass through the bemis machine every 30 minutes or so. Tr. at 20-21.

Petitioner also testified that he would personally operate two machines at most while he was employed with Respondent, usually one at a time, but sometimes simultaneously. Tr. at 20-21. The second machine was smaller, but the shaft weighed approximately 30-40 pounds despite the fact that it was smaller because it was older and made up a heavier metal unlike the bemis machine with an aluminum shaft. Tr. at 21-22. He explained that the "passes" through these machines were quicker taking anywhere from 8 minutes to 20 minutes per roll. 20-21.

Petitioner also described his duties relating to the smaller machines. Tr. at 22. He explained that the rolls tended to be smaller so he did not have to use a forklift, but he would stack a full pallet of rolls next to the machine and dump those onto a cart to roll them over to the machine as needed. *Id.* Occasionally, Petitioner would need a forklift to lower rolls located at the top of the pallet down to the cart before loading the shaft into the rolls and onto the machine. Tr. at 22-23. Petitioner estimated the smaller rolls measured approximately 30 inches in length and 20 inches in diameter weighing between 200 and 500 pounds. Tr. at 24, 57.

Petitioner testified that an average workday he would change the rolls on the bemis machine 16 times, or once every 30 minutes, and 32 times on the smaller machine, or approximately 4 times per hour. Tr. at 24-25, 57-58.

September 24, 2012

On September 24, 2012, Petitioner testified that he began work at 6:00 a.m. and worked until 2:00 p.m. Tr. at 26. He testified that he experienced a sharp pain in his lower back that shot down his right leg during the day. Tr. at 26-28. He attributed the sharp pain to repetitive lifting, bending, and twisting while webbing rolls through the machines. Tr. at 27. Petitioner testified that he just continued working until the end of the shift that day. Tr. at 28.

Petitioner testified that he then went into the locker room to change from his uniform and felt another sharp pain in his lower back that went down his right leg. Tr. at 28. He explained that he could barely stand up straight again to change his clothes. Tr. at 28-29. He explained that he tried to stretch because he figured he pulled something so he was just going to change and go home and try it rest it off. Tr. at 29. Petitioner then punched out and went home. Tr. at 29-30.

When he arrived home, Petitioner testified that the pain was not going away. Tr. at 30. He took ibuprofen and tried not to move for a while, but his pain got worse. Tr. at 30. After he went to sleep, he awoke around 4:15 a.m. and he could barely stand again. Tr. at 30-31. Petitioner testified that he called his supervisor, Jim Williams ("Mr. Williams") a few minutes later and left him a voicemail message. Tr. at 31-32.

Mr. Williams returned his call around 7:00 a.m. Tr. at 32. Petitioner testified that he told Mr. Williams that he hurt his back on the job the day before and again in the locker room. *Id.* He testified that Mr. Williams told him to go to the Dreyer clinic right away. *Id.*

Respondent submitted into evidence a form entitled "Supervisors 1st Report of Accident" dated September 28, 2012 about an accident occurring on September 24, 2012 at 2:55 p.m. RX3; Tr. at 73, 80-81. The supervisor, Daniel Carlson ("Mr. Carlson") completed this report and noted the following accident description: "Employee

was changing from his uniform to street clothes when he pulled a muscle in his back." *Id.* Petitioner testified that he did not complete this form, but acknowledged that he signed it. Tr. at 52-55; *see also* Tr. at 81-82.

Medical Treatment

The medical records reflect that Petitioner presented to the Dreyer Medical Occupational Health Clinic ("Dreyer Clinic") on September 25, 2012. PX1 at 12. A form entitled "workers' compensation preliminary report" notes a patient statement as follows: "Patient states was changing out of his uniform when he began to feel pain in his back." *Id.* Petitioner then saw Dr. Christofersen. PX1 at 49-51. The history noted at this initial visit states as follows:

> The patient presents to Occupational Health Services with complaint of pain in the low back. He states that yesterday at the end of work, he was changing out of his uniform and began to feel pain in the low back. He had that pain in the right lower back. This morning he was feeling worse, very sore, having trouble moving. Cannot bend or squat. He indicates the pain is entirely in the right lower lumbar area. There is no radiation of the pain. No tingling, numbness or weakness. He has not had bowel or bladder difficulties.

Id. Dr. Christofersen diagnosed Petitioner with a lumbosacral strain and restricted him to light duty work alternating sitting and standing, occasional climbing, bending and stooping, and no lifting over 20 pounds or floor level lifting. *Id.* He also noted that Petitioner had no significant injury event and he was hopeful the injury would improve rapidly. *Id.* Petitioner testified that they did not ask him about his job duties at this point. Tr. at 33.

When he returned on September 28, 2012, Petitioner reported that he was a lot better than he was initially, but that he was experiencing a fair amount of trouble and he could not put his socks on. PX1 at 45-48. Dr. Christofersen kept Petitioner restricted to light duty. *Id.*

On October 2, 2012, Dr. Christofersen ordered physical therapy. PX1 at 41-44. By October 9, 2012, Petitioner reported that he had been working and had no trouble with light duty, but had the most trouble sleeping. PX1 at 37-40. Dr. Christofersen restricted Petitioner to light duty. *Id.*

Petitioner began physical therapy at PDR Physical Therapy & Wellness Center on October 12, 2012. PX1 at 56-57; PX2 at 119-123. He reported "low back pain mostly on right side; he states he pulled the muscle while at work reaching forward and down." *Id.*

When he returned to the Dreyer Clinic on October 16, 2012, Petitioner reported that physical therapy seemed to be helping, but some soreness in the mornings and "annoying" pain later in the day. PX1 at 34-36. Dr. Christofersen lessened Petitioner's work restrictions to no lifting over 30 pounds. *Id.* By October 23, 2012, Petitioner reported that he was "pretty good" and that he had a little pain in the right lateral thigh, but that the "back feels good." PX1 at 30-33. Dr. Christofersen released Petitioner to full duty. *Id.*

On November 6, 2012, Petitioner returned to Dr. Christofersen and reported that he was not good and, in fact, he felt worse. PX1 at 26-28. He reported pain in the right leg, numbness in the anterior shin, shooting pain in the back, and that he was not using any medication. *Id.* Dr. Christofersen ordered a lumbar MRI to rule out disk disease and kept Petitioner on light duty. *Id.* Petitioner underwent the recommended MRI on November 12, 2012. PX1 at 54-55; PX3 at 132-134. The interpreting radiologist found a 3.5-millimeter disc herniation at

L4-5 with associated canal narrowing and bilateral foraminal stenosis. *Id.* He further noted a 3-millimeter posterocentral disc herniation at L1-2. *Id.*

Petitioner returned to Dr. Christofersen on November 20, 2012 reporting no significant change, and persistent numbness in the anterior aspect of the right shin, more pain in the right anterior thigh, and some back pain that occasionally radiated to the leg from the back. PX1 at 18-21. Dr. Christofersen reviewed Petitioner's MRI finding a right-sided 3.5 mm disk herniation at L4-5 with canal narrowing and bilateral foraminal stenosis and a 3 mm posterior central disk herniation at L1-2 with central canal narrowing but no foraminal stenosis. *Id.* He diagnosed Petitioner with a lumbosacral strain with radicular pain and disk herniation that correlated to his symptoms. *Id.* Dr. Christofersen noted again "[a]s I mentioned on his first visit, [Petitioner] did not have report of any significant injury event at work. This was described as starting when he was changing out of his uniform at work. He did not describe a fall or lifting event associated with it. I really could no ascribe his findings on the MRI to the event of changing clothes." *Id.* Petitioner was released to light duty work with occasional climbing, bending and stooping, and no lifting over 20 pounds or any floor-level lifting. *Id.*

By November 30, 2012, Petitioner reported continued pain and having run out of his pain medication, but that he did not feel that it was helping a lot. PX1 at 13-16. He reported being off work and that no light duty work was available. *Id.* Regarding his symptoms, Petitioner reported numbness in the anterior right lower leg with worsened pain when sleeping or sitting for a long time and feeling better when he was moving. *Id.* Dr. Christofersen diagnosed Petitioner with a lumbosacral strain with disk disease and radicular pain and prescribed 1-week of prednisone. *Id.* He maintained Petitioner's work restrictions. *Id.*

Petitioner was next evaluated by a spine specialist, Dr. Michael Rabin, on December 10, 2012. PX1 at 52-53. Petitioner completed an intake form at that time. PX1 at 69. The form requested that Petitioner make a statement of the injury. *Id.* He indicated "I was changing out of my work uniform and pulled something, it was tough to put my shoes on. It was sore the rest of the day. When I woke up the following morning I could barely stand up on my own." *Id.* Petitioner also completed a patient medical history form in which he stated "I was changing after work + pulled something in my back. I could barely stand up. Now the pain goes from my back down my leg." PX4 at 189-190.

In his handwritten primary neurological examination notes, Dr. Rabin noted Petitioner's report of "Onset: 9/24/12 when changing clothes." PX4 at 191. During his evaluation of Petitioner, Dr. Rabin more specifically noted Petitioner's report of an injury occurring on "September 24, 2012 while changing his clothes and started experiencing pain in his low back radiating down his right leg with numbness as well that stops at about the ankle." PX1 at 52-53; PX4 at 187-188. Petitioner denied improvement with physical therapy. *Id.*

Dr. Rabin reviewed Petitioner's MRI and noted "probably congenital stenosis with superimposed disk bulges which may have created a situation where the stenosis is now symptomatic. He also has a disk herniation on the right at L4-5." *Id.* Dr. Rabin recommended epidural steroid injections and noted a brief discussion about a decompressive laminectomy with microdiscectomy versus an isolated microdiscectomy. *Id.* He recommended that Petitioner remain off work. *Id.*

First Section 12 Examination – Dr. Goldberg

On January 14, 2013, Petitioner presented for an independent medical evaluation with Dr. Edward Goldberg at Respondent's request. RX1. Petitioner gave a history and stated that "on 9/24/2012, he was changing clothes at

this work facility to go home. He states that when changing pants, he developed low back pain. He reports that he has subsequently saw a company physician and was told he had a lumbar strain." *Id.*

Dr. Goldberg diagnosed Petitioner with a right-sided disc herniation with congenital lumbar stenosis at L4-5 causing right leg radicular pain. *Id.* He opined that Petitioner injured his lower back while changing his clothes and noted Petitioner had no prior problems. *Id.* Dr. Goldberg agreed with the recommendation for lumbar epidural steroid injections. *Id.* Dr. Goldberg further indicated that, if Petitioner did not experience relief, he would be a candidate for a microdiscectomy on the right at L4-5 and noted the recommended surgery would be related to the September 24, 2012 clothes-changing accident. *Id.* He recommended work restrictions including no lifting greater than ten pounds and noted Petitioner had yet to reach maximum medical improvement. *Id.*

Continued Medical Treatment

On February 14, 2013, Dr. James Wilson administered an L4-5 lumbar transforaminal epidural steroid injection. PX4 at 232-233; PX7 at 393-394. At the time of his second injection on March 5, 2013, Petitioner only noted 30% improvement following the first injection. PX4 at 230-231; PX7 at 397-398. Petitioner reported 75% relief after his second epidural steroid injection, and a third epidural steroid injection was administered on March 19, 2013. PX4 at 228-229; PX7 at 405-406.

Dr. Rabin reevaluated Petitioner on April 29, 2013. PX4 at 186. Petitioner reported a great deal of improvement with epidural steroid injections, although he still could not sleep at night and wished to proceed with surgery. *Id.* Dr. Rabin recommended a microdiscectomy and an updated lumbar spine MRI. *Id.* On May 3, 2013, Dr. Rabin ordered an updated MRI. PX4 at 185.

Petitioner underwent a second lumbar spine MRI on June 5, 2013. PX4 at 192-193; PX9 at 471-472. The interpreting radiologist noted multi-level spondylitic changes and disc protrusions with the most prominent findings at L4-5 on the right where there was spinal stenosis due to a disc bulge with a paracentral disc protrusion, facet disease and ligamentum flavum thickening, and posterior elements in the lumbar spine that contributed to the spinal stenosis. *Id.*

Dr. Rabin reevaluated Petitioner on June 24, 2013. PX4 at 184. Petitioner reported ongoing low back pain and numbness that radiated down his right leg. *Id.* Dr. Rabin noted that the radiologist who performed Petitioner's MRI on June 5, 2013 did not compare it to Petitioner's prior MRI. *Id.* Dr. Rabin indicated after his review that Petitioner's condition had worsened noting stenosis at L3-4 and L4-5, symptoms consistent with L5 radiculopathy, and a left-sided disc herniation at L1-2 which he felt were not the source of Petitioner's symptoms as they were right-sided in an L5 distribution. *Id.* He recommended an L3-S1 decompression with possible microdiscectomy at L4-5. *Id.* Petitioner returned for an evaluation on July 17, 2013 and at that time, Dr. Rabin agreed to do a right L4-5 microdiscectomy. PX4 at 181.

On August 13, 2013, Dr. Rabin performed a right L4-5 microdiscectomy with foraminotomy at Edward Hospital. PX4 at 205-207; PX6. Pre- and post-operatively, he diagnosed Petitioner with a herniated nucleus pulposus, right L4-5. *Id.*

Petitioner testified that he began post-operative physical therapy at Accelerated Rehabilitation Centers on November 19, 2013, which continued through January 29, 2014. Tr. at 45; *see also* PX8 at 451-454. He explained that his low back pain started to get worse and it started to come down his right leg again. Tr. at 46. Specifically, Petitioner testified that he started lifting weights from a bent position during physical therapy and

he re-injured his disc. *Id.* Petitioner testified on cross examination that he told Dr. Rabin about this re-injury. Tr. at 59; *but see* PX4.

On January 30, 2014, Petitioner underwent a third, updated MRI of the lumbar spine. PX4 at 194-195; PX9 at 469-470. The interpreting radiologist noted 1.1 cm soft tissue structure within the L4-5 anterior epidural space at the right side with no significant central enhancement. *Id.* He noted that the findings were suspicious for a recurrent residual disc protrusion with associated deformity of the thecal sac and right lateral recess stenosis. *Id.*

Dr. Rabin reevaluated Petitioner on February 3, 2014 noting a possible disc recurrence. PX4 at 146-147. He also noted that Petitioner was virtually pain free for a month following surgery but had a gradual return of symptoms. *Id.* Petitioner denied any fall or injury to account for these symptoms. *Id.* On March 3, 2014, Dr. Rabin recommended Petitioner obtain a repeat MRI. PX4 at 150-151. When he returned on March 5, 2014, Dr. Rabin reviewed the MRI and felt that it likely represented post-operative fluid rather than a recurrent disc, but given his symptoms it may well be a recurrent disc. PX4 at 149. Petitioner was discharged from physical therapy on March 11, 2014. PX8 at 414.

Second Section 12 Examination – Dr. Goldberg

Petitioner submitted to a second independent medical evaluation with Dr. Goldberg on March 21, 2014. RX2. After examining Petitioner, taking further history from him, and reviewing additional medical records, Dr. Rabin rendered various opinions. *Id.*

Dr. Goldberg opined that Petitioner's condition of ill-being was causally related to the September 24, 2012 incident and noted Petitioner's medical treatment had been appropriate and necessary. *Id.* He indicated "I do believe his condition of ill being is due to the accident of September 24, 2012. … Again, I do not believe that the patient had any prior lumbar problems prior to the work accident of September 24, 2012." *Id.*

He recommended an additional two epidural steroid injections and, if that did not provide any relief, to proceed with a repeat discectomy at L4-L5. *Id.* Dr. Goldberg did not believe that waiting three months to observe the lumbar spine would be helpful for Petitioner. *Id.* He indicated that Petitioner had not yet reached maximum medical improvement. *Id.*

Continued Medical Treatment

Dr. Rabin again ordered a fourth MRI on May 12, 2014. PX4 at 152-153. Petitioner was reporting low back pain with numbness in his toes. *Id.* Petitioner underwent the recommended MRI on May 15, 2014. PX9 at 467-468. The interpreting radiologist noted no significant change since his prior examination. *Id.*

When Petitioner returned to Dr. Rabin on June 4, 2014, he noted that Petitioner had developed recurrent symptoms during physical therapy. PX4 at 154. He recommended re-exploration of the prior surgery, but determined that a fusion surgery was not warranted at that time. *Id.*

Dr. Rabin composed a letter in response to inquiries from Petitioner's attorney on July 7, 2014. PX4 at 155; PX10 at 473. He advised that Petitioner reported an injury due to changing his clothing after work and "[s]ince the clothing change occurred after work, it would seem that the injury occurred from his work; that would be the link that I would provide you based on the history he presented with." *Id.* Dr. Rabin also stated that Petitioner's

work as a machinist, specifically "repetitive lifting and handling of material would contribute to his back injury and was likely the source of it." *Id.*

Dr. Rabin completed a second narrative report in response to Petitioner's counsel's request on August 8, 2014. PX4 at 142-143; PX10 at 474-475. He noted that Petitioner reported on December 10, 2012 "that he was finishing work and when he was changing his clothes, he was twisting and began having pain radiating down his right leg with numbness, etc." *Id.* Dr. Rabin was asked to opine whether Petitioner's low back condition was connected to his work as described in his job description. *Id.* He responded that "the patient described the injury as occurring at work when he was changing his clothes" and "[a]s stated, the patient injured himself while changing his clothes." *Id.*

Dr. Rabin last evaluated Petitioner on October 13, 2014. PX4 at 140. On this date, Dr. Rabin noted that "[w]e reviewed his history-he is a machinist and stands all day. He began having pain while working at his machine and then when he was changing clothes in the locker room he had sharp pain and likely completed the disc herniation." *Id.* Dr. Rabin recommended re-exploration and a microdiscectomy. *Id.*

Deposition Testimony – Dr. Rabin

Petitioner called Dr. Rabin as a witness and he provided testimony at an evidence deposition on November 19, 2014. PX11. Dr. Rabin is a board certified neurosurgeon. PX11 at 5-7. Dr. Rabin testified about Petitioner's lumbar spine condition, medical treatment, and he rendered various opinions. *See generally* PX11.

Dr. Rabin testified that the care and treatment that he rendered to Petitioner beginning in December of 2012 was reasonable and necessary to treat his symptoms. PX11 at 30. Dr. Rabin also testified that the surgery that he performed was causally related to Petitioner's job duties as described to him by Petitioner in the written job description provided to him. PX11 at 30-32. He understood Petitioner's work to require repetitive lifting and bending on a daily basis. PX11 at 32. Dr. Rabin testified that those types of activities would be competent to cause or aggravate Petitioner's back condition. *Id.*

On cross examination, Dr. Rabin testified that he understood Petitioner's incident to have occurred while changing his clothes. PX11 at 33-34. He acknowledged that Petitioner did not mention his job duties during his treatment prior to October of 2014 until Dr. Rabin received the job description created by Petitioner. PX11 at 34-36. Dr. Rabin also testified that the clothes-changing incident contributed to Petitioner's condition. PX11 at 35-36. But, Dr. Rabin also testified that if job duties are repetitive in nature, they can cause spinal stenosis over years, but that is a more drawn out process, and such duties can cause a herniation. PX11 at 38-39.

Dr. Rabin reiterated his recommendation for a second surgery, which he testified was also related to the original injury as Petitioner described it to him. PX11 at 32-33.

Additional Information

Petitioner testified that Dr. Rabin continues to prescribe pain medication for him and he sees him once a week. Tr. at 50-51. Petitioner explained that if he does not take his medication he cannot move, he experiences pain standing up and sitting down, and he has difficulty sleeping such that he is lucky if he sleeps 3-4 hours per night. Tr. at 51-52. Petitioner testified that he cannot move at all and his pain is at a level of 10/10 if he does not take any Vicodin. Tr. at 52.

On cross examination, Petitioner testified that he did report to his doctors during his treatment that he had an onset of low back pain during work and while changing his clothes. Tr. at 55-56. He testified that, if the medical records did not reflect his reports about this, the medical records would be incorrect. Tr. at 56.

Chris Jilka

Respondent called Mr. Jilka as a witness. Tr. at 60. He testified that he is a plant manager and his job duties include scheduling operators and machines and managing employees. *Id.* He testified that he is familiar with the operation of Respondent's machines, workers' compensation claims, and Petitioner. Tr. at 60-61.

Mr. Jilka testified that he understood that Petitioner injured himself while changing his clothes at work. Tr. at 61. He described that Respondent's facility has a bank of lockers in the men's room and a bench right down the middle. Tr. at 62. He testified that employees wear a grey polo shirt and regular Dickie's brand slacks. Tr. at 62-63. Mr. Jilka testified that he was not aware of anything unusual about the uniform clothes that caused Petitioner's injury. Tr. at 63. He did not have any knowledge of Petitioner injuring himself during the day while performing his job duties. *Id.* Mr. Jilka also explained that he first learned that Petitioner was alleging a mechanism of injury at work approximately one week before the hearing. *Id.* For over two years previously he understood that Petitioner injured himself while changing his clothes. Tr. at 63.

Mr. Jilka also testified that on the claimed date of accident Petitioner was working on the bemis machines. Tr. at 63. He testified that this machine required the employee to work with large rolls weighing from 800 to 1100 pounds and that these rolls are maneuvered using forklifts and push carts. Tr. at 64. He also testified that it is not difficult to push a cart with the material on it. *Id.*

Regarding the amount of rolls processed per shift, Mr. Jilka testified that the bemis machine processes five rolls per shift and that each roll takes approximately 50 minutes to process. Tr. at 65. While the machine is processing the roll, the machine operator can walk over to another machine and help another operator, process larger rolls into smaller rolls on another machine, sweep, or sit and watch the rolls if there is nothing else to do. Tr. at 65-66. Machine operators may have to handle the shaft on the bemis machine approximately 5-10 times per shift; that is, when putting a roll on or taking a roll off of the machine. Tr. at 66. Mr. Jilka estimated that the shaft weighs about 60-65 pounds. Tr. at 66. He explained, however, that most of the weight is realistically being moved by the forklift and cart, not by the operator himself. Tr. at 67. Mr. Jilka testified that working on the bemis machine did not require constant or repetitive bending, kneeling or twisting. Tr. at 67-68.

On cross examination, Mr. Jilka testified that he operates the bemis machine during sample runs or if an employee is absent. Tr. at 69. He also testified that he has observed Petitioner move the rolls on many occasions, but he does not recall whether it was on the claimed date of accident. Tr. at 71. He maintained that, while Petitioner gave an accurate description of the process of loading a machine, it did not involve much twisting but rather pushing and pulling of the cart. Tr. at 69-70. He acknowledged that positioning the rolls while on the cart into the bemis machine would involve movement of the back. Tr. at 70-71. Mr. Jilka testified that guiding the rolls into the bemis machine did not require any lifting. Tr. at 74.

Mr. Jilka acknowledged that he was not aware of Petitioner sustaining any injury outside of work. Tr. at 73.

Daniel Carlson

Respondent called Mr. Carlson as a witness. Tr. at 78. Mr. Carlson testified that he is the first shift supervisor and that he was Petitioner's supervisor on September 24, 2012. Tr. at 79.

Mr. Carlson testified that Petitioner did not report an accident to him occurring on September 24, 2012. Tr. at 79. He explained that he was aware of reports of an injury on that date where Petitioner strained his back while changing his clothes in the locker room. *Id.* He is not aware of Petitioner injuring himself while at work and not while changing his clothes. Tr. at 79-80.

Mr. Carlson testified that he first learned the Thursday of the last week before the hearing that Petitioner injured himself at work as a result of his job duties and not while changing his clothes. Tr. at 82, 87-88. He testified that the employees' uniform including a pullover polo shirt and cotton/polyester pants. Tr. at 83. He also testified that the bemis machine handled five rolls per shift that took approximately 50 minutes to process. Tr. at 84, 86. Employees did not lift the rolls, but maneuvered them with a forklift and then on a cart to the machine. Tr. at 84-85.

Mr. Carlson explained that pushing the carts was not easy, but not strenuous either. Tr. at 85. He also testified that the work did not require constant bending, kneeling and twisting. Tr. at 86. The lifting performed would be for items weighing up to 40 pounds and they would only be required to lift these items (i.e., cores, end boards, shafts) once or twice per roll. Tr. at 87.

On cross examination, Mr. Carlson testified that he has observed Petitioner push a cart with a roll on it 10-15 times per day. Tr. at 88-89. He acknowledged that pushing a roll car may not have been strenuous to him, but it may have been strenuous to Petitioner. Tr. at 89. He also testified that if a roll was not pushed in correctly, the operator would have some trouble getting the roll onto the machine. Tr. at 90. But Mr. Carlson denied that the rolls had to be worked into the machine because they were not easily pushed in on the cart. Tr. at 89-90. Mr. Carlson acknowledged that he was not aware of Petitioner sustaining any injury outside of work. Tr. at 92.

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 hearing as follows:

In support of the Arbitrator's decision relating to Issues (C) and (D), whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent and the date of the accident, 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 2011). 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 (Ill. Sup. Ct. 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 asserts that he sustained an injury to his low back due, in part, to his repetitive work duties as opined by Dr. Rabin on September 24, 2012. Respondent disputes this asserting that Petitioner's reports consistently reference an injury while changing his clothes in the locker room at work and thus he was at no greater risk than the general public rendering his claim non-compensable. The fact that Petitioner was at work on September 24, 2012 is not in dispute. The fact that he reported pain in his back while changing his clothes is not in dispute. The disagreement between the parties appears to center on Petitioner's testimony at trial that he also experienced pain and symptoms while in the performance of what he described as repetitive job duties before he changed his clothes after work when he experienced a second episode of pain.

The facts must be closely examined in repetitive-injury cases to ensure a fair result for both the faithful employee and the employer. *Durand v. Industrial Comm'n*, 224 Ill. 2d 53, 71 (2006) (*citing Three "D" Discount Store*, 198 Ill. App. 3d 43, 49 (4th Dist. 1989)). Compensation is allowable where an injury is not sudden, but gradual so long as it is linked to the claimant's work. *Durand*, 224 Ill. 2d at 66 (*citing Peoria County Belwood Nursing Home v. Industrial Comm'n*, 115 Ill. 2d 524, 529 (1987)). The Illinois Supreme Court went on to highlight its *Peoria County* decision stating that "To deny an employee benefits for a work-related injury that is not the result of a sudden mishap *** penalizes an employee who faithfully performs job duties despite bodily discomfort and damage." *Durand*, 224 Ill. 2d at 66 (*citing Peoria County*, 115 Ill. 2d at 529-30).

An employee claiming that he suffered a repetitive-trauma injury must still point to a date within the statutory limitations period on which both the injury *and its causal link to his work* became plainly apparent to a reasonable employee. *Durand*, 224 Ill. 2d at 65 (*emphasis* added) (*citing Williams v. Industrial Comm'n*, 244 Ill. App. 3d 204, 209 (1st Dist. 1993)); *see also Peoria County*, 115 Ill. 2d at 531. "[B]ecause repetitive-trauma injuries are progressive, the employee's medical treatment, as well as the severity of the injury and particularly how it affects the employee's performance, are relevant in determining objectively when a reasonable person would have plainly recognized the injury and its relation to work." *Id.*, (*citing Oscar Mayer v. Industrial Comm'n*, 176 Ill. App. 3d 607, 610 (4th Dist. 1988)).

In addition, it has long been held that an employer takes its employee as it finds him. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 204-206 (2003) (*citing Baggett v. Industrial Comm'n*, 201 Ill.2d 187, 199 (2003)). 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)).

After a careful review of the record and in consideration of all the evidence, the Arbitrator finds that Petitioner failed to establish that he sustained a compensable accident on September 24, 2012 as claimed. In so finding, several facts are uncontroverted.

Petitioner reported an injury occurring on September 24, 2012 to his supervisor. He went to the Dreyer clinic the following day at which time they noted his report that he "was changing out of his uniform when he began to

feel pain in his back." Mr. Carlson's September 28, 2012 incident report entitled "Supervisors 1st Report of Accident" signed by Petitioner noted a similar description of the accident when: "Employee was changing from his uniform to street clothes when he pulled a muscle in his back."

As of his first visit on December 10, 2012 with Dr. Rabin, Petitioner completed various forms in which he was asked to make a statement of the injury. He indicated "I was changing out of my work uniform and pulled something, it was tough to put my shoes on. It was sore the rest of the day. When I woke up the following morning I could barely stand up on my own." Petitioner also completed a patient medical history form in which he stated "I was changing after work + pulled something in my back. I could barely stand up. Now the pain goes from my back down my leg."

Dr. Rabin's handwritten and dictated examination notes corroborate Petitioner's reports of "Onset: 9/24/12 when changing clothes[]" and "of an injury occurring on "September 24, 2012 while changing his clothes and started experiencing pain in his low back radiating down his right leg with numbness as well that stops at about the ankle." Dr. Rabin's initial inclination that Petitioner's low back became symptomatic only after the reported clothes-changing incident at work is echoed by Respondent's Section 12 examiner, Dr. Goldberg, shortly thereafter.

Respondent sent Petitioner for an evaluation by Dr. Goldberg on January 14, 2013. In his report, Dr. Goldberg opined that Petitioner injured his lower back while changing his clothes. He noted Petitioner had no prior low back problems and agreed with the recommended course of conservative treatment including epidural steroid injections followed by surgery if those measures failed.

After a second evaluation on March 21, 2014, Dr. Goldberg again opined that Petitioner's condition of ill-being was causally related to the September 24, 2012 incident. He reiterated his causal connection opinion based on Petitioner's reported mechanism of injury while changing his clothes. It appears from the opinions of both Dr. Rabin and Dr. Goldberg were based not only on his lack of low back symptoms before September 24, 2012, but also on their understanding that Petitioner's injury occurred during the clothes-changing incident.

At his deposition, Dr. Rabin was specifically asked to opine on whether Petitioner's low back condition was connected to his work as described in the job description he ultimately understood was created by Petitioner. He responded to Petitioner's counsel's inquiry that "the patient described the injury as occurring at work when he was changing his clothes" and "[a]s stated, the patient injured himself while changing his clothes." Dr. Rabin also testified that if job duties are repetitive in nature they can cause a herniations and spinal stenosis, albeit over years. With regard to his opinion that repetitive job duties could have contributed to Petitioner's condition, Dr. Rabin made a significant concession.

His medical records reflect that he last evaluated Petitioner on October 13, 2014 at which time he noted that "[w]e reviewed his history-he is a machinist and stands all day. He began having pain while working at his machine and then when he was changing clothes in the locker room he had sharp pain and likely completed the disc herniation." At the time of his deposition, Dr. Rabin acknowledged that he first became aware of Petitioner's job duties in October of 2014. Whether Petitioner created the job description submitted to Dr. Rabin or not, the fact remains that Dr. Rabin was of the impression that Petitioner injured himself while changing his clothes during almost two years of medical treatment. His impression was shared by the staff at Dreyer Clinic, Petitioner's physical therapists, Respondent's Section 12 examiner, Dr. Goldberg, and Petitioner's supervisors for as long a period of time.

Thus, from September 25, 2012 through October 13, 2014, all of the medical evidence corroborates Petitioner's testimony that he felt pain in his low back and right leg while changing out of his uniform at the end of the work day. Petitioner consistently reported only this mechanism of injury to every treating medical provider and Respondent's independent medical examiner for slightly over two years. Notably, the medical records during this two-year period reflect Petitioner's own handwritten reports as well as the histories noted by various medical providers that Petitioner reported that his pain began during the clothes-changing incident. The record is devoid of any general, much less specific, reference to an onset of pain or other symptoms during the work day as asserted by Petitioner for the first time at trial. Petitioner's testimony that he first experience a sharp pain in his low back while engaged in what he testified were repetitive lifting, bending, and twisting activities while webbing rolls through the machines at work is wholly uncorroborated.

In addition to the lack of corroborating reports noted in any medical records or Section 12 reports through October 13, 2014, Respondent proffered the testimony of two supervisors about the circumstances of Petitioner's alleged accident. Mr. Jilka and Mr. Carlson confirmed that they were unaware of any alleged injury suffered by Petitioner, or symptoms experienced by him, occurring during the work day while in the performance of his duties. Both specifically testified that they only recently became aware of Petitioner's claimed injury stemming from his performance of his work duties on September 24, 2012.

Petitioner's testimony at trial that he felt an onset of pain during the work day while performing his job duties and then again while changing his clothes is wholly uncorroborated, and contradicted by the testimony of two witnesses and that of his own treating physician, Dr. Rabin, for years. The consistently corroborated mechanism of injury that he reported (i.e., that he went into the locker room to change from his uniform and felt a sharp pain in his lower back that went down his right leg) to everyone for over two years cannot simply be set aside. While Dr. Rabin testified that, after receiving information about Petitioner's job duties in October of 2014, he believed that those types of activities would be competent to cause or aggravate Petitioner's back condition his opinion is not persuasive in consideration of the record as a whole.

Thus, the Arbitrator finds that Petitioner failed to establish that he sustained an accident that arose out of and in the course of his employment with Respondent on September 24, 2012 as claimed. By extension, all remaining issues are rendered moot and all requested benefits and compensation are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

☐ 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

JEFFERY S. DARNELL,

Petitioner,

15IWCC0849

vs.

NO: 14 WC 25138

WATCO COMPANIES, LLC,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, notice and temporary disability and being advised of the facts and law, reverses the Decision of the Arbitrator with respect to the issue of accident and notice as stated below and, accordingly, addresses those issues that had been deemed moot in the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Petitioner, a carman whose work activities include repairing and refurbishing railcars, testified to working ten-hour workdays, save two ten-minute breaks in the morning and afternoon, respectively, and a half-an-hour lunch. In performing those work activities, he employed a variety of electrical and pneumatic vibratory devices that resulted in him experiencing symptoms of numbness and tingling as well as cramping in both hands. His right hand was more symptomatic than his left hand. Carpal tunnel syndrome was diagnosed in both hands as well as right radial neuropathy. Carpal tunnel releases and a right radial tunnel release were recommended to cure these conditions. These facts are not disputed.

The disputed facts are the date Petitioner became aware of the interrelationship between his work activities and the condition of his hands; whether Petitioner provided notice to

Respondent of a work accident within the time prescribed under Section 6(c); what medical expenses, if any, are compensable; what medical treatment, if any, is appropriate; and whether Petitioner is entitled to any temporary disability benefits. The Commission finds in Petitioner's favor with respect to all of these issues.

In the instant case, the Commission finds the controversy not about whether Petitioner's work activities resulted in the injuries to his hands but as to when Petitioner sustained said injuries, a question made more difficult as Petitioner's injuries involve repetitive trauma and not acute injuries. "[C]ourts considering various factors have typically set the manifestation date on either the date on which the employee requires medical treatment or on the date on which the employee can no longer perform work activities." *Durand v. Industrial Commission*, 224 Ill.2d 53, 72, 862 N.E.2d 918, 308 Ill. Dec. 715 (2006). The *Durand* Court, however, also provided, more specifically, "The manifestation date is not the date on which the injuries and its causal link to work became plainly apparent to a reasonable physician, but the date on which it became plainly apparent to a reasonable employee." *Durand*, 224 Ill.2d at 72. Though Petitioner complained of symptoms in his right wrist as early as 2013 and treated said symptoms with Dr. Michael Beatty as early as February 19, 2014, the Commission finds it was not until June 9, 2014, that the requisite relationship between the condition of Petitioner's hands and his work activities became apparent.

Petitioner's treatment with Dr. Beatty on February 19, 2014 and, thereafter, does not confer knowledge of any relationship between his work activities and the condition of his hands. It infers that Petitioner sought treatment for his symptomatic hands from Dr. Beatty. Petitioner testified that it was only after he discussed the positive results of the motor nerve condition velocity study that Dr. Beatty had him undertake,did he realize that there was a relationship between his work activities and the condition of his hands, namely carpal tunnel syndrome. That discussion between Petitioner and Dr. Beatty occurred on June 9, 2014. The Commission finds Petitioner credible and, as a result, finds June 9, 2014, to be the date on which Petitioner became aware that his work activities negatively affected his hands. Thus, the Commission finds June 9, 2014, to be the manifestation date of Petitioner's injuries and, in so doing, reverses the finding contained in the Decision of the Arbitrator of that date to be February 19, 2014.

Respondent, through the testimony of its plant manager, Steve Prokopitch, claims that it received notice of Petitioner's claimed injuries on July 22, 2014, in the form of a copy of Petitioner's Application for Adjustment of Claim. July 22, 2014, is forty-three days after Petitioner learned he had compensable injuries and is within the time parameters as set forth in Section 6(c) of the Act. Respondent did not argue and the Commission found no defect occurred in the manner Petitioner chose to inform Respondent of his accident. Section 6(c) of the Act states only that notice be given within forty-five days but does not prescribe the manner in which it is done. The Commission finds the notice provided by Petitioner to Respondent following his learning of the compensable nature of his injuries on June 9, 2014, was in harmony with Section 6(c) of the Act. Having so found, the Commission reverses the Decision of the Arbitrator, finding Petitioner's notice as untimely.

The Decision of the Arbitrator found Petitioner failed to prove a compensable accident occurred on the date claimed and that no notice of the accident was provided, found all other

contested issues to be moot and declined to address them. The Commission, having reached the opposite conclusions with respect to accident and notice, now addresses these issues.

Petitioner claims to have incurred, as of the date of the arbitration hearing, $445.00 in medical expenses as result of treating his symptoms with Dr. Beatty. Dr. Beatty testified to the reasonableness, necessity and propriety of the services he provided to Petitioner. The Commission, in reviewing the medical records attributable to the claimed medical expenses, found nothing to contradict Dr. Beatty's self-assessment. The Commission, therefore, finds the claimed medical expenses causally related to and both reasonable and necessary for the treatment Petitioner received to address his compensable injuries. The Commission finds Petitioner entitled to an award of medical expenses per the medical fee schedule.

Dr. Beatty recommended that Petitioner undergo further treatment to address the carpal tunnel syndrome present in Petitioner's hands. He proposed a carpal tunnel release and a radial tunnel release to Petitioner's right hand that would then be followed with a carpal tunnel release to Petitioner's left hand. Dr. Beatty testified that he would expect Petitioner to be able to return to work eight weeks after the respective procedures and be at MMI three to four months after same. The Commission finds the recommended surgeries to be causally related to Petitioner's work accident and both reasonable and necessary to allow Petitioner to return to his normal work activities. The Commission, therefore, orders Respondent to authorize the bilateral carpal tunnel releases and the right-sided radial tunnel release as recommended by Dr. Beatty. The Commission further orders Respondent to authorize any reasonable postoperative care prescribed by Dr. Beatty meant to further the healing process in Petitioner's hands.

The Commission finds, as result of his injuries, Petitioner was precluded from working from December 1, 2014, up to and including December 16, 2014. Dr. Beatty medically excused Petitioner from working on December 1, 2014, and on December 2, 2014, and Respondent would not permit Petitioner to return to work until he was medically cleared. That clearance was provided by Dr. Beatty on December 16, 2014, and indicated Petitioner could return work the next day, December 16, 2014. Petitioner, therefore, is entitled to sixteen days of temporary total disability benefits under Section 8(a) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $600.00 per week for a period of 2-2/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $445.00 for medical expenses under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent authorize the bilateral carpal tunnel release and right radial tunnel release as recommended by Dr. Beatty as well as reasonable postoperative treatment.

15IWCC0849

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 $2,000.00. 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: NOV 2 0 2015
KWL/mav
O: 09/21/15
42

Michael J. Brennan

Thomas J. Tyrrell

DISSENT

I respectfully dissent from the decision of the majority. Arbitrator Lindsay's findings are both thorough and well reasoned. This decision is correct and should be affirmed.

Kevin W. Lamborn

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

15IWCC0849

DARNELL, JEFFREY S
Employee/Petitioner

Case# **14WC025138**

WATCO COMPAINES LLC
Employer/Respondent

On 2/20/2015, 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 0.06% 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:

0487 SMITH MENDENHALL SELBY & COLE
STEVE SELBY
510 E 6TH
ALTON, IL 62002

2904 HENNESSY & ROACH PC
MICHAEL J HOLT
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

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)

15IWCC0849

Jeffrey S. Darnell
Employee/Petitioner

Case # **14** WC **25138**

v.

Consolidated cases: **N/A**

Watco Companies, LLC.
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 **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Collinsville**, 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. ☒ 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, **6/9/14**, 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.

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 **44** 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, $**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** for any medical bills paid by its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove he sustained an accident on June 9, 2014 that arose out of and in the course of his employment with Respondent; rather, Petitioner's accident manifested itself on February 19, 2014; however, Petitioner failed to give proper notice of said accident in the manner 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.

Henry Bundley
Signature of Arbitrator

February 13, 2015
Date

FEB 20 2015

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner alleges repetitive trauma injuries to his hands which manifested themselves on June 9, 2014. Two witnesses testified at the hearing: (1) Petitioner and (2) Respondent's representative, Steve Prokopich.

The Arbitrator finds:

According to the medical records Petitioner presented to Dr. Michael Beatty on February 19, 2014 with regard to bilateral hand complaints of numbness and tingling. Petitioner reported experiencing complaints over the previous year increasing in severity over the previous six to eight months. Petitioner also provided a history of repetitive work as a welder and use of a jackhammer a lot while working for Respondent. As part of the visit Petitioner completed a "Job Description" setting forth his work duties for Respondent. Dr. Beatty's office notes state, "Patient feels work causes problem." (PX 1, Dep. Ex. 2) Dr. Beatty suspected multiple nerve issues and recommended a nerve conduction study (ncs/emg). (PX 1, Dep. ex. 2)

As instructed Petitioner returned to see Dr. Beatty on March 24, 2014 at which time they reviewed the emg/ncs which Dr. Beatty was not entirely satisfied with. He recommended a second study by a neurologist, Dr. Naseer. That was performed and Petitioner returned again to see Dr. Beatty. (PX 1, Dep. ex. 2)

At the visit of June 9, 2014, Dr. Beatty noted ongoing symptoms in Petitioner's right wrist and documented a working diagnosis of bilateral carpal tunnel syndrome and right radial tunnel neuropathy. Dr. Beatty ordered a cervical MRI in light of Dr. Naseer's recommendation for same. (PX 1, Dep. ex. 2)

On June 30, 2014 Petitioner signed his Application for Adjustment of Claim herein. (RX 1)

On July 23, 2014 Petitioner signed an incident accident report. (RX 2)

On July 23, 2014 Petitioner's attorney wrote to Respondent demanding that Petitioner be returned to work after being sent home on July 23, 2014. (RX 3)

On July 24, 2014 Petitioner's wife called Dr. Beatty's office reporting that Respondent had "found out" Petitioner was filing a workers' compensation claim and Petitioner needed a note stating he could work without any restrictions because he had been sent home and could not return without a release. She also reported that the cervical MRI had not been done because the hospital was requiring money be paid up front for it and they did not have the funds. Dr. Beatty provided the release. (PX 1, Dep. Ex. 2)

Dr. Michael Beatty testified by deposition on December 18, 2014. (PX 1) Dr. Beatty is a board-certified plastic surgeon specializing in hand surgery. Dr. Beatty testified that he first saw Petitioner on February 19, 2014 when Petitioner presented with numbness in both hands. He indicated Petitioner is right-handed. Dr. Beatty explained that Petitioner had associated tingling in the right hand that was worse than the left hand from the standpoint of symptoms complex. He reported the symptoms of approximately one year which had been increasing in severity for 6 to 8 months prior to seeing him on February 19, 2014. Dr. Beatty testified that Petitioner "presented a history to me of repetitive work activity as a welder and using a jackhammer as he quoted 'a lot' on railroad cars working at [Respondent.] There had been no prior treating and his feeling at the time was that this activity was a bothersome type of activity that caused him to believe that the work was causing these problems of numbness in his hands." (PX 1, pp. 6-7) It was Dr. Beatty's understanding that Petitioner worked 10-hour shifts. Dr. Beatty went on to testify that as of that date it was him impression and diagnosis that Petitioner exhibited compressive neuropathy involving his upper extremities in particular median, ulnar and radial nerve problems. (PX 1, p. 7)

After examining Petitioner Dr. Beatty ordered electrical studies as his initial impression was that Petitioner was suffering from compressive neuropathy of the upper extremities.

Dr. Beatty testified that he again saw Petitioner in March and there was really nothing new except that the electrical studies that had been completed we're insufficient. Additional studies were ordered and he next saw Petitioner on June 9, 2014. At that visit Petitioner had the continuing inability to extend his right wrist that reflected a radial neuropathy and was consistent with the progression and not relief of the radial nerve compression and he continued to exhibit carpal tunnel issues. After the June 9, 2014 visit, additional testing of a cervical MRI was ordered. That test was denied by Respondent's group insurance carrier by way of a letter contained in attachment 1 to Dr. Beatty's deposition. Dr. Beatty continued to wait for authorization of the cervical MRI and he also took Petitioner off work in December because of Petitioner's symptoms.

Dr. Beatty testified that pending a lack of cervical pathology he would like to perform at bilateral carpal tunnel syndrome release as well as the release of the radial nerve in the forearm for radial tunnel syndrome. Dr. Beatty also had the benefit of reviewing the job description from Respondent, marked deposition attachment 4. After reviewing the same, it was Dr. Beatty's opinion that the work activities described to him by Petitioner and contained in the job description, were the responsible agent and causal basis of these compressive neuropathies or worsening of pre-existing carpal tunnel syndrome more than the radial nerve. However all of it would be related to the work activity. (PX 1)

On cross-examination, Dr. Beatty acknowledged that Petitioner came to him as a self-referral and not from a family physician. Dr. Beatty thought that the conditions were work-related on his first visit in February 2014 and that he related that opinion to Petitioner at that time. (PX 1, pp. 15-16)

On re-direct examination Dr. Beatty testified that the June 9th visit would have been" the golden date" that he told him of his diagnoses and treatment plan. Dr. Beatty thought the initial visit on March 19th showed that there was a Gold standard with regard to the carpal tunnel syndrome but the radial nerve issue was very difficult and that needed to be established by further testing but as far as manifestation goes, the June 9, 2014 visit would have been the next visit after Dr. Beatty had reviewed electrical studies that he was comfortable with using.

Petitioner testified that he is 44 years of age and his 6 feet tall, weighing 205 pounds. He denied having any health problems such as diabetes or hypertension. Petitioner testified that for the last ten years he has worked as a carman for Respondent, a railroad car repair and refurbishing company, at its dome facility in Wood River Illinois. Petitioner's job requires 10-hour shifts with a 10-minute break in the morning and a 30-minute break in the afternoon for lunch. He is right-handed. He is required to cut up railroad cars, weld, grind, jackhammer, and rebuild the railroad cars. Petitioner testified that he uses pneumatic tools such as jackhammers, grinders, and crowbars. Petitioner also testified that he is exposed to vibration with most of those activities and is required to crawl on his hands and knees to chip rust or grind.

Petitioner testified that in 2013, he began having problems with his right wrist. Petitioner explained that he had some numbness in his right hand and cramping in his finger and problems flexing and extending his wrist. At the time of arbitration he was experiencing some cramping in his left hand but he could fully use it. Petitioner explained that his hand would cramp up and go numb with welding and using the jackhammer.

Petitioner testified that he decided to see Dr. Beatty on the referral of a friend who had gone to him, as he needed someone who knew a lot about hands and arms. Petitioner testified he saw Dr. Beatty on February 19, 2014. He also testified that he gave Dr. Beatty a history of his work duties at that visit and told the doctor that he thought his hand condition with work-related. Petitioner further testified that Dr. Beatty examined him and told him he thought he had a work-related problem. Petitioner acknowledged that he didn't tell anyone at Respondent's facility that he had a work-related hand problem until he met with his attorney.

Petitioner further testified that although Petitioner thought that his problems were work-related, Dr. Beatty told him that he wanted to get some tests done to find out what was wrong. Petitioner did not report his condition immediately to his employer because Dr. Beatty had not completed testing was not sure precisely was going on and what the treatment was

going to be. On June 9, 2014 Petitioner testified he saw Dr. Beatty and the EMG test had been completed and Dr. Beatty thought he needed bilateral carpal tunnel surgery.

Petitioner testified that his hands are getting worse and would like to have them fixed. He no longer works for the Respondent for reasons unrelated to this claim.

Petitioner testified that his hands hurt badly enough that he had to be taken off of work for two weeks time from 12/3/14 thru 12/17/14 (See also PX 1, Dep. ex. 2) Petitioner testified he gave his accident report to Jarell Grant and Steve Prokopich.

Respondent called Petitioner's supervisor, Steve Prokopich, to testify. Mr. Prokopich testified that he did not receive notice of a work-related condition until receiving the Application for Adjustment of claim on 7/22/14. While Mr. Prokopich initially thought that he could not have had Petitioner examined after Petitioner hired a lawyer, on cross Mr. Prokopich acknowledged that he could have Petitioner examined at any time but would "have to go through his lawyer and the insurance company". Mr. Prokopich acknowledged that there are a number of work comp cases at the facility and he knew he could have Petitioner examined but had not done so.

The Arbitrator concludes:

Issues (C)Accident and (D) Date of Accident.

Petitioner failed to prove he sustained a repetitive trauma injury to his hands and wrists that manifested itself on June 9, 2014.

The Arbitrator concludes that the date of manifestation for Petitioner's repetitive injury is February 19, 2014 when Petitioner presented himself to Dr. Beatty, clearly associated his hand/wrist symptoms with his work duties for Respondent and requested medical care and treatment for them. It is on February 19, 2014 that both the fact of injury and its causal relationship to Petitioner's employment would have become plainly apparent to a reasonable person. That Petitioner did not definitely know that he had bilateral carpal tunnel syndrome on that date does not negate that February 19, 2014 is the date of manifestation. Indeed many an employee sustains an accident on a specific date but does not know the full extent of the injury or diagnosis until a later time. That does not mean an accident did not occur on a particular date.

Issue (E) Was timely notice of the accident given to Respondent?

As Petitioner failed to prove he sustained an accident arising out of and in the course of his employment on June 9, 2014, the issue of notice is moot.

However, assuming Petitioner's date of accident should be February 19, 2014 Petitioner failed to prove he provided timely notice of that accident to Respondent.

The giving of notice under Section 6(c) of the Act is jurisdictional and is a prerequisite to the right to maintain a claim under the Illinois Workers' Compensation Act. It is undisputed that Petitioner told Dr. Beatty on February 19, 2014 that he believed his hand condition was related to his work duties for Respondent. Petitioner, however, did not report his work accident until July 22, 2014, which is beyond the 45 day notice period of the Act. This is not a case of defective notice as Petitioner did not provide any type of notice within the 45 day notice period.

Issues (F) Causal Connection, (J) Medical Expenses, (K) Prospective Medical Care, and (L) Temporary Total Disability Benefits.

Based upon the Arbitrator's decision on Issues (C) and (E) these issues are moot.

Petitioner's claim for compensation is denied and no benefits are awarded.

****

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mark B. Ridgeway,

Petitioner,

vs.

NO: 14WC 32709

15IWCC0841

Kohl's Department Stores,

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, ex-parte hearing due to non-compliance with commission rules, jurisdiction and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 27, 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 $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: NOV 19 2015
o110515
DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

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

RIDGEWAY, MARK B
Employee/Petitioner

Case# **14WC032709**

15IWCC0841

KOHL'S DEPARTMENT STORE
Employer/Respondent

On 4/27/2015, 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 0.09% 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:

2847 TAPELLA & EBERSAPCHER LLC
DANIEL C JONES
PO BOX 627
MATTOON, IL 61938

0000 KOHL'S DEPARTMENT STORE
1600 FORD AVE
EFFINGHAM, IL 62401

15IWCC0841

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)

Mark B. Ridgeway
Employee/Petitioner

Case # 14 WC 32709

v.

Consolidated cases: n/a

Kohl's Department Store
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 March 12, 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 of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on April 8, 2014. According to the Application, Petitioner was riding in the back of a company van which was driven over a curb which caused Petitioner to sustain injuries to the back and lower body (Petitioner's Exhibit 1). This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of temporary total disability benefits and medical as well as prospective medical treatment. As is noted herein, no one appeared on behalf of the Respondent when this case was tried.

On September 25, 2014, Petitioner filed a Petition for Immediate Hearing under Section 19(b) of the Act. Copies of the Petition were served on the Respondent at its retail store in Effingham, Illinois; Respondent's corporate headquarters; and Michelle Glodoski, Claims Examiner for Sedgwick, CMS (Petitioner's Exhibit 2).

On December 26, 2014, Petitioner filed a Notice of Motion and Order with a Request that the case be set for a trial date certain. This was set for hearing at the Quincy Workers' Compensation Docket on January 7, 2015. Copies of this notice were sent to Respondent's retail store in Effingham, Illinois; Respondent's corporate headquarters; and Michelle Glodoski, Claims Examiner for Sedgwick, CMS. No one appeared on behalf of the Respondent in Quincy on January 7, 2015. At that time, the Arbitrator entered an Order setting the case for a trial date certain during the Urbana Workers' Compensation Docket that was scheduled to begin on March 10, 2015 (Petitioner's Exhibit 3).

Petitioner's counsel subsequently sent a copy of the aforestated Order by certified mail/return receipt requested to Respondent's retail store in Effingham, Illinois; Respondent's corporate headquarters; and Michelle Glodoski, Claims Examiner for Sedgwick, CMS. At trial, the signed return receipts were tendered into evidence which showed that they were received by the preceding on January 16, January 20, and January 20, 2015, respectively (Petitioner's Exhibits 4, 5 and 6).

No one ever filed and Entry of Appearance or any type of responsive pleading on behalf of the Respondent and Petitioner proceeded with the default hearing in Urbana on March 12, 2015.

At trial, Petitioner testified that he was employed by Respondent as a Loss Prevention Supervisor at their store in Effingham, Illinois. Petitioner's job duties consisted of auditing of the cash receipts, making certain that the alarms were operating properly, dealing with shoplifters, etc. Petitioner was required to periodically walk through the store and, on occasion, run to apprehend shoplifters.

Petitioner testified that his date of birth was July 3, 1954, that he was married and had no dependent children. Petitioner further stated that his average weekly wage was $598.40.

Petitioner testified that his supervisor was Raphael Martinez. On the date of the accident, April 8, 2014, Petitioner, Martinez and a number of other loss prevention personnel were in a van being driven by Martinez in Milwaukee, Wisconsin. Their presence in Milwaukee was required by Respondent for a meeting of various loss prevention personnel.

FINDINGS

On the date of accident, April 8, 2014, Respondent was operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned $31,116.80; the average weekly wage was $598.40.

On the date of accident, Petitioner was 59 years of age, married with 0 dependent child(ren).

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

Respondent shall be given a credit of $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 reasonable and necessary medical services as identified in Petitioner's Exhibit 8, 11, 12 and 13 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, treatment recommended by Dr. Sanjiv Jain.

Respondent shall pay Petitioner temporary total disability benefits of $398.93 per week for 44 5/7 weeks commencing May 3, 2014, through March 12, 2015, 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)

April 21, 2015
Date

APR 27 2015

While Petitioner and the group of loss prevention personnel were in the van being driven by Martinez, they were on their way to dinner. At that time, Martinez missed a turn to the restaurant they were going to and, rather than going up to the next block and turning around, Martinez made a turn directly into a median that Petitioner estimated was four to six inches high. This caused a severe bouncing of the vehicle which, in turn, caused Petitioner to bounce up and down. When Petitioner came down, he struck the seat very hard. Petitioner was in the back row seat of the van so it took a considerable impact.

Petitioner testified that he had significant back issues prior to the accident. He had back surgery performed at L4-L5 in 1984 as well as a fusion from L3 to L5 in 2003. However, Petitioner stated that he recovered from these prior surgical procedures and was able to perform all of his job duties.

Subsequent to the accident, Petitioner attended the meetings in Milwaukee, but his back pain got progressively worse and began to go into his legs. Following his return to Illinois, Petitioner initially sought medical treatment at the ER of Sarah Bush Lincoln Health Center on May 3, 2014. At that time, Petitioner had complaints of low back pain with radiation into both legs as well as chronic numbness in the right leg which the record indicated was from a prior back injury. Petitioner was transferred to Carle Foundation Hospital so that an MRI scan could be performed (Petitioner's Exhibit 7).

Petitioner was hospitalized at Carle Foundation Hospital from May 3, 2014, through May 9, 2014. On May 6, 2014, Petitioner had back surgery performed by Dr. Arash Farahuar and the procedure consisted of an L3-L4 redo decompression laminectomies; removal of hardware at L4 to S1; placement of pedicle screws at L3 and L4 with placement of rods; arthrodesis and grafting at L3-L4; and discectomy at L3-L4 (Petitioner's Exhibit 9; Part 1).

Petitioner was subsequently a patient at Carle Foundation Hospital Inpatient Rehabilitation Unit from May 9, through May 30, 2014. During that stay, Petitioner received extensive rehabilitation and physical therapy (Petitioner's Exhibit 9; Parts 4-12).

Following his discharge, Petitioner continued to receive rehabilitation and physical therapy at Carle Foundation Hospital. Petitioner's primary treating physician has been Dr. Sanjiv Jain. At trial, records of the treatment Petitioner received from June, 2014, through January, 2015, were received into evidence (Petitioner's Exhibit 10).

When the case was tried, Petitioner appeared in a wheelchair. He testified that he resided in an assisted living center for approximately one month and, at the time the case was tried, he was living in a senior apartment complex. Petitioner still has significant low back and leg symptoms and has not been able to return to work. At the time of trial he was still receiving rehabilitation and physical therapy.

Conclusions of Law

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

The Arbitrator concludes that Respondent was operating under and subject to the Illinois Workers' Compensation Act.

In support of this conclusion the Arbitrator notes the following:

The uncontroverted evidence as noted in the findings of fact mandate this conclusion.

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

The Arbitrator concludes that on April 8, 2014, there was an employee-employer relationship between the Petitioner and Respondent.

In support of this conclusion the Arbitrator notes the following:

The uncontroverted evidence as noted in the findings of fact mandate this conclusion.

In regard to disputed issues (C) and (D) 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 his employment by Respondent on April 8, 2014.

In support of this conclusion the Arbitrator notes the following:

The uncontroverted evidence as noted in the findings of fact mandate this conclusion.

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

The Arbitrator concludes Respondent had notice of Petitioner's accident within the time limit prescribed by the Act.

In support of this conclusion the Arbitrator notes the following:

The uncontroverted evidence as noted in the findings of fact mandate this conclusion.

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

The Arbitrator concludes that Petitioner's current condition of ill-being is causally related to the accident of April 8, 2014.

In support of this conclusion the Arbitrator notes the following:

The uncontroverted evidence as noted in the findings of fact mandate this conclusion.

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

The Arbitrator concludes that Petitioner's average weekly wage at the time of the accident was $598.40.

In support of this conclusion the Arbitrator notes the following:

The uncontroverted evidence as noted in the findings of fact mandate this conclusion.

In regard to disputed issues (H) and (I) the Arbitrator makes the following conclusions of law:

The Arbitrator concludes that at the time of the accident, Petitioner was 59 years old, married without dependent children.

In support of this conclusion the Arbitrator notes the following:

The uncontroverted evidence as noted in the findings of fact mandate these conclusions.

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.

In support of this conclusion the Arbitrator notes the following:

The uncontroverted evidence as noted in the findings of fact mandate this conclusion.

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

Arbitrator concludes Petitioner is entitled to prospective medical treatment including, but not limited to, the treatment prescribed by Dr. Jain.

In support of this conclusion the Arbitrator notes the following:

The uncontroverted evidence as noted in the findings of fact mandate this conclusion.

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

Arbitrator concludes Petitioner is entitled to temporary total disability benefits of 44 5/7 weeks beginning May 3, 2014, through March 12, 2015.

In support of this conclusion the Arbitrator notes the following:

The uncontroverted evidence as noted in the findings of fact mandate this conclusion.

William R. Gallagher, Arbitrator

15IWCC0841

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 Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Bernice Kimmons,

Petitioner,

vs. NO: 14 WC 34696

15IWCC0846

Pleasant Plains School District,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 13, 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.

15IWCC0846

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: NOV 2 0 2015
TJT:yl
o 11/9/15
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KIMMONS, BERNICE
Employee/Petitioner

Case# **14WC034696**

PLEASANT PLAINS SCHOOL DISTRICT
Employer/Respondent

15IWCC0846

On 5/13/2015, 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:

1727 LAW OFFICES OF MARK N LEE
ALLEN C MUELLER
1101 S 2ND ST
SPRINGFIELD, IL 62704

2865 KEEFE CAMPBELL BIERY & ASSOC
NATHAN S BERNARD
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

15IWCC0846

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

BERNICE KIMMONS,
Employee/Petitioner

v.

PLEASANT PLAINS SCHOOL DISTRICT,
Employer/Respondent

Case # **14** WC **34696**

Consolidated cases: _____

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Springfield**, on **4/22/15**. By stipulation, the parties agree:

On the date of accident, **1/31/14**, 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 $**13,715.00**, and the average weekly wage was $**263.75**.

At the time of injury, Petitioner was **54** years of age, ***married*** with **no** dependent children.

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

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**.

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

ORDER

Respondent shall pay Petitioner the sum of $253.00/week for a further period of 62.675 weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **petitioner a 37.5% loss of use of her right foot**.

Respondent shall pay Petitioner compensation that has accrued from **1/31/14** through **4/22/15**, 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.

Signature of Arbitrator

5/11/15
Date

MAY 13 2015

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 54 year old substitute bus drive, sustained an accidental injury to her right ankle that arose out of and in the course of her employment by respondent on 1/31/14. On this day petitioner was working the morning and afternoon run. She testified that it was snowing and sleeting that day. Petitioner completed the morning run without incident. Petitioner got to work by 2 PM for the afternoon run, and went into the bus barn to pick up the keys for the Suburban. Petitioner started the car to warm it up, and went to scrape the back window with her hand, and fell onto the ground. Her right leg went underneath her. Another driver got assistance and helped petitioner up off the ground and took her to the bus garage. Petitioner was taken to Express Care and was sent to the emergency room for a reduction. She had a CT scan done and was noted to have a distal fibula fracture and a posterior malleolus fracture.

On 2/4/14 petitioner presented to Dr. Barry Mulshine an orthopedic surgeon, for evaluation of her left ankle. Petitioner presented nonweightbearing in a splint in a wheelchair. X-rays were taken of the left ankle and Dr. Mulshine's assessment was right trimalleolar ankle fracture including a fairly large posterior malleolus fragment. He discussed surgery with the petitioner, and instructed her to remain nonweightbearing until the surgery.

On 2/7/14 petitioner underwent an open reduction and internal fixation of a right trimalleolar ankle fracture with fixation of the posterior malleolus. Her postoperative diagnosis was trimalleolus fracture of the right ankle. Petitioner followed up postoperatively with Dr. Mulshine.

On 2/20/14 petitioner complained of toe numbness and mild pain. An examination revealed mild swelling, and a fracture blister area at the anterior ankle that had not yet completely dried up. Dr. Mulshine placed petitioner into an immobilizer boot. He instructed petitioner to remain nonweightbearing. By 3/25/14 petitioner stated that she was doing better and her pain had improved. On examination Dr. Mulshine noted that the fracture blisters had resolved and the incision looked great. Petitioner only had mild swelling, and she was able to demonstrate some motion across the ankle. He did not feel any crepitus. X-rays showed that the hardware along the distal fibula was in good position and the fracture appeared to be healing. A small chip at the medial malleolus was noted. Dr. Mulshine was of the opinion that petitioner should begin progressing to weight bearing as tolerated. He told her she could remove her boot for motion exercises and for sleeping. On 4/28/14 petitioner was weight bearing as tolerated. She stated she was doing well and takes Advil for pain as needed. She stated that she was still experiencing numbness in her great toe and using crutches. An examination revealed mild swelling, and decreased sensation to light touch through the plantar aspect of the hallux. Dr. Mulshine instructed petitioner to progress her weight bearing as tolerated and wean from the

crutches and then wean from the both. Dr. Mulshine order physical therapy. He allowed petitioner to return to work in a sitdown work only position.

On 5/29/14 petitioner returned to Dr. Mulshine. She stated that physical therapy had been helpful. She stated that she was using her boot some of the time and a regular shoe the other times. She again reiterated that she still has numbness in the big toe. She stated that her ankle motion was improving. Dr. Mulshine noted that petitioner was able to ambulate without any ambulatory aids, but had a fairly stiff legged gait. She lacked some plantar flexion on the right compared with the left. She had about 5° of dorsiflexion on the right compared to 10° on the left. Some edema was noted. X-rays showed the lateral malleolus hardware was in good position and the fracture appeared to be healed. The two screws and the distal tibia were in good position. Dr. Mulshine continued petitioner in physical therapy. He believed petitioner would be able to safely drive a bus in two weeks.

On 6/26/14 petitioner returned to Dr. Mulshine. She stated she was doing well and had completed physical therapy. He noted that petitioner was walking nearly normally. She again reiterated her numbness in her big toe, and felt that the motion in her big toe was restricted. She stated that she occasionally has shooting pains from the toe. Dr. Mulshine noted a little bit of residual swelling of the right foot when compared with the left. She also had a few degrees of dorsiflexion that appeared to be a little short of her dorsiflexion on the left. She had limited first MTP motion on the right compared with the left. Palpable spurring across the dorsal aspect of the joint was noted. Petitioner had some pain with passive terminal dorsiflexion of the joint. Dr. Mulshine recommended that petitioner continued to progress her walking and standing. He was of the opinion that the numbness in her toes was probably related to the fracture and or the surgery and he hoped it would improve with time. He believed the restricted motion that she had in the toe was actually related to arthritis at the first MTP joint, that was not related to her injury. He indicated that petitioner could continue working without restrictions.

On 9/11/14 petitioner last followed up with Dr. Mulshine. She stated that she has returned to work full duty at school bus driver, but had to quit due to unrelated medical conditions. She stated that she did not have much pain in her ankle, but stated that it still gives her a little trouble when she is descending stairs. Petitioner still reported numbness in her great toe. She denied any popping or grinding. An examination revealed that petitioner lacked just a couple degrees of dorsiflexion on the right compared with the left. She lacked about 5° of plantar flexion on the right compared with the left. She had limited motion across the right first MTP joint with palpable spurring across the dorsal aspect of the joint. Dr. Mulshine was of the opinion that petitioner had reached maximum medical improvement and that her limitations of ankle motion would be a permanent impairment. Petitioner still had numbness in her great toe, that Dr. Mulshine said may or may not improve with

time. Dr. Mulshine was of the opinion that petitioner had a risk of developing hardware pain which may necessitate hardware removal, and there was also a future risk of developing posttraumatic arthritis because of her injury. He released petitioner from his care on an as needed basis.

Currently, petitioner reported that her ankle is the same as it was on the day she was released from care. She still experiences problems going up and down stairs and getting up off the floor, getting up out of chairs and tripping on throw drugs at home. Petitioner testified that her ankle does not bend and flex when she goes downstairs. She testified that she can't go downstairs straight, and goes down sideways. She also cannot extend her foot as far as she used to. She testified that when she is on her foot a lot she has pain. He stated that her foot is numb all the time from the ball of her foot to her toes, and her right leg is weaker than ever before. She stated that she has trouble getting into the stands at the races. She stated that she pays attention to uneven grounds so that her ankle does not roll. Due to the difficulty she has cleaning bathrooms and mopping floors she hired a cleaning lady. She testified that when she drives she can't keep her foot flexed up all the time. She stated that she can only be on her foot from one to 1 1/2 hours at a time due to pain. Petitioner testified that on bad weather days she gets an electrical shock sometimes. Despite these complaints petitioner testified that she has not gone back to see Dr. Mulshine since she was released on 9/11/14.

As a result of the injury on 1/31/14 petitioner sustained a right trimalleolar ankle fracture including a fairly large posterior malleolus fragment. Petiitoner underwent an open reduction and internal fixation of a right trimalleolar ankle fracture with fixation of the posterior malleolus. Her post-operative diagnosis was trimalleolus fracture of the right ankle.

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

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a substitute bus drive at the time of the accident and that she was able to return to work in her prior capacity as a result of said injury. The Arbitrator notes that following her post-operative treatment petitioner ultimately returned to her full duty job without restrictions, but left her job as a substitute bus driver due to unrelated medical conditions. Petitioner did not describe any difficulty performing her duties after she returned to work. Because petitioner has returned to her full duty job and is longer doing it due to unrelated medical conditions, the Arbitrator gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 54 years old at the time of the accident. Because petitioner has returned to his regular duty job without restrictions and is only not working in her regular duty job due to unrelated medical conditions, the arbitrator gives lesser weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that no evidence was offered to support a finding that petitioner's future earnings capacity has been impacted in anyway by his injury, 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 when petitioner last followed-up with Dr. Mulshine on 9/11/14 she stated that she did not have much pain in her ankle, but stated that it still gives her a little trouble when she is descending stairs. Petitioner still reported numbness in her great toe. She denied any popping or grinding. An examination revealed that petitioner lacked just a couple degrees of dorsiflexion on the right compared with the left. She lacked about 5° of plantar flexion on the right compared with the left. She had limited motion across the right first MTP joint with palpable spurring across the dorsal aspect of the joint. Dr. Mulshine was of the opinion that her limitations of ankle motion would be a permanent impairment. Petitioner still had numbness in her great toe, that Dr. Mulshine said may or may not improve with time. Dr. Mulshine was of the opinion that petitioner had a risk of developing hardware pain which may necessitate hardware removal, and there was also a future risk of developing posttraumatic arthritis because of her injury. Petitioner testified at trial to other complaints that were not corroborated by the medical records. Because of this, the Arbitrator gives greater weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 37.5% loss of use of right foot pursuant to §8(e) of the Act.

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

Curtis Stevenson,
Petitioner,
vs.

NO: 14WC 37069

Cook County Sheriff's Dept.,
Respondent,

15IWCC0856

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 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 March 20, 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: NOV 2 3 2015
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DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

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

STEVENSON, CURTIS
Employee/Petitioner

Case# **14WC037069**

15IWCC0856

COOK COUNTY SHERIFF'S DEPT
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:

2675 COVEN LAW GROUP
MARK J SCHECHTER
180 N LASALLE ST SUITE 3650
CHICAGO, IL 60601

0132 ASSISTANT STATE'S ATTORNEY OFF
JEREMY SCHWARTZ
500 DALEY CENTER ROOM 509
CHICAGO, IL 60602

15IWCC0856

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)

CURTIS STEVENSON
Employee/Petitioner

v.

COOK COUNTY SHERIFF'S DEPT.
Employer/Respondent

Case # **14** WC **37069**

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 **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **02/26/15**. 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. ☐ 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 _____

15IWCC0856

FINDINGS

On the date of accident, **10/14/14**, 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 $**65,000.00**; the average weekly wage was $**1,250.00**.

On the date of accident, Petitioner was **49** 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 $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $0.00.

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

ORDER

The petitioner has not proven, by a preponderance of the evidence, that an accident occurred, which arose out of and in the course of his employment by Respondent therefore, no benefits are awarded, pursuant to the Act.

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

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

FINDINGS OF FACT

The disputed issues in this matter are: 1) accident; 2) causal connection; 3) medical services; 4) temporary total disability; and 5) the nature and extent of Petitioner's injuries. *See,* AX1.

Petitioner testified that he is an officer for the Cook County Sheriff's Department and has worked in that capacity for thirteen (13) years. Petitioner testified that his shift on October 14, 2014 was from 11:00 p.m. the preceding day, October 13, 2014, to 7:00 a.m. on October 14, 2014 and that on the 14th, his duties included the responsibility for maintaining security at the front entrance of the Division 3 building at Cook County Jail at 26th and California. Petitioner's job included unlocking the door for those who enter. Due to the nature of the secured facility, the door had to be repeatedly unlocked and locked, to allow entry into and exit from the building. Petitioner was assigned to a desk by the door and performs this function.

The petitioner testified that when someone desired to get in to the building, he gets up from his desk and walk over to the door. Petitioner would then unlock the door for those who desired to enter. Petitioner testified that during the 6:00 A.M. to 7:00 hour, which is a shift change, he was up and down answering the door several times. Petitioner testified that he experienced no pain to his right knee prior to October 14, 2014, nor did he ever have an accident to his right knee prior or subsequent to that date.

Petitioner's testimony

Petitioner testified that on October 14, 2014, the area leading to the Division 3 entrance was long and narrow and had a concrete/linoleum floor. His desk was situated several feet away from the entrance, to the right of the entrance door (facing the entrance). He testified that on that date the floor had moisture on it from the weather and was slippery from all the people coming in from outside.

Petitioner testified that the accident occurred between 6:00 – 7:00 a.m., in the heart of a shift change, which was one hour before the end of his shift. Petitioner testified that the end of the shift was particularly busy, due to people coming and going, requiring Petitioner to repeatedly get up from his desk, walk over to the door and unlock it.

Petitioner testified that around 6:00–6:15 a.m., he got up from his desk to open the door for Nurse Torres, a medical worker. As he approached the door, Petitioner testified that he lost his footing from moisture on the floor and slipped and twisted his right knee, at which time he felt a pop. He testified that he did not fall and he continued to proceed to open the door. At the time, he did not think much of the injury and proceeded to complete his shift. He testified that as he left to go home, he began to limp and by the next morning, his right knee was swollen. He did not go to work that day and scheduled an appointment with his personal physician, Jerry Jensen, D.O., who Petitioner saw on October 15, 2014. PX4.

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On October 15, 2014, Dr. Jensen examined Petitioner's right knee and determined that he had sustained a medial meniscal tear. He ordered an MRI of the right knee, which was performed on December 30, 2014, at St. James Hospital and referred Petitioner to Dr. Ram Aribindi, an orthopedic specialist. PX1 & 2.

Petitioner initially presented to Dr. Aribindi on October 29, 2014, stating that he twisted his right knee while going to open a door. Dr. Aribindi's diagnosis was internal derangement of right knee with synovitis. The doctor administered a steroid injection and prescribed modified duty with limited walking. Petitioner remained off work.

On October 30, 2014, Petitioner sought a second opinion from Dr. Matthew Jimenez, a board certified orthopedic surgeon. Dr. Jimenez noted that Petitioner's right knee had been asymptomatic before the incident, but subsequent to it, he had clicking, popping and swelling; and was unable to perform his duties. His examination of the right knee revealed tenderness and swelling surrounding the knee in the join line, consistent with meniscal damage. Dr. Jimenez's impression was injury to the right knee, with some minimal pre-existing degenerative changes, that were exasperated and worsened as a result of the accident in question. The treatment plan was to keep Petitioner off work, take analgesics, and start gentle strengthening and range of motion exercises at physical therapy, to be followed-up by an MRI. PX3.

Petitioner returned to Dr. Aribindi on December 24, 2014, with Petitioner noting no significant improvement following the steroid injection, having pain over the medial aspect of the right knee, with limited ability to bend it. Dr. Aribindi noted that Petitioner walked with a limp and his assessment was osteoarthritis of the right knee, internal derangement of the knee with synovitis. Dr. Aribindi requested an MRI of the right knee since Petitioner showed no improvement.

Petitioner returned to Dr. Aribindi on January 2, 2015 and a review of the MRI revealed a tear of the posterior horn of the right medial meniscus, with arthritic changes. Dr. Aribindi prescribed modified duty with no kneeling or squatting, and refraining from prolonged walking or climbing stairs. Also, the petitioner was not to lift or carry over twenty (20) pounds. Dr. Aribindi discussed arthroscopic versus knee replacement surgery.

Petitioner returned to Dr. Jimenez on January 6, 2015, who also reviewed the December 30, 2014, MRI of the right knee. He read it as finding a tear of the posterior horn of the medial meniscus, as well as tri-compartmental degenerative changes, particularly in the patellofemoral joint, as well as a small intra-capsular osteochondral fragment. According to Dr. Jimenez, there was also tendinitis in the lateral collateral ligament, which was inflamed and a function of Petitioner's initial injury. Dr. Jimenez recommended a knee arthroscopy for the meniscal tear, followed by physical therapy. Petitioner was kept off work and Dr. Jimenez noted that the injury was caused by a slip and twist,

while walking across a wet floor; and that the petitioner was asymptomatic, prior to the incident. The Arbitrator notes that this is the first time a wet floor is mentioned.

Petitioner testified that he returned to work on December 16, 2014, in a sedentary capacity, admitting visitors into a garage. He stated that he continues to have pain in his right knee because his "modified" job still requires him to walk and stand up from a seated position. He testified that he continues to experience pain in his right knee and walks with a limp, as a result of his injury. He testified that he now has pain in his left knee from overcompensation. Respondent has accommodated the petitioner's restrictions and he is currently working security in the parking lot of the building.

Upon cross-examination, the petitioner was shown Petitioner's exhibits five and six, which do not mention mud, water or moisture on the floor. In addition, Petitioner admitted that his has an arthritic right knee.

Respondent's witness' testimony

Respondent called Sgt. Stephen Bouffard, who testified that he had been employed by the respondent for approximately twenty (20) years; and that he is in charge of video operations. He showed a video of the petitioner actions, during the relevant time-period. The Arbitrator notes that the video does not show moisture or mud on the floor nor does it show the petitioner twisting his knee, as he gets up from his desk, to unlock the door for Nurse Torres. RX1.

CONCLUSIONS OF LAW

A decision by the Commission cannot be based upon speculation or conjecture. *Deere and Company v Industrial Commission*, 47 Ill.2d 144, 265 N.E. 2d 129 (1970). A petitioner seeking an award before the Commission must prove by a preponderance of credible evidence each element of the claim. *Illinois Institute of Technology v. Industrial Commission*, 68 Ill.2d 236, 369 N.E.2d 853 (1977). Where a petitioner fails to prove by a preponderance of the evidence that there exists a casual connection between work and the alleged condition of ill-being, compensation is to be denied. Id. The facts of each case must be closely analyzed to be fair to the employee, the employer, and to the employer's workers' compensation carrier. *Three "D" Discount Store v Industrial Commission*, 198 Ill.App. 3d 43, 556 N.E.2d 261, 144 Ill.Dec. 794 (4th Dist. 1989).

The burden is on the Petitioner seeking an award to prove by a preponderance of credible evidence all the elements of his claim, including the requirement that the injury complained of arose out of and in the course of his or her employment. *Martin vs. Industrial Commission*, 91 Ill.2d 288, 63 Ill.Dec. 1, 437 N.E.2d 650 (1982). The mere existence of testimony does not require its acceptance. *Smith v Industrial Commission*, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require

that an award be entered or affirmed whenever a claimant testified to an injury no matter how much his testimony might be contradicted by the evidence, or how evident it might be that his story is a fabricated afterthought. *U.S. Steel v Industrial Commission*, 8 Ill.2d 407, 134 N.E. 2d 307 (1956).

It is not enough that the petitioner is working when an injury is realized. The petitioner must show that the injury was due to some cause connected with the employment. *Board of Trustees of the University of Illinois v. Industrial Commission*, 44 Ill.2d 207, 214, 254 N.E.2d 522 (1969); see also *Hansel & Gretel Day Care Center v Industrial Commission*, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991).

The Illinois Supreme Court has held that a claimant's testimony standing alone may be accepted for the purposes of determining whether an accident occurred. However, that testimony must be proved credible. *Caterpillar Tractor vs. Industrial Commission*, 83 Ill.2d 213, 413 N.E.2d 740 (1980). In addition, a claimant's testimony must be considered with all the facts and circumstances that might not justify an award. *Neal vs. Industrial Commission*, 141 Ill.App.3d 289, 490 N.E.2d 124 (1986). Uncorroborated testimony will support an award for benefits only if consideration of all facts and circumstances support the decision. *See generally, Gallentine v. Industrial Commission*, 147 Ill.Dec 353, 559 N.E.2d 526, 201 Ill.App.3d 880 (2nd Dist. 1990), see also *Seiber v Industrial Commission*, 82 Ill.2d 87, 411 N.E.2d 249 (1980), *Caterpillar v Industrial Commission*, 73 Ill.2d 311, 383 N.E.2d 220 (1978). It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence, and assign weight to the witness' testimony. *O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253, 403 N.E.2d 221, 223 (1980); *Hosteny v Workers' Compensation Commission*, 397 Ill. App. 3d 665, 674 (2009).

Upon a review of the video disk, the Arbitrator does not find that the petitioner has proven, by a preponderance of the evidence, that an accident occurred, which arose of and in the course of his employment by Respondent therefore, no benefits are awarded, pursuant to the Act. As the petitioner has not proven an accident, the other disputed issues are moot and will not be addressed.