STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

David Paul Lemin,

Petitioner,

vs.

NO: 13 WC 5725

17IWCC0435

Al-Amin Brothers Transportation,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and notice provided to all parties, the Commission after considering the issues of employment relationship, accident including date and notice, causal relationship, medical expenses, temporary total disability benefits, and nature and extent of the disability, and being advised in the facts and the law reverses the Decision of the Arbitrator.

PROCEDURAL HISTORY

On June 16, 2016 the Arbitrator issued his decision. On July 21, 2016 Petitioner filed his Petition for Review. On August 8, 2016 Respondent filed its Motion to Dismiss Review. On September 28, 2016 a hearing was conducted on Respondent's Motion to Dismiss Review wherein both parties were present. On December 23, 2016 the Commission entered an Order denying Respondent's Motion to Dismiss Review.

STATEMENT OF FACTS

At the May 3, 2016 arbitrator hearing, Petitioner testified he worked as an owner/operator for Respondent; in effect a truck driver. T. 9. Petitioner testified he drove LTL freight (less than a truck load) from the Lansing, Illinois area to the East Coast. *Id.*

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Petitioner testified on October 4, 2012 while unloading product at John R. Morreale, he slipped and fell on the ice located in the refrigerated truck trailer. T. 11. Petitioner testified his brother and an employee of John Morreale completed the unloading of the product. T. 12. Petitioner testified he felt immediate pain in his lower back, on his right side to his buttocks all the way to his feet. T. 13. Petitioner testified he continued on to his next delivery and due to his pain, his brother unloaded the product. *Id.*

Petitioner testified he proceeded to Respondent's warehouse that afternoon and rested in his truck. T. 14-15. Petitioner testified he eventually went into the warehouse around 5 or 6 p.m. to use the facilities and check on paperwork. T. 16. Petitioner testified to experiencing severe pain, shortness of breath, and difficulty walking. *Id.* Petitioner testified he spoke with Rafi Al-Amin who was the dispatcher and one of the owners of Respondent and advised him of his back injury. T. 16-17. Petitioner testified he also informed Adrienne and Tyrek Al-Amin, both owners of Respondent, of his back injury. T. 19.

Petitioner testified he continued to work, driving a load to the East Coast with the assistance of his brother. T. 21. Petitioner testified he was unable to perform the loading/unloading of the product and relied on his brother to perform the same. *Id.*

Petitioner testified his back pain became so severe he sought treatment from an emergency room and underwent an MRI on November 5, 2012. T. 23. Petitioner testified he was evaluated by his primary care physician, Dr. Meyer who referred Petitioner to a back specialist, Dr. Maserati. T. 24-25. Petitioner testified that during his treatment he continued to inform Rafi Al-Amin as to his progress. T. 24.

Petitioner testified Dr. Meyer provided pain medication, and Petitioner underwent physical therapy with surgery being undertaken on April 15, 2013 performed by Dr. Maserati. T. 28-29. Petitioner testified prior to the surgery he spoke with Rafi Al-Amin about workers' compensation insurance, and Rafi advised Respondent carried workers' compensation insurance the premiums of which were deducted from the Petitioner's paycheck. T. 29. (PX4 evidences that such premiums were, in fact, deducted from the Petitioner's pay). Petitioner testified Rafi eventually provided the phone number for the workers' compensation insurance carrier which subsequently denied Petitioner's claim. T. 30. Petitioner testified he was terminated by Respondent as he could no longer perform his job. T. 30.

Petitioner testified following the initial surgery he continued to experience pain especially when sitting for prolonged periods of time. T. 32. Petitioner testified he attended physical therapy but eventually underwent a second surgery on August 13, 2013. T. 33-34. Petitioner testified he has not felt normal since his second surgery. T. 35. Petitioner testified he is in constant pain and when he sits for too long, he becomes numb from the waist down and experiences bouts of urinary incontinence. *Id.* Petitioner testified he has not looked for employment since his injury. T. 36. Petitioner testified since the second surgery he has not undergone any significant treatment other than physical therapy and steroid injections. *Id.*

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Petitioner testified he sought treatment from Dr. Moossy on two occasions on the referral of Dr. Meyer. T. 37-38. Petitioner testified Dr. Moossy recommended either a disc fusion or a spinal cord stimulator neither of which treatment options Petitioner wishes to pursue. T. 38-39. Petitioner testified he is presently receiving social security disability benefits and has not received any temporary total disability benefits. T. 39. Petitioner testified the majority of his medical bills have been paid by his wife's group health insurance but approximately $5000.00 remains outstanding. T. 41.

On cross-examination Petitioner testified on the date of accident he advised Rafi Al-Amin of the particulars of the injury that being he fell while pulling a pallet. T. 44. Petitioner testified he paid his brother the lumper fees allowed by Respondent for unloading the freight. T. 45. Petitioner testified he signed a driver's contract and identified Respondent's Exhibit 1 as the contract he signed. T. 47. The Commission notes the contract was not offered into evidence.

Petitioner testified prior to the October 4, 2012 injury he experienced low back pain such as sore muscles but nothing requiring surgery. T. 47. Petitioner testified to obtaining an MRI 5 to 7 years prior to his employment with Respondent. T. 48. Petitioner testified he advised Dr. Meyer of his prior back problems which he described as a pulled muscle. T. 50. Petitioner testified he was able to drive a vehicle currently, but the furthest he would drive is 30 miles. T. 51. Petitioner testified to being involved in a motor vehicle accident in August or September of 2014. T. 52.

Petitioner testified he began his employment with Respondent on August 21, 2012, and prior to his accident of October 4, 2012 he took a week off of work. T. 53. Petitioner testified he became angry with the dispatcher and thusly made a decision not to work for a week. T. 54. Petitioner testified he was not directed by Respondent as to which routes to take in making his deliveries. *Id.* Petitioner testified he paid for overhead expenses including tolls and fuel as well as for licensing/tags. T. 54-55. Petitioner testified he received a set of company tags, and the expense for the same was deducted from his pay check. T. 55.

Petitioner testified after the accident he began taking pain medication which he obtained from his wife. T. 57. Petitioner testified with the use of the pain medication he was able to continue to drive. T. 58. Petitioner testified he discussed with Adrienne Al-Amin his possible inability to pass a drug test given the use of pain medication, and Adrienne Al-Amin advised he would take care of it. T. 58. Petitioner testified he did eventually take the drug test and passed. T. 59.

On re-direct examination Petitioner testified Respondent directed him as to what product to load; where to deliver it; and when to deliver it. T. 60.

Mr. Rafi Al-Amin was called to testify on behalf of Respondent. Mr. Al-Amin testified he along with his two brothers, he owned and operated Al-Amin Brothers, an over the road LTL, less than truck load refrigerated carrier. T. 77. Mr. Al-Amin testified he entered into an

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agreement with Petitioner to lease Petitioner and his truck to haul product from the Chicagoland area to the East Coast. T. 78. Mr. Al-Amin testified he considered Petitioner an independent contractor. *Id.* Mr. Al-Amin testified pursuant to Department of Transportation rules, Respondent must provide permits/licensing, but the cost was charged to the driver. T. 78-79. Mr. Al-Amin identified a lease agreement purportedly signed by the parties. T. 79.

Mr. Al-Amin testified Petitioner was required to undergo a pre-employment drug test at the start of his employment on August 21, 2012. T. 80. Mr. Al-Amin testified Petitioner was called for a random drug test in September of 2012 after he began his employment. T. 83. Mr. Al-Amin testified Petitioner advised he was unable to pass the drug test as he was taking pain pills he obtained from his wife. T. 85. Mr. Al-Amin identified the driver's manifest which showed Petitioner hauling a load on September 14, 2012 and the next load hauled was September 28, 2012. T. 87-88. Therefore if Petitioner needs to take a drug test, it would be when he returned to the Lansing, IL facility. T. 89.

Mr. Al-Amin testified he spoke with Petitioner on October 4, 2012 and witnessed Petitioner walking slowly and slumped to his side causing Mr. Al-Amin to inquire about Petitioner's condition. T. 89-90. Mr. Al-Amin testified Petitioner advised him that he hurt his back, but Mr. Al-Amin denied that Petitioner advised hurting his back while pushing a pallet. T. 90. Mr. Al-Amin testified based upon the manifest, Petitioner continued to work after October 4, 2012, and during that time, Mr. Al-Amin had no knowledge of Petitioner advising him regarding hurting his back while pushing a pallet. T. 91.

Mr. Al-Amin testified as to the procedure if a driver failed a drug test stating the driver would either be terminated or allowed to complete a drug rehabilitation program. T. 93. Mr. Al-Amin testified in Petitioner's case, he would not be terminated given his good work ethic. *Id.*

Mr. Al-Amin testified Petitioner was paid 70% of freight revenue plus fuel surcharges, unloading charges, handling fees, and gate fees. T. 94. Taxes were not withheld from Petitioner's pay check, but certain expenses were such as payment for insurance or license plates. *Id.*

On cross-examination Mr. Al-Amin testified he possessed no documentation as to the requested random drug test, but such documentation existed just not in his possession. T. 95-96. Mr. Al-Amin testified on the date of accident he saw Petitioner having difficulty moving but again stated Petitioner did not advise of a fall at John Morreale. T. 96. Mr. Al-Amin testified he did receive notice of Petitioner's accident through dispatch. T. 97. Mr. Al-Amin testified his brothers were in the office Friday night, and it was very possible Petitioner discussed his accident with them. T. 98.

The medical records evidence on November 2, 2012 Petitioner sought treatment from an emergency room complaining of pain radiating down his right leg which he associated to pulling a pallet. Petitioner provided a history of experiencing back pain for some duration and

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attempting to obtain an MRI for some years. There is no diagnosis or recommendation for treatment as page 2 of the record is not in evidence. PX2.

Thereafter on November 5, 2012 Petitioner sought treatment from Dr. Matthew Meyer and provided a history of severe low back pain. Petitioner stated a history of chronic back problems with a recent injury approximately one week prior while pulling a pallet, he slipped and fell backwards. Given the severity of Petitioner's symptoms, Dr. Meyer prescribed an MRI and referred Petitioner to a neurosurgeon. An MRI was undertaken on November 6, 2012 which evidenced a herniation at the L4-L5 level obscuring the right L5-S1 foramen and impinging the right L5 dorsal root. PX2.

On November 9, 2012 Dr. Matthew Maserati of Allegheny Brain and Spine Surgeons evaluated Petitioner. Petitioner provided a history of back and right leg pain which began on October 5, 2012 when he fell backwards while pulling a pallet. Dr. Maserati diagnosed a lumbar disc herniation with radiculopathy. Dr. Maserati recommended surgery as he did not feel conservative treatment would resolve the problems but recommended injections and physical therapy in the meantime. PX3.

In the interim, on December 6, 2012 Dr. Meyer re-evaluated Petitioner who continued to complain of severe back pain. Dr. Meyer authorized Petitioner off work and continued to prescribe Percocet. Dr. Meyer deferred to the neurosurgeon and his recommendations for surgery. On January 8, 2013 Dr. Meyer re-evaluated Petitioner who continued to complain of low back pain. Petitioner advised he was waiting on a decision from the workers' compensation insurance and would proceed with surgery thereafter. Petitioner also complained of symptoms consistent with a diagnosis of depression. Dr. Meyer prescribed Prozac and hydrocodone. On February 18, 2013 Dr. Meyer re-evaluated Petitioner who continued to complain of severe back pain and depression. Petitioner advised he recently initiated physical therapy without a significant improvement in his pain. Dr. Meyer continued to recommend follow-up with physical therapy and injections as well as possible surgery. Dr. Meyer diagnosed depression and recommended an increase in the amount of Prozac. PX2.

Thereafter on April 5, 2013 Dr. Maserati evaluated Petitioner who advised he underwent physical therapy as well as an epidural steroid injection neither of which provided any relief. Dr. Maserati recommended a repeat MRI given Petitioner's symptom of increased left leg numbness. Petitioner underwent the MRI on April 10, 2013 with surgery performed by Dr. Maserati on April 15, 2013 consisting of a minimally invasive right L4 hemilaminotomy, partial medial facetectomy, foraminotomy, and discectomy. On May 3, 2013 Dr. Maserati re-evaluated Petitioner at which time physical therapy was recommended, and Petitioner was continued to be authorized off work. On May 31, 2013 Dr. Maserati re-evaluated Petitioner who complained of increased pain which he associated to physical therapy. Dr. Maserati advised therapy to be placed on hold and a Medrol dose pack instituted. Petitioner was continued off work. PX3.

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Dr. Maserati evaluated Petitioner on July 2, 2013 and recommended an updated MRI to rule out a re-herniation. An MRI was performed on July 11, 2013 which evidenced a new herniation at the L4-L5 level new since April 2013. Dr. Maserati re-evaluated Petitioner on July 31, 2013 and diagnosed a recurrent herniation at L4-L5 and recommended surgery. Dr. Maserati performed surgery on August 22, 2013 consisting of a re-exploration of right L4-L5 microdisectomy. Dr. Maserati re-evaluated Petitioner on September 4, 2013 at which time physical therapy was recommended. Petitioner was authorized to drive and lift up to 25 lbs. but was not released to return to work until his re-evaluation on October 2, 2013. There is no documentation of an evaluation on October 2, 2013 other than an off work note. PX3.

Petitioner testified he was evaluated on two occasions by Dr. John Moossy although the medical records only document one visit on December 8, 2015. Dr. Moossy recommended either a spinal cord stimulator or a spinal fusion. PX5. Dr. Moossy failed to provide an opinion as to the causal relationship between the proposed treatment and the accident of October 4, 2012.

Petitioner also offered into evidence certain 1099's as well as wage records and driving manifests regarding his employment with Respondent. PX4. The driving manifest documents a delivery at John R. Morreale on October 4, 2012. PX4. A further hearing was undertaken on May 26, 2016 where no evidence was received, and the parties closed proofs. The parties stipulated to an average weekly wage of $1947.66, and the Petitioner's age at the time of injury to be 41 years.

The Commission makes the following factual findings:
*Petitioner established an employment relationship of that of employee/employer.
*Petitioner sustained an accident on October 4, 2012 while moving pallets he fell backwards injuring his back.
*Petitioner suffered a herniated disc at L4-L5 level requiring two surgeries with MMI being reached by October 2, 2013.

CONCLUSIONS OF LAW

"Whether a claimant is classified as an independent contractor or an employee is crucial, for it is the employment status of a claimant which determines whether he is entitled to benefits under the Act. *Earley v. Industrial Comm'n*, 197 Ill. App. 3d 309, 314 (1990); see also *Roberson v. Industrial Comm'n*, 225 Ill. 2d 159, 174 (2007) (noting that an employment relationship is a prerequisite for an award of benefits under the Act)." *Steel & Machinery Transportation Inc. v. The Illinois Workers' Compensation Commission*, 2015 IL App (1st) 133985WC, ¶30.

> Our supreme court has identified a number of factors to assist in determining whether a person is an employee. Among the factors cited by the supreme court are: (1) whether the employer may control the manner in which the person performs the work; (2) whether the employer dictates the person's schedule; (3) whether the employer compensates the person on an hourly basis; (4) whether the employer withholds income and social security

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taxes from the person's compensation; (5) whether the employer may discharge the person at will; and (6) whether the employer supplies the person with materials and equipment. *Roberson*, 225 Ill. 2d at 175. Another relevant factor is the nature of the work performed by the alleged employee in relation to the general business of the employer. *Id.*; see also *Ware*, 318 Ill. App. 3d at 1122. The label the parties place on their relationship is also a consideration, although it is a factor of "lesser weight." *Ware*, 318 Ill. App. 3d at 1122. The significance of these factors rests on the totality of the circumstances, and no single factor is determinative. *Roberson*, 225 Ill. 2d at 175. Nevertheless, whether the purported employer has a right to control the actions of the employee is "[t]he single most important factor." *Ware*, 318 Ill. App. 3d at 1122; see also *Bauer v. Industrial Comm'n*, 51 Ill. 2d 169, 172 (1972). The nature of the claimant's work in relation to the employer's business is also an important consideration. *Kirkwood*, 84 Ill. 2d at 21; *Steel & Machinery Transportation, Inc. v. Illinois Workers' Compensation Comm'n*, 2015 IL App (1st) 133985WC, ¶ 31. *Esquinca v. The Illinois Workers' Compensation Commission*, 2016 IL App (1st) 150706WC, ¶47.

A. Employment Relationship

The single most important factor is the right of control. Certainly Petitioner owned the truck, but the control asserted by Respondent is indicative of an employment relationship. Petitioner hauled exclusively for Respondent during his employment. The driving manifests and testimony of Petitioner and Mr. Al-Amin evidence Petitioner began his employment on August 21, 2012, and he drove without interruption through October 30, 2012. PX4; T. 30; 80. Petitioner testified he failed to work one week due to a disagreement with the dispatcher, but the issue was resolved after a discussion with Mr. Rafi Al-Amin. T. 53-54. In contrast, Mr. Al-Amin testified Petitioner was asked to undergo a random drug test which Petitioner indicated he could not pass. T. 85-86. As such Petitioner decided not to work for a time period presumably so he could avoid and/or pass the drug test at a later date. The Commission finds Petitioner's testimony more credible than that of Mr. Rafi Al-Amin.

Not only did Petitioner work exclusively for Respondent, his deliveries were pre-determined by Respondent and commenced each week on Friday. Mr. Rafi Al-Amin testified Respondent provided twice weekly service to the East Coast on either Tuesday or Friday, and Mr. Rafi Al-Amin identified Petitioner as a Friday truck. T. 84. Such facts indicate a level of control consistent with an employee/employer relationship as Petitioner's schedule was dictated solely by Respondent.

Additionally, Respondent had the authority to discharge Petitioner at will. Petitioner testified he was terminated by Respondent when he could no longer perform his job and received a letter advising him accordingly. T. 30. Mr. Rafi Al-Amin did not dispute this testimony. In fact, Mr. Rafi Al-Amin confirmed Respondent's ability to terminate Petitioner at will testifying if Petitioner failed a drug test, he would either be terminated or allowed to enter a drug treatment

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program. T. 92-93. Again such is consistent with an employment relationship as is the requirement that Petitioner pass a pre-employment drug test even if the same may be required by the rules of the Department of Transportation. T. 80.

Factors exist which weigh towards an independent contractor relationship such as Petitioner's ownership of the truck (T. 78); Petitioner's ability to hire his brother to perform loading services (T. 45); method of payment (PX4); and the purported lease agreement (T. 78), but taken as a whole, the evidence supports a finding of an employment relationship. Further the nature of the work supports a finding of an employment relationship. Respondent is an over the road LTL, less than truck load refrigerated carrier which services the food industry. T. 77. Petitioner's job was to transport the product for Respondent's customers, and Petitioner did so exclusively for Respondent from his date of hire. The Commission believes contracting parties are free to establish an employment relationship in a manner in which they see fit even if the nature of the business involves over the road trucking and this does not necessarily pre-ordain a finding of the establishment of an employee/employer relationship. The facts of the present case lead to the conclusion Petitioner established the existence of an employee/employer relationship notwithstanding the fact Petitioner was entitled to coverage under workers' compensation insurance even assuming *arguendo* an independent contractor relationship given his purchase of such coverage.

B. Accident

"We begin our analysis by recognizing that in order for an injury to be compensable under the Workers' Compensation Act, the injury must 'arise out of' and 'in the course of' the employment. (Ill. Rev. Stat. 1987, ch. 48, par. 138.2.) The phrase 'in the course of' refers to the time, place and circumstances under which the accident occurred. (*Orsini v. Industrial Comm'n (1987), 117 Ill. 2d 38, 44.*)." *Caterpillar Tractor Company v. The Industrial Commission*, 129 Ill. 2d 52, 57 (1989). "Injuries sustained at a place where the claimant might reasonably have been while performing his duties, and while a claimant is at work, or within a reasonable time before and after work, are generally deemed to have been received in the course of the employment. *Caterpillar Tractor Co., 129 Ill. 2d at 57*; *Wise v. Industrial Comm'n, 54 Ill. 2d 138, 142, 295 N.E.2d 459 (1973).*" *Cox v. Illinois Workers' Compensation Commission*, 406 Ill. App. 3d 541, 545 (2010). The Commission finds Petitioner proved he sustained an accident on October 4, 2012 which arose of and occurred in the course of his employment.

Petitioner credibly testified on October 4, 2012 he was performing a delivery at John R. Morreale when he injured his back. T. 11. The driver's manifest confirms Petitioner was making a delivery at John R. Morreale on October 4, 2012. Petitioner's injury occurred in the course of his employment.

"Typically, an injury arises out of one's employment if, at the time of the occurrence, the employee was performing acts he was instructed to perform by his employer, acts which he had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to his assigned duties. [citations omitted]." *Caterpillar Tractor Company v. The Industrial Commission*, 129 Ill. 2d 52, 58 (1989). Petitioner credibly testified

while unloading product he slipped and fell, an act Respondent would reasonably expect Petitioner to perform incidental to his duties to haul product. T. 11. (Under a traveling employee analysis, Petitioner's injury arises out of his employment as such conduct was reasonable and foreseeable. See *Cox v. Illinois Workers' Compensation Commission*, 406 Ill. App. 3d 541 (2010)). There exists slight discrepancies in the initial histories provided by Petitioner to his medical providers as to the mechanism of injury and/or date of accident but taken as a whole, Petitioner proved an accident occurred on October 4, 2012.

As for notice, Petitioner credibly testified he advised Mr. Rafi Al-Amin on October 4, 2012 as to the particulars of his accident. T. 16-17. Mr. Rafi Al-Amin testified on October 4, 2012 he witnessed Petitioner having difficulty walking and slumped over and inquired about Petitioner's condition. Mr. Rafi Al-Amin testified Petitioner advised of an injury to his back but denied Petitioner advised it was due to a work injury. T. 90. The Commission finds Petitioner's testimony credible over that of Mr. Rafi Al-Amin. Additionally, Mr. Rafi Al-Amin testified he subsequently received notice of the accident through dispatch as well as the possibility his brothers were advised by Petitioner of the accident. T. 97-98. Such is consistent with Petitioner's testimony he advised Adrienne and Tyrek Al-Amin of his accident. T. 79.

C. Causal Relationship

The Commission finds Petitioner proved a causal relationship between his accident of October 4, 2012 and his subsequent need for treatment. After an emergency room visit on November 2, 2012, Petitioner sought treatment with Dr. Matthew Meyer who subsequently referred Petitioner to Dr. Matthew Maserati. PX2 & PX3. Following diagnostic testing and conservative treatment of physical therapy and injections, Dr. Maserati performed surgery on April 15, 2013 consisting of a minimally invasive right L4 hemilaminotomy, partial medial facetectomy, foraminotomy, and discectomy. Due to continued pain complaints voiced by Petitioner, Dr. Maserati performed surgery on August 22, 2013 consisting of a re-exploration of right L4-L5 microdisectomy. Dr. Maserati re-evaluated Petitioner on September 4, 2013 at which time physical therapy was recommended. Petitioner was authorized to drive and lift up to 25 lbs. but was not released to return to work until his re-evaluation on October 2, 2013. There is no documentation of an evaluation on October 2, 2013 other than an off work note. PX3.

The Commission finds Petitioner reached maximum medical improvement as of October 2, 2013 given the medical records do not evidence any additional medical treatment after this date other than on one occasion more than two years later. As such his condition had stabilized.

D. Temporary Total Disability Benefits

"To show entitlement to TTD benefits, claimant must prove not only that he did not work, but that he was unable to work. [citation omitted]." *City of Granite City v. The Industrial Commission*, 279 Ill. App. 3d 1087, 1090, 666 N.E.2d 827 (1996). Petitioner was authorized off work by Dr. Meyer as of December 6, 2012. PX2. Both Dr. Meyer and Dr. Maserati continued to authorize Petitioner off of work throughout their treatment. PX2 & PX3. Further "[t]he dispositive test is whether the claimant's condition has stabilized, that is, whether the claimant has reached maximum medical improvement. [Citation omitted]." *Mechanical Devices v. The*

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Industrial Commission, 344 Ill. App. 3d 752, 759. Petitioner reached MMI as of October 2, 2013. The Commission finds Petitioner is entitled to temporary total disability benefits of $1295.47 per week for the period of December 6, 2012 through October 2, 2013 or 43 weeks pursuant to §8(b) of the Act.

E. Medical Expenses

Section 8(a) of the Illinois Workers' Compensation Act entitles a claimant to recover medical expenses which are reasonable, necessary, and causally related to an accident. *820 ILCS 305/8(a)* (West 2010); *Zarley v. The Industrial Commission*, 84 Ill. 2d 380, 418 N.E.2d 718 (1981). The Commission finds Petitioner is entitled to payment of medical bills contained in PX1 through October 2, 2013 (date of MMI) and awards the same pursuant to §§8(a) and 8.2 of the Act.

F. Permanent Partial Disability Benefits

Petitioner testified he was terminated by Respondent but has not looked for employment since the accident. T. 36. Petitioner testified he is presently receiving social security disability benefits. T. 39. Petitioner testified since the second surgery he has not undergone any significant medical treatment other than physical therapy and steroid injections. T. 36.

The medical records evidence Petitioner last sought treatment with Dr. Maserati on September 4, 2013 at which time he complained of burning pain in his left leg and trouble ambulating. PX3. Dr. Moossy evaluated Petitioner on December 8, 2015 and recommended either a spinal cord stimulator or a spinal fusion both procedures which Petitioner declined. PX5 & T. 38-39. Further there is no opinion from Dr. Moossy that the recommended treatment is a result of the October 4, 2012 accident.

The Commission weighs the following five factors accordingly:

1) AMA Impairment Rating- Neither party obtained an impairment rating, so no weight is assigned to this factor.
2) Occupation of Petitioner- Petitioner testified he has not returned to work in his occupation as a truck driver but admitted he has not looked for employment. The Commission assigns no weight to this factor.
3) Age of Petitioner- The Stipulation Sheet memorializes Petitioner was 41 years of age at the time of the accident. Petitioner has a significant work life expectancy which will require him to manage the effects of his injury for a greater period of time. As such the Commission assigns weight to this as an aggravating factor.
4) Petitioner's Future Earning Capacity- Petitioner testified he is currently receiving social security disability benefits but provided no testimony regarding any effect on his future earning capacity. As such the Commission assigns weight to this as a mitigating factor.
5) Evidence of Disability/Treating Records- Petitioner testified he is in constant pain requiring pain medication. T. 35. Petitioner testified he goes numb if he sits for prolonged periods of time and experiences bouts of urinary incontinence. *Id.* The September 4, 2013 medical record of Dr. Maserati memorializes Petitioner's

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complaints of pain and numbness as well as use of pain medication. PX3. As such the Commission assigns weight to this as an aggravating factor.

Based upon the above numerated factors as well as the record taken as a whole, the Commission awards Petitioner permanent partial disability benefits of $712.55/week for the period of 100 weeks, because the injuries sustained caused the loss of use of 20% of person as a whole, as provided by §8(d)2 of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's June 16, 2016 decision is reversed for the reasons stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,295.47 per week for a period of 43 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 for medical expenses contained in Petitioner's Exhibit 1 through October 2, 2013 pursuant to §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $712.55 per week for a period of 100 weeks, as provided in §8(d)2 of the Act, for the reason that the lumbar spine injuries sustained caused the permanent disability of the person as a whole to the extent of 20%.

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 13 2017
LEC/maw
o05/17/17
43

L. Elizabeth Coppoletti

Joshua D. Luskin

Charles J. DeVriendt

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

Catherine Berger,
Petitioner,
vs.

NO: 12 WC 01388

Illinois Department of
Commerce & Economic Opportunity,
Respondent,

17IWCC0463

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, 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 December 15, 2016, 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.

JUL 21 2017

DATED:
o062917
DLG/mw
045

David L. Gore

Stephen Mathis

Kevin Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BERGER, CATHERINE
Employee/Petitioner

Case# **12WC001388**

IL DEPT OF COMMERCE & ECONOMIC OPPORTUNITY
Employer/Respondent

17IWCC0463

On 12/15/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.64% shall accrue from the date listed above to the day before the 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
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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

DEC 15 2016

RONALD A RASCIA Acting Secretary
Illinois Workers' Compensation Commission

C. Berger v. Illinois Dept. of Commerce, etc.

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

Catherine Berger
Employee/Petitioner

Case # 12 WC 01388

IL Dept. of Commerce & Economic Opportunity
Employer/Respondent

17IWCC0463

An *Application for Adjustment 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 **October 6, 2016**. After reviewing all of the 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 _____

C. Berger v. Illinois Dept. of Commerce, etc.

17IWCC0463

FINDINGS

On **1/5/2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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* causally related to the accident.

In the year preceding the injury, Petitioner earned **$74,147.80**; the average weekly wage was **$1,425.92**.

On the date of accident, Petitioner was **56** 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

Claim for compensation denied. Petitioner failed to prove that she sustained accidental injuries which arose out of and in the course of her employment by Respondent.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 14, 2016
Date

ICArbDec p. 2

DEC 15 2016

FINDINGS OF FACT

Petitioner worked for Respondent as an Executive Assistant from 2005 to 2015. She worked on the 3rd floor of the James R.Thompson Center (JRTC) , a building owned by Respondent, State of Illinois. Petitioner was working for Respondent on January 5, 2012. That afternoon, Petitioner took a walk for her afternoon break. She was walking through the ground floor atrium of the JRTC when her right foot slipped and she fell to the ground. Petitioner testified that she was on a mandatory, paid, break and was returning to her office from going to the bank. She testified that she walks to stretch her legs during her breaks. She testified that Respondent suggests that employees leave Respondent's premises for their breaks. She was not required to leave the premises on her break. After the fall, Petitioner immediately felt pain in her right arm, left arm, and left shoulder. Upon surveying the scene Petitioner saw a yellow cone, approximately 18-24 inches high, placed on the marble floor in the area when she had slipped. Petitioner testified that she was wearing rubber-soled heels and that she believes that she slipped on something slick. In her mind, Petitioner thought that she slipped on something wet, but she did not see anything. Petitioner's fall was on the street level of the building in the area near the Randolph/Clark street entrances. She fell in front of what is now the Walgreens. The Illinois State Police immediately responded and Petitioner was transported to Northwestern Memorial Hospital, via ambulance.

Petitioner filled out a Notice of Injury, dated January 20, 2012. In this document, she reported that her right heel slipped on something on the floor. After she fell, she noticed the yellow cone about 6-8 feet from where she slipped. The weather outside was dry all day and she did not know why the cone had been placed there. She did not report that the floor was wet and did not say that her pants or purse was wet. (PX 1) After Petitioner submitted the injury report, she was advised that her claim was denied.

The JRTC building has entrances on 3 sides of the building. Respondent did not direct her as to which entrance to use. The building is open to and used by various members of the public. At least hundreds of people come through the JRTC every day.

Petitioner was treated in the emergency department at Northwestern. She complained of left shoulder pain radiating to her elbow. X-rays of Petitioner's left arm revealed a non-displaced fracture of the left greater tuberosity and a mildly displaced fracture fragment from the surgical neck. According to the triage notes, Petitioner reported that she had been walking and her right foot slipped on a marble floor and she fell, bracing herself with her left arm. The history contained in the ATTENDING INPUT was: "Pt is a 56 yo female o/w healthy who slipped on wet floor falling on outstretched hand. Had pain to her L shoulder immediately with limited ROM." The nurses' notes state that she was walking and tripped on a marble floor. The history of present illness states that the patient was walking at work on a marble floor and slipped. Petitioner was discharged with a sling, prescribed Norco and was advised to follow up with an orthopedist. (PX 2)

Petitioner sought follow up care with Dr. Robert Carbone, her PCP, at DuPage Medical Group on January 9, 2012. Dr. Carbone noted that Petitioner had slipped and fallen at work on January 5, 2012. (PX 3) Petitioner was referred for an orthopedic consultation. On January 11, 2012, she saw Dr. Samuel Park with DuPage Medical Group. Dr. Park diagnosed the Petitioner with fractures in her left arm, placed Petitioner in a sling, and took Petitioner off work until January 17, 2012. Petitioner testified that she used her personal days and received full pay from the Respondent while she was off work during the lost time from work.

Petitioner followed up with Dr. Park on January 18, 2012 and physical therapy was ordered. It was noted that the fracture alignment was maintained. Petitioner had physical therapy performed at DuPage Medical Group from January 20, 2012 through March 31, 2012. (PX 3)

Petitioner followed up with Dr. Park on February 6, 2012 and it was noted that the fractures were healing. Physical therapy was continued. On April 2, 2012, Petitioner again saw Dr. Park and it was noted that she was having difficulty reaching behind her back and had a positive impingement test in her left shoulder. Dr. Park recommended an MRI and discussed injections, which the Petitioner declined. Petitioner testified that it was discussed that she could potentially have surgery or simply live with the issues. This is not charted. (PX 3)

An MRI of the Petitioner's left shoulder, performed on May 19, 2012 at Chicago Ridge Radiology, revealed mild degenerative changes of the A/C joint, partial tear of the supraspinatus tendon, tendinosis of the distal subscapularis tendon and impingement. (PX 4)

Following the MRI, Petitioner did not seek any further medical care for her condition, opting to "live with it", as she did not wish to have any surgery. Petitioner testified that prior to January 5, 2012 she had never had any issues with her left shoulder or arm. Since the injury, she has been unable to do things such as swim, push herself up from a seated position, or lift things such as pans. She continues to complain of pain, weakness, and limited range of motion. She takes Aleve whenever she has pain, which is typically twice per month. She is right handed and performs most tasks with her right upper extremity.

Respondent submitted no witnesses or documentary evidence. Neither Party submitted any video evidence.

CONCLUSIONS OF LAW

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

B. ACCIDENT

Petitioner failed to prove that she sustained accidental injuries which arose out of and in the course of her employment by Respondent on January 5, 2012.

Petitioner was on break and in Respondent's building where she worked (albiet in an area regularly traversed by members of the public who are not employees of Respondent) when she slipped and fell, injuring her left arm. The injury occurred in the course of her employment.

If the fall occurred on Respondent's premises and it was due to a hazardous condition of the premises, the injury would arise out of Petitioner's employment. In this case, Petitioner's testimony, the Notice of Injury, and the medical records do not establish that there was a hazardous condition of Respondent's premises that caused

the fall. There is a lack of evidence regarding what Petitioner slipped on. Therefore, it cannot be said that Respondent's premises was defective and contributed to the fall. Liability cannot be based upon conjecture-it must be based on facts contained in the Record. Here, it was not shown that the fall was as a result of a hazardous condition of Respondent's premises or was associated with a risk incidental to or connected with the employment. Caterpillar Tractor Co. v. Industrial Comm'n, 129 Ill.2d 52 (1989)

The injury did not arise out of Petitioner's employment by Respondent. Therefore, the claim for compensation is denied.

F. CAUSAL CONNECTION; J. MEDICAL EXPENSES; L. NATURE & EXTENT

As the Arbitrator has found that Petitioner failed to prove that she sustained accidental injuries which arose out of and in the course of her employment by Respondent, the Arbitrator needs not decide these issues.

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

Elaine Theobold,
Petitioner,
vs.
Rockford Mass Transit,
Respondent.

NO: 12WC 44320

17IWCC0448

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 6, 2016, 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: JUL 14 2017
MJB/bm
o-7/11/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

THEOBALD, ELAINE
Employee/Petitioner

Case# **12WC044320**
13WC017909

ROCKFORD MASS TRANSIT
Employer/Respondent

17IWCC0448

On 9/6/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.48% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0139 CORNFIELD & FELDMAN LLP
JIM M VAINIKOS ESQ
25 E WASHINGTON ST SUITE 1400
CHICAGO, IL 60602

0563 WILLIAMS McCARTHY LLP
CAROL A HARTLINE
120 W STATE ST SUITE 400
ROCKFORD, IL 61105

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

Elaine Theobald
Employee/Petitioner

v.

Rockford Mass Transit
Employer/Respondent

Case # **12** WC **44320**

Consolidated cases: **13 WC 17909**

17IWCC0448

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Rockford**, on **July 15, 2016**. After reviewing all of the 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 _____

17IWCC0448

FINDINGS

On **October 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 $**49,708.29**; the average weekly wage was $**955.93**.

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

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

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

Respondent shall be given a credit of $**0.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**8,390.94** for other benefits, for a total credit of $**8,390.94**.

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

ORDER

Respondent shall pay reasonable and necessary medical services of $19,565.37, as provided in Sections 8(a) and 8.2 of the Act to the providers as listed in Petitioner's Exhibit 14 including the out of pocket costs incurred by Petitioner of $70.61. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $637.29/week for 47 3/7 weeks, commencing November 16, 2012 through April 23, 2013, and commencing May 14, 2013 through November 3, 2013, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $**8,390.94**.

Respondent shall pay Petitioner permanent partial disability benefits of $573.56/week for 37.5 weeks, because the injuries sustained caused the 7.5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

September 1, 2016
Date

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SEP - 6 2016

Statement of Facts

Petitioner filed two separate Applications for Adjustment of Claim: 12 WC 44320 (accident date: October 19, 2012) and 13 WC 17909 (accident date: May 11, 2013) alleging accidental injuries to her right arm and shoulder. These matters were consolidated for hearing and a single transcript was prepared. The Arbitrator has issued separate decisions with respect to these claims.

Petitioner Elaine Theobald testified that she was employed by Respondent Rockford Mass Transit since December 20, 1995. In October, 2012, she was a fixed route bus driver. Her duties were to pick up and transport passengers. Petitioner testified that she is 5' 9" tall. She is right handed. The Petitioner identified Respondent's Exhibit 2 as the Recaro driver's seat she would use. Petitioner testified that she was required to change the head sign. The head sign panel is a small square panel. She pushes the buttons on it to change the sign on the outside of the bus. Petitioner identified Petitioner's Exhibit 13 as showing this panel above her head on the bus. Petitioner testified that in order to reach the head sign she needed to lift herself out of the seat and reach with her right arm to push the button to change the sign. She would change the sign every hour, 8 times a day.

Cedric Ketton testified for Respondent. He testified that he was originally employed as a bus driver for the respondent until 2005 and returned in 2009 as a bus driver. In 2011, he was promoted to supervisor. He knew Petitioner through training and supervising her occasionally. In training, he shows drivers the location of the controls and how to change the sign. Mr. Kenton viewed the videotape admitted as Respondent's Exhibit 1. The video accurately depicts the seat set up and controls. The video accurately shows the control pad for the head sign in the 700 series. To change the sign, you have to get out of the chair and reach up to change the buttons. The driver puts in the digits on the control pad to make the change. It does not take much force. Mr. Ketton is 6 feet tall, and from a seated position he can touch the panel but can't reach to change the buttons. When he worked as a driver, he would stand up to change the sign. He trains people to stand up to change the sign. When standing to change the sign the arm is at a 45 degree angle, and the shoulder is at 90 degrees. The video also demonstrates a shorter female, 5'3" to 5'4" standing to change the sign with the arm bent at the elbow without stress on the shoulder.

Petitioner testified that on October 19, 2012 she got out of her seat and stepped up on a little step to reach up with her right arm and change the head sign. Petitioner testified that she felt a pop in her shoulder, but continued to change the head sign. She continued to work that day. She had only two more runs remaining and finished her shift. Petitioner testified she was off work for a long weekend and returned on Tuesday October 23, 2012. She testified that as she continued to work her regular duty over the next few days, she noticed her pain increasing. Petitioner did not report the accident on the date it occurred. She mentioned it to Cedric on the date she went to the hospital for medical care.

Petitioner first sought medical treatment on October 25, 2012 at the Swedish American Hospital Emergency Room. The records of Swedish American were admitted as Petitioner's Exhibit 1. Petitioner provided a history of injury to the right shoulder on Friday reaching above her head. She reported she over extended reaching to change a sign. She reported she heard a pop. She complained of pain in the right shoulder and pain with raising her arm internally and above her head. She was diagnosed with a sprain and advised to follow up with Dr. Stocker (PX 1).

Petitioner saw Dr. Stocker on October 27, 2012. She was given restrictions. On November 16, 2012, Dr. Stocker ordered an MRI of the right shoulder and took Petitioner off of work. The MRI performed on November

30, 2012 found impingement, rotator cuff partial tear, possible labral tear and possible bursitis. On December 3, 2012, Dr. Stocker referred Petitioner to Lundholm Orthopedics (PX 2).

Petitioner was seen by Dr. Milos beginning January 2, 2013. Petitioner provided a consistent history of reaching up to change a sign and feeling a "pop." Petitioner complained of severe right shoulder pain with limited range of motion. Dr. Milos noted that the MRI showed a high grade partial rotator cuff tear, but her symptoms are more related to adhesive capsulitis. Dr. Milos provided an injection, prescribed physical therapy and an anti-inflammatory cream. He ordered restricted work activity of no driving city buses, lifting of 5 pounds to waist level and no overhead reaching. On February 12, 2013, Petitioner continued having significant pain despite conservative treatment. She reported she has been unable to return to work. Dr. Milos discussed continued conservative care versus surgical repair. On April 8, 2013, Dr. Milos released Petitioner to return to full unrestricted duty as of April 23, 2013 (PX 1). Petitioner had a Fitness for Duty physical with Dr. Bashku at Physicians Immediate Care on April 19, 2013. His report states that the shoulder is now feeling fine and has no pain. The exam is completely normal. He released Petitioner to return to full duty (PX 3).

Petitioner was examined by Dr. Borchardt at Respondent's request on December 12, 2012. The report of that examination was admitted as Respondent Exhibit 4. Dr. Borchardt recorded a history that on October 19, 2012, Petitioner reached up with her right arm to change her bus designation and felt a pop in her shoulder. Petitioner complained of pain with movement and loss of strength. Dr. Borchardt reviewed the treatment records and the MRI performed on November 30, 2012. He performed a physical examination. His impression was a right shoulder rotator cuff tear with acromioclavicular osteoarthritis, impingement syndrome, and possible adhesive capsulitis (RX 4).

Dr. Borchardt went on site and performed the activity of changing the sign as described by Petitioner. Dr. Borchardt stated that it would be impossible for Petitioner to change the sign in a seated position given her height. She would have to stand up, and then her shoulder would be in a bent position. Dr. Borchardt found that pushing the buttons requires very little force. Dr. Borchardt opined that raising her arm would not have caused the significant injuries she has. He further opines that he does not believe her current diagnosis is related to her job activities. He states her impingement syndrome and a grade three acromial process would contribute to her diagnosis. He agrees that Petitioner is not at MMI and that arthroscopic surgery is necessary. He recommends that Petitioner have restrictions (RX 4).

Petitioner testified that she returned to work on April 23, 2013. She noticed her arm was better, but was still quite guarded. It was stiffer than before. She worked until her alleged second accident on May 11, 2013 (the subject of consolidated claim 13 WC 17909). Petitioner testified that on that Saturday, she began her shift at 6:00 AM. She had a problem with the bus on the first run. When she returned to the main garage, Bill the dispatcher had brought out the wrong series bus for her and she was told to go into the garage to get another. While in the garage she had a conversation with her supervisor Michael Amans as to why she was taking another bus. She testified he yelled at her. She testified that she left on her 7:15 AM run a little late. When she returned to the garage, there was another bus in her berth. She testified that means someone else was going to cover her run.

Petitioner testified that she went to dispatch to find out what was going on. She was asked to go to the garage by Mr. Amans. He told her that he was going to train her on the 1300 series bus. They went over the controls and the wheelchair hook up. Petitioner testified that they had completed the training and she was sitting in the driver's seat when Mr. Amans grabbed her right wrist in both of his hands and twisted it behind her back to the

knob on the seat. Pain shot through her shoulder. She testified that she was in fear, so she clammed up and walked off the bus. Petitioner testified that she finished her shift and reported the incident to LaVonne, another dispatcher.

Petitioner testified that she had reported prior accidents without fear. She had prior "discussions" with Mr. Amans where he wanted her to do something and she told him she could not do it. She wrote him up at least a couple of times before the May, 2013 incident. She testified she was told that Mr. Amans thinks he owns the company. She testified that she felt the company should handle it. Petitioner and Mr. Amans had issues and discussions about the dress code. She testified that Mr. Amans would grab her tie and try to fix it for her. She testified that she tried to avoid him. Petitioner filed an EEOC claim with respect to the May 11, 2013 incident. She received a dismissal and notice of rights from the EEOC. Petitioner also called the Rockford Police Department and told them Mr. Amans assaulted her. The police never charged him.

Michael Amans testified for Respondent. He testified that he was a safety supervisor for approximately 15 years. He retired from Respondent in April of 2015. He would occasional do route supervision. He would supervisor Petitioner approximately every other Saturday. On May 11, 2013, he was the supervisor on duty. He testified that Petitioner would have started her shift at 6:05 AM. The first time he spoke with Petitioner that day is when he received a call from the garage that she had a problem with her bus. He assumed that the problem was that she did not want to take out the bus she was assigned. Petitioner had a medical exemption not to drive one of model buses, and an arrangement was made that if she got a bus that she didn't want to drive, she was supposed to take it out for the first run and give the garage a chance to replace it. Mr. Amans testified that he put a show up driver on the route. He and Petitioner discussed the issue. Mr. Amans testified that she was angry.

Mr. Amans testified that he decided to train Petitioner on a new 1300 series bus while they waited for the route bus to come back. The training started almost immediately after this conversation. Mr. Amans testified that Petitioner did not take any initial run before the training. He testified that training started around 6:20 AM. The training took place in the garage. When the training started, Petitioner was in the driver seat and he was standing right alongside her at the fare box pointing out the control panels. Respondent's Exhibit 2 depicts the type of seat Petitioner was seated in at the time of the training. There was no argument or disagreement with Petitioner during the training. Mr. Amans testified that Petitioner acted like she didn't know where the control knob was for the seat back tilt. He reached up and took her right hand from the 3 o'clock position on the steering wheel and said "Elaine, the control knob is back here for the seat." Mr. Amans testified that there was a little sarcasm in his voice. Mr. Amans denied that he took her arm or wrist with both hands. He did not twist her arm back. He did not yell at her. Mr. Amans testified that Petitioner did not scream out in pain. She did not indicate she was injured. The training took about 15 minutes. He then put Petitioner back out on her route. He went back upstairs.

Mr. Amans testified he was called by police the following Tuesday. He was interviewed by the police and upper management. He was not charged with any crime. Mr. Amans testified that he had a strained relationship with Petitioner. He did not feel she was a very good employee. She was not a very good driver. She had no respect for the company. Before the training on May 11, 2013, he was aware that Petitioner had been off work but he did not know that she had a shoulder injury.

Petitioner went to Physicians Immediate Care on May 11, 2013. The record states that Petitioner has an extensive history of ongoing shoulder problem. Today she reinjured her arm when supervisor pulled right arm

behind back (PX 3). Petitioner was given an off work note by Dr. Milos' physician's assistant on May 14, 2013 (PX 1). Petitioner saw Dr. Stocker on May 22, 2013 with the same history. Petitioner stated she has been under a lot of stress with her shoulder symptoms (PX 2). She continued her care with Dr. Milos. A May 21, 2013 MRI noted partial thickness tears which had worsened since the earlier study, a possible labral tear and mild bursitis (PX 1). Dr. Milos performed an arthroscopic debridement and subacromial decompression on July 2, 2013. The post operative diagnosis was partial thickness rotator cuff tear, less than 25%, impingement syndrome and labral tear. Dr. Milos released Petitioner to modified work on September 23, 2013 and to full, unrestricted duty effective November 4, 2013 (PX 1).

Dr. Milos prepared a report dated January 13, 2014 which was admitted as Petitioner Exhibit 4. He notes some confusion as to the date of accident, but states that Petitioner reported that she was reaching up to change the sign on a bus when she felt a pop in her shoulder and had aching and burning and severe limitation of motion. Dr. Milos stated he evaluated Petitioner and felt she had adhesive capsulitis which can occur from injuries and strains of the shoulder capsule. He opined that the reported accident is a reasonable mechanism that could explain the development of the condition. Dr. Milos states that he advised Petitioner surgery was an option when he saw her in February, 2013. Dr. Milos noted Petitioner's improvement with therapy and that he anticipated continuing therapy to work on overhead motion pain and shoulder mechanics (PX 4).

Dr. Milos stated his physician assistant saw Petitioner on May 16, 2013 and that she reported that her supervisor moved her arm posteriorly. A new MRI was performed on May 21, 2013 and read as showing a minimal worsening of the changes in the shoulder. On July 2, 2013, Petitioner underwent surgery to the right shoulder, with findings of less than 25% thickness tear of the rotator cuff so no procedure was performed on the rotator cuff tendon. Petitioner had a type III acromion with bursitis that was shaved down, and a labral tear was debrided. After surgery Petitioner attended physical therapy and follow up visits. She was seen for a final visit with Dr. Milos on December 9, 2013. At that time she had some neck pain and trapezial symptoms, therefore the doctor provided her a prescription for a TENS unit. Petitioner was discharged from his care at that time (PX 4).

Dr. Milos opined Petitioner had an acute event when she reached up to change the sign that is consistent with her symptoms and the pain she experienced. The second injury can also be consistent with her complaints, so he believes that both of those incidents may have caused and aggravated her symptoms (PX 4).

Petitioner testified that she does not have the free range of motion she had before this accident. She cannot extend the arm because of stiffness and she guards the arm. Her reaching ability is limited. Washing and blow drying her hair is a difficult task. Petitioner testified she has not seen Dr. Milos since November, 2013. He did not provide any permanent restrictions. She is not taking any medication for her shoulder. She has been performing her regular job duties as a fixed route driver.

Conclusions of Law

In support of the Arbitrator's decision with respect to (C) Accident, the Arbitrator finds as follows:

To obtain compensation under the Act, the claimant must show, by a preponderance of the evidence, that she suffered a disabling injury that arose out of and in the course of her employment. An injury occurs "in the

course of employment when it occurs during employment and at a place where the claimant may reasonably perform employment duties, and while a claimant fulfills those duties or engages in some incidental employment duties. An injury "arises out of" one's employment if it originates from a risk connected with, or incidental to, the employment and involves a causal connection between the employment and the accidental injury. There are three categories of risks an employee may be exposed to: (1) risks distinctly associated with the employment; (2) risks personal to the employee; and (3) neutral risks which have no particular employment or personal characteristics.

Petitioner testified that her injury occurred on October 19, 2012. She testified that when she got out of her seat to reach up with her right arm to change the head sign, she felt a pop in her shoulder. Petitioner provided a consistent history of this mechanism of injury at the emergency room, to Dr. Stocker, Dr. Milos and Dr. Borchardt. The Arbitrator finds Petitioner's testimony that she felt a pop while changing the head sign credible. There is no dispute that this activity occurred during the course of her employment.

The Arbitrator finds that the act of reaching upward from the driver's seat of a bus to change the head sign is a risk associated with the employment. *Young v. Ill. Workers Comp. Comm'n*, 2014 IL App (4th) 130392WC; 13 N.E.3d 1252; 2014 Ill. App. LEXIS 498; 383 Ill. Dec. 131 (4th Dist, 2014). An injury arises out of one's employment if, at the time of the occurrence, the employee was performing acts he was instructed to perform by his employer, acts which he had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to his assigned duties. A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties. Here, Petitioner's injury arose out of an employment-related risk and is compensable. The record shows claimant was injured while performing her job duties, namely reaching up to change the head sign a required part of her assignment. This task and the mechanism of injury described are distinct to her job duties as a bus driver and connected with her assigned duties.

Based upon the record as a whole, the Arbitrator finds that Petitioner proved by a preponderance of the evidence that she sustained accidental injuries arising out of and in the course of her employment with Respondent on October 19, 2012.

In support of the Arbitrator's decision with respect to (F) Causal Connection, the Arbitrator finds as follows:

Based upon the Arbitrator's finding with respect to Accident, the Arbitrator finds Petitioner sustained an injury to her right shoulder as a result of the accidental injuries sustained on October 19, 2012. Petitioner has no history of any prior complaints or treatment to the right shoulder. She sought medical treatment within a few days of the injury and provided a consistent history of the accident and the acute onset of symptoms. The MRI performed on November 30, 2012 found impingement, rotator cuff partial tear, possible labral tear and possible bursitis. On January 2, 2013, Dr. Milos noted that the MRI showed a high grade partial rotator cuff tear, but her symptoms are more related to adhesive capsulitis. Dr. Milos states that he advised Petitioner surgery was an option when he saw her in February, 2013. Dr. Milos stated he felt Petitioner had adhesive capsulitis which can occur from injuries and strains of the shoulder capsule. He opined that the reported accident is a reasonable mechanism that could explain the development of the condition.

Dr. Borchardt performed the activity of changing the sign as described by Petitioner. Dr. Borchardt opined that raising her arm would not have caused the significant injuries she has. He further opines that he does not

believe her current diagnosis is related to her job activities. He states her impingement syndrome and a Grade III acromial process would contribute to her diagnosis. He agrees that Petitioner is not at MMI and that arthroscopic surgery is necessary.

The Arbitrator notes that Dr. Borchardt acknowledged her condition of impingement syndrome and a Grade III acromial process. He agreed that Petitioner was a candidate for arthroscopic surgery on the right shoulder. The Arbitrator notes that Dr. Milos noted that the MRI showed a high grade partial rotator cuff tear, but her symptoms are more related to adhesive capsulitis. The surgery performed on July 2, 2013 confirmed findings of less than 25% thickness tear of the rotator cuff so no procedure was performed on the rotator cuff tendon. Petitioner had a type III acromion with bursitis that was shaved down, and a labral tear was debrided. This is consistent with Dr. Milos' assessment.

Based upon the medical evidence submitted, the Arbitrator finds the opinions of Dr. Milos more persuasive that those of Dr. Borchardt. The Arbitrator finds that Petitioner suffer an aggravation of her right shoulder impingement and adhesive capsulitis and finds that Petitioner's condition of ill being in the right shoulder is causally connected to the accidental injuries sustained on October 19, 2012.

Petitioner suffered an additional injury on May 11, 2013 which is the subject of the consolidated case 13 WC 17909. As more fully discussed in the decision in that claim, the Arbitrator finds that that injury was not a permanent aggravation or intervening injury with respect to Petitioner's condition of ill being in the right shoulder, which condition therefore remains related to the original injury on October 19, 2012. The Arbitrator finds that Petitioner's condition of ill being after May 11, 2013, including her treatment and disability, remains causally connected to the accidental injuries sustained on October 19, 2012.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that the condition of ill being in her right shoulder including all treatment, lost time and disability is causally related to the accidental injuries sustained on October 19, 2012.

In support of the Arbitrator's decision with respect to (J) Medical, the Arbitrator finds as follows:

Based upon the Arbitrator's findings with respect to Accident and Causal Connection, all medical treatment provided for Petitioner's condition of ill being in the right shoulder would be causally connected to the accidental injuries sustained on October 19, 2012. Petitioner admitted outstanding medical bills as Petitioner's Exhibits 5-11 and out of pocket prescription costs as Petitioner's Exhibit 12. Petitioner's Exhibit 14 is a summary prepared showing total charges, payments and adjustments, and outstanding balances. The parties have stipulated that Respondent is self insured for group insurance and that Respondent is entitled to credit under Section 8(j) for payments made by group insurance.

PX 14 calculates total outstanding medical balances, after all payment and adjustments, of $19,494.76. There is a claim for out of pocket payments of $89.79. The Arbitrator has reviewed the medical bill exhibits and the medical records and finds that the bills submitted are supported by the records admitted and that the medical claimed is reasonable, necessary and causally connected to the accidental injuries sustained on October 19, 2012. The Arbitrator finds the balances listed on PX 14 to Swedish American Medical Group ($10,530.00), Swedish American Hospital ($7,159.36), SAMG Lundholm Orthopedics ($784.46), Rockford Anesthesiologist Associated ($231.94), EMPI ($460.00) and Rockford Associated Clinical Pathologists ($51.00 and $278.00)

are substantiated by the bills and treatment records. The Arbitrator reviewed PX 12 and noted several duplicate charges included. The Arbitrator finds the out of pocket costs for medication is $70.61. The total outstanding balances and out of pocket costs incurred total $19,565.37.

Based upon the record as a whole, the Arbitrator finds that Respondent shall pay reasonable and necessary medical services of $19,565.37, as provided in Sections 8(a) and 8.2 of the Act to the providers as listed in Petitioner's Exhibit 14 including the out of pocket costs incurred by Petitioner of $70.61. 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.

In support of the Arbitrator's decision with respect to (K) Temporary Compensation, the Arbitrator finds as follows:

The parties stipulated that Petitioner was off work following October 19, 2012 from November 16, 2013 through April 23, 2013, a period of 22 3/7 weeks and following May 11, 2013 from May 14, 2013 through November 3, 2013, a further period of 24 3/7 weeks. Based upon the Arbitrator's finding with respect to Causal Connection in this matter as well as in the consolidated claim 13 WC 17909 decided in conjunction with this matter, the Arbitrator finds that the entire condition of ill being in Petitioner's right shoulder is causally connected to the accidental injuries incurred on October 19, 2012. The Arbitrator therefore finds that both stipulated periods of temporary total disability are causally related to this matter.

The parties stipulated that Respondent paid $3,047.55 in benefits following October 19, 2012 (Arb Ex 1) and an additional $5,343.39 (Arb Ex 2) in benefits following May 11, 2013. The Arbitrator awards Respondent credit for both of these payments totaling $8,390.94 in this matter.

Based upon the record as a whole, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits for 47 3/7 weeks, commencing November 16, 2012 through April 23, 2013, and commencing May 14, 2013 through November 3, 2013, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $8,390.94.

In support of the Arbitrator's decision with respect to (L) Nature and Extent, the Arbitrator finds as follows:

Petitioner's date of accident is after September 1, 2011 and therefore the provisions of Section 8.1b of the Act apply to the determination of partial permanent disability.

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 fixed route bus driver at the time of the accident and that she has been able to return to work in her prior capacity as a result of said injury. The Arbitrator notes she has been performing the full duties of her employment since November, 2013. Because of this, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 51 years old at the time of the accident. Petitioner would not be considered either a younger or older worker. Petitioner would be expected to continue with active employment for in excess of 10 years. Petitioner has been able to return to her full duty regular employment since November, 2013. Because of this, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner has returned to her regular employment as a fixed route bus driver and has performed the full duties of her employment since November, 2013. The Arbitrator also notes the testimony that Petitioner is protected by a Union agreement and has 20 years seniority. The Arbitrator also notes that Respondent has made accommodation to Petitioner's need for driving only certain buses in the past. Because of these facts, the Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of §8.1b (b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner sustained an injury to her right shoulder. The MRI performed on November 30, 2012 found impingement, rotator cuff partial tear, possible labral tear and possible bursitis. After the May 11, 2013 episode, a new MRI was performed on May 21, 2013 and read as showing a minimal worsening of the changes in the shoulder. On July 2, 2013, Petitioner underwent surgery to the right shoulder, with findings of less than 25% thickness tear of the rotator cuff so no procedure was performed on the rotator cuff tendon. Petitioner had a type III acromion with bursitis that was shaved down, and a labral tear was debrided. Petitioner was released to return to full, unrestricted duty in November, 2013 and has worked her regular job as a fixed route bus driver through the date of trial. Petitioner testified that she does not have the free range of motion she had before this accident. She cannot extend the arm because of stiffness and she guards the arm. Her reaching ability is limited. She has not seen Dr. Milos since November, 2013. She is not taking any medication for her shoulder. Because of this, the Arbitrator therefore gives some weight to this factor.

Pursuant to *Will County Forest Preserve Dist. v. IWCC*, 2012 Ill. App. LEXIS 109, 361 111, permanent partial disability for shoulder injuries resulting in internal structural changes should be compensated under §8(d)2 of the Act instead of §8(e). The Arbitrator finds the Commission decisions in *Brian Jones v. Southwest Airlines*, 16 IWCC 0137; *Tabatha White v. Helia Healthcare*, 15 IWCC 719; and *Kevin Acosta v. State of Illinois, Dept. of Transportation*, 15 IWCC 698, instructive as to the determination of permanent partial disability.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 7.5% loss of use of person as a whole pursuant to §8(d)2 of the Act.

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

Kim Hartnell,
Petitioner,

vs.

No: 09 WC 24716

17IWCC0482

JC Penney Corporation, Inc.,
Respondent.

DECISION AND OPINION ON REVIEW

Respondent and Petitioner have sought timely review of the decision of Arbitrator Pulia, filed on February 25, 2016, following arbitration hearing on January 27, 2016. The Commission hereby modifies Arbitrator Pulia's decision as described below.

This matter was initially tried under §19(b) on September 10, 2010 by Arbitrator White. In her decision, filed November 2, 2010, she found causation between Petitioner's February 13, 2009 accident and her neuropsychological injury. Arbitrator White awarded temporary total disability benefits, medical expenses, and prospective treatment. Respondent did not seek review of this §19(b) decision.

In the decision now under review, Arbitrator Pulia found Petitioner to be entitled to temporary total disability benefits from September 11, 2010 through June 24, 2015 (an additional 249 and 4/7 weeks beyond the date of the §19(b) hearing). Arbitrator Pulia also awarded permanent partial disability compensation reflecting 30% loss of the person as a whole under §8(d)(2).

The Commission, after considering issues including causal connection, temporary total disability, and nature and extent of permanent disability, and being advised of the facts and law, finds that Petitioner has failed to prove entitlement to temporary total disability benefits beyond May 18, 2011. As discussed in detail below, the Commission finds that Petitioner by that date reached maximum medical improvement as to the injury sustained during her accident. Any symptoms or other ill-being reported or experienced thereafter are unrelated. Further, the Commission reduces the award of permanent partial disability to 15% loss of the person as a whole.

FACTS

A. Pre-§19(b) Background

Petitioner was working at her second job as a part-time retail clerk at Respondent, JC Penney, when she had her work-related accident. Her primary job was underwriter assistant at State Farm, where she began employment about several years prior. On February 13, 2009, while retrieving shoes for a customer, she fell off a ladder, a distance of 12 to 15 feet, onto a concrete floor and sustained a closed head injury. Thereafter, she developed symptoms of post-concussion syndrome, including nausea, blurred vision, dizziness, headaches, memory problems, and other difficulties.[1]

A brain MRI performed on February 19, 2009 was interpreted as showing non-specific white matter lesions of unclear significance. In early April 2009, she came under the care of neurologist Dr. Karyn Catt. Dr. Catt was familiar with Petitioner, having treated her in 2004 for complaints of migraines and right facial numbness. Dr. Catt compared a brain MRI taken in connection with that 2004 treatment to the February 2009 MRI. Dr. Catt determined that there were no significant changes between the two. Of note, on July 29, 2009, she wrote, "Nonspecific white matter lesions on MRI of the brain from February 2009, not significantly changed compared to 2004, most likely due to diabetes. It is not felt to represent demyelinating disease with the negative CFS analysis in 2004." (RX 7).

Dr. Catt referred Petitioner to Dr. Jospeh Alper, Ph.D., of Carle Clinic in Urbana for neuropsychological testing. Dr. Alper conducted tests over three days in August and September 2009. Dr. Alper noted that her test results suggested significant symptom magnification; however, he concluded that she was impaired and in need of treatment. His diagnosis was post-concussion syndrome with psychiatric features, including depression and anxiety, and higher level cognitive deficits. Dr. Catt reviewed Dr. Alper's findings, opined that Petitioner's ill-being was caused by the fall, and recommended prospective psychiatric treatment and psychotherapy. (RX 7).

In her §19(b) decision, Arbitrator White made favorable reference to Dr. Catt's and Dr. Alper's assessments of Petitioner. Arbitrator White found causal relatedness between Petitioner's fall and her "cognitive difficulties, memory impairment, daily headaches, depression

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[1] In late March 2009, Petitioner and her husband went on a vacation in Mexico. At the hearing before Arbitrator Pulia, Respondent submitted a print-out of comments and photos of this vacation that were posted to Facebook. (RX 4). This evidence apparently had not been presented to Arbitrator White.

and anxiety, as well as her post-concussion syndrome[.]" (Arb. White's decision at 5). Arbitrator White's award included prospective medical treatment in the form of "psychiatric therapy and medications and psychotherapy with biofeedback, as suggested by the neuropsychological evaluation [performed by Dr. Alper] and endorsed further by Dr. Catt...as well as ongoing treatment under Dr. Catt." (Arb. White's decision at 6).

B. Treatment and Assessments Post-§19(b)

Subsequent to the favorable §19(b) decision, Petitioner came to be treated and/or assessed by four services providers. These providers, and the approximate time spans of their interaction with Petitioner, are as follows: (1) Dr. Pamela Warren, Ph.D. of Carle Physician Group (April 2011 to June 2011); (2) clinical psychologist Wilma McLaughlin, M.A. of Agape Counseling (June 2011 to May 2012); Dr. Virginia Moody, M.D., of Central Illinois Psychiatric Associates (November 2011 to June 2012); and Dr. Alvin House, Ph.D., of the Illinois Department of Human Services (December 2011).

The records from these providers (with the exception of therapist McLaughlin of Agape Counseling) indicate a pattern of behavior from Petitioner wherein she would initiate treatment or entreat assistance from providers, only to abandon the relationship once it became apparent that the provider believed that Petitioner was not as disabled as she claimed (i.e., suspected malingering) or otherwise would not assist her in obtaining the result she seeks in her workers' compensation case (that result being an award of permanent total disability). The treatment with these providers is described below.

Dr. Pamela Warren, Ph.D.

For unexplained reasons, Petitioner did not return to Dr. Catt for ongoing treatment after Arbitrator White's §19(b) decision. She did not receive any treatment from anyone for 5 months after the decision. Eventually, Petitioner presented to Dr. Pamela Warren, Ph.D., to whom Petitioner had been referred. On April 5, 2011, in a "Workers' Compensation Psychiatric Diagnostic Evaluation" report, Dr. Warren discussed Dr. Alper's prior testing from August and September 2009. Dr. Warren wrote that Dr. Alper "completed a great deal of neuropsychological testing of which he noted that there were anxiety and depressive symptoms but also that there was a strong element of symptom exaggeration and potentially malingering occurring as well." (RX 3). As to Petitioner's cognitive functioning, the measure of memory impairment displayed at that time, about 7 months post-injury, was remarkable:

> Dr. Alper also stated that, while there were some mildly suppressed performance on measures of intellect, executive functions and some measures of language relative to an individual at her expected premorbid level of functioning, there were some moderate-to-severe impairments on measures of memory. The level of memory impairment would be more typical with an individual who has unambiguous degenerative dementia of the Alzheimer's type rather than mild traumatic brain injury.

(RX 3, 4/5/2011 at 3). Petitioner does not have unambiguous degenerative dementia of the Alzheimer's type (at least none alleged to be work-related). Dr. Warren noted that excellent recovery from an injury such as Petitioner's -- classified as a mild traumatic brain injury -- typically is obtained in 3 to 12 weeks. That Petitioner was producing these kind of test results 7 months post-injury suggested to Dr. Warren that her current dysfunction was not due to any physical trauma to the brain, but instead were indications of an affective disorder and deliberate "insufficient effort" on Petitioner's part during testing. As Dr. Warren continued:

> [M]ore telling is that the performances on symptom validity reflected an inability and [un]willingness to sustain effort to obtain a valid representation of her current cognitive potential. Dr. Alper noted that, in the absence of any objective evidence of a very unlikely preexisting dementia, the indications were of an affective disorder and insufficient effort that were related to the persistence of her symptoms. Dr. Alper noted that her medical records reflect a history of memory problems in response to stress and stress created by her head injury in her daily life appears to be a major mediating influence on her level of functioning.

(RX 3, 4/5/2011 at 3). Dr. Warren also noted, "Ms. Hartnell reports profound recent and remote memory problems. Again, this is typically inconsistent with a mild head injury, particularly when there is no objective medical evidence aside from some changes that were seen on an MRI but were later deemed to not be at the root of her memory problems in accordance with Dr. Joseph Alper and Dr. Catt.... Ms. Hartnell's judgment, intellectual level, and IQ, based on the answers given, were estimated to be within normal ranges." (RX 3, 4/5/2011 at 5).

On May 18, 2011, Petitioner underwent further psychological testing and scored high for malingering. At that time, Dr. Warren was of the opinion that Petitioner's issues were "far more likely" related to some underlying depression and anxiety disorder, as opposed to any type of brain injury or any sustained effects from the fall. Dr. Warren concluded that Petitioner "is likely to be greatly exaggerating any cognitive concerns that she has" and that she was engaged in "frank malingering." (RX 3, 5/18/11). Shortly after this testing, Petitioner stopped seeing Dr. Warren. Petitioner stated that she stopped seeing Dr. Warren because she felt Dr. Warren disliked her and her husband. (Tr. 71).

Wilma McLaughlin, M.A. and Dr. Alvin House, Ph.D.

Beginning in June 2011 and up through May 2012, Petitioner underwent counseling sessions with clinical psychologist Wilma McLaughlin, M.A., of Agape Counseling. Petitioner sought out this therapy on her own. Ms. McLaughlin noted diagnoses of major depressive disorder, cognitive disorder not otherwise specified, and post-concussion disorder with associated depression. Ms. McLaughlin's recommendations included evaluation by a psychiatrist for antidepressant medication and to seek assistance from the Illinois Department of Human Services, Office of Rehabilitation Services (DHS-ORS) for job retraining evaluation. (PX 3).

Pursuant to Ms. McLaughlin's recommendation, Petitioner contacted DHS-ORS to apply for job search and job retraining assistance. In connection therewith, on December 28, 2011, Petitioner underwent an interview and psychological testing conducted by Dr. Alvin House, Ph.D. Afterwards, Dr. House authored a psychological assessment report, which report is

notable for Petitioner's low scores of intellectual functioning. Startlingly, Petitioner's IQ tested at 79, which the doctor noted "falls in the borderline range of intellectual functioning." (PX 4).[2]

The Commission notes here that Dr. House's report, on its face, supports Petitioner's claims of significant cognitive deficits. However, when viewed in light of the test results that would be obtained a year later by Petitioner's own independent medical examiner, Dr. Steven Rothke -- Dr. Rothke tested her IQ at 102, or average -- the conclusion that Petitioner is engaged in purposeful symptom exaggeration is inescapable. (Dr. Rothke's examination is discussed in more detail below.)

At any rate, Dr. House recommended that he be given Petitioner's treatment records for review. He also recommended "helping Ms. Hartnell seek a relatively low stress position for at least the time being," as "she has good social skills and some experience in retail work, [and] possibly this could be used as a basis for re-entering employment." (PX 4). Petitioner did not follow through with DHS-ORS, which eventually closed her file for missed appointments. Petitioner claimed that she could not remember that she had appointments. (Tr. 74-76). Her husband testified that she could not make it to her appointments due to her severe headaches. (Tr. 46-47).

Dr. Virginia Moody, M.D.

Ms. McLaughlin also referred Petitioner to psychiatrist Dr. Virginia Moody. Petitioner treated with Dr. Moody from November 2011 through June 2012, receiving therapy and medication management. Petitioner reported sleep problems and anxiety, and displayed hypersensitivity to hearing, tactile, and visual stimuli. Dr. Moody also noted that prior psychological testing suggested that some of her dysfunction might be "due to anxiety or depression, and not completely due to underlying brain damage, such as Alzheimer's or tissue damage from the fall." Dr. Moody diagnosed generalized anxiety disorder and post-concussive syndrome. (PX 5).

Of note, Dr. Moody's records indicate that Petitioner was focused on her workers' compensation claim. On May 31, 2012, Dr. Moody wrote, "Court in June for benefits. I explained I cannot speak to her prior function or attribute current symptoms to accident because I was not treating her prior to accident. I can't speculate." On June 27, 2012, Dr. Moody wrote, "[Petitioner] tells me she's disappointed I'm not more cooperative with lawyer....I explained my response to lawyer that I can't make predictions or correlations he's asked for," and that Petitioner is "frustrated by me and work comp. claim." Petitioner made about one more visit to Dr. Moody and, as she did with Dr. Warren and Dr. House, stopped seeing this provider. (PX 5).

HEARING TESTIMONY

Before Arbitrator Pulia, Petitioner testified regarding her alleged ongoing constellation of disabling symptoms and their effect on her life. As corroborating witnesses, she called her husband, her daughter, and two longtime friends. The theme of Petitioner's and her witnesses'

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[2] At hearing, Arbitrator Pulia denied admission of Dr. House's records in to evidence, upon Respondent's objection. Dr. House's records are included in the transcript of hearing as the rejected exhibit, PX 4.

testimony is that, ever since her head injury, Petitioner has been a different person. According to this account, Petitioner pre-accident was highly social and outgoing, energetic, often planning social events with friends. But now she is depressed, anxious, fearful, avoids crowds, stays home a lot, and is socially withdrawn.

Petitioner's cognitive impairment includes problems with memory and executive functioning. She is easily confused, easily overwhelmed, cannot concentrate, cannot complete tasks, and is very forgetful. As an example of her impairment, it was related that if she starts in the kitchen to do dishes, and then goes to the laundry room, she will start doing laundry, but then she will see something that needs to go to the bathroom, so she will leave the laundry incomplete as well. (Tr. 37-39; 83). Her husband testified that she cannot manage the family's finances as she used to, because she forgets to balance the checkbook and their bank account gets overdrawn. (Tr. 19-20). On a typical day, she has "headaches, anxiety, some depression," but she will have "one or two" good days per week. (Tr. 84-85). Her chronic headaches or migraines can be triggered by noise and inclement weather, and are sometimes so severe she is unable to leave the house, not even to show up for work. (Tr. 47-48, 85-86). She has gotten lost while driving, and is comfortable driving only distances of 7 to 10 miles. However, occasionally, she will "get brave" and will drive to Bloomington, 15 miles away. (Tr. 86). Her husband bought her a new car in September 2013. (RX 8).

INDEPENDENT MEDICAL EVALUATIONS

Both parties presented the medical testimony of their retained experts, whose evaluations of Petitioner included interview and neuropsychological testing of Petitioner. These experts' findings and opinions are discussed below.

Dr. Steven Rothke, Ph.D.

On December 13, 2012, Petitioner was evaluated by neuropsychologist Dr. Steven Rothke, Ph.D., at her counsel's request. Dr. Rothke's diagnoses were depressive disorder and generalized anxiety disorder. As to causal connection between these diagnoses and her accident of February 2009, Dr. Rothke opined that there was none:

> Q: Is there any relationship between a head injury or any kind of specific trauma to the body that would have caused this depression and anxiety?
>
> A: No, the depression and anxiety are not – they can be; but, in her case, I don't think they are directly due to brain changes. Brain changes can affect the way emotion is expressed, but hers is what's called a reactive depression and a reactive anxiety.

(PX 2 at 58-59).

Regarding Dr. Rothke's neuropsychological testing, the results were remarkable for the mildness of any purported impairment in cognitive functioning. For example, in the Wechsler Memory Scale, 4th edition, a widely-used test of memory, Dr. Rothke found that Petitioner scored no worse than in the "mild or borderline impaired" range in some components of the test,

and even scored in the "average to high average" range on other components. (PX 2 at 25-27). There were no indications of any severe impairment on any component of any test. Petitioner often scored in the normal and average ranges, including on the Wechsler Adult Intelligence Scale, which indicated an average IQ of 102 (far higher than the score obtained by Dr. House just a year prior). (PX 2 at 21-22). Significantly, Dr. Rothke opined that, while Petitioner had memory difficulties, "they don't rise to a level that she can't function or couldn't learn to work around in somewhat, given the right interventions." (PX 2 at 27-28).

Of note, although Dr. Rothke avoided speaking of Petitioner in terms of "symptom magnification" or "malingering," even he was obliged to note that there may be an issue of "over-reporting" of certain symptoms. When asked to elaborate, he testified that he did not find indication of "overstatement of psychological or psychiatric problems." However, regarding "cognitive and somatic problems," Petitioner's score fell in "what's called the possible range of over-reporting." (PX 2 at 43-46). In other words, while Dr. Rothke did not question the sincerity of Petitioner's self-report of depression, anxiety, and other emotional distress, he acknowledged that she was exaggerating the nature and extent of her intellectual disabilities (such as memory problems) and her physical problems, i.e., her headaches.

Dr. Alexander Obolsky, M.D.

Respondent presented the medical opinion testimony of its §12 examiner, forensic psychiatrist Dr. Alexander Obolsky, M.D. Dr. Obolsky interviewed Petitioner in May 2013 and also administered an extensive battery of neuropsychological tests, including several symptom validity tests (designed to spot malingering) Dr. Obolsky's opinion was that Petitioner was malingering both her cognitive and emotional symptoms. He opined that, at worst, Petitioner experienced a mild traumatic brain injury, and her expected course of recovery to her pre-existing level of functioning would have been 3 months post-injury. He opined that Petitioner's current mental health treatment was not related to her injury on February 13, 2009 and that she was mentally fit for full-time employment. (RX 1).

In both his written report and his evidence deposition, he pointed out that Dr. Alper and Dr. Warren both indicated the possibility of symptom magnification. Dr. Obolsky noted (as did Dr. Warren) that Dr. Alper discerned that Petitioner's memory impairment appeared to be on the level of someone with Alzheimer's. Regarding Petitioner's performance on the Green's Word Memory Test, administered by Dr. Obolsky's office, Petitioner's results were "worse than those individuals that experienced severe traumatic brain injury and were in a coma ...worse than people with severe depression ...worse than people with dementia." The forensic psychiatrist stated that "if you gave this test to children who have a very low IQ, they will perform better than [Petitioner] did." (RX 1 at 38-39).

Regarding Petitioner's emotional state at the time of her interview with Dr. Obolsky, it should be noted that she had recently lost her house in foreclosure and an adult son had died of a cardiac event. (RX 1 at 24-26).

VOCATIONAL ASSESSMENTS

Both parties also retained vocational rehabilitation experts. Petitioner's expert, Dennis Gustafson, opined that Petitioner was permanently and totally disabled from work because of her debilitating headaches, lack of focus, impaired memory and anti-social disorders. (PX 2). Not even Dr. Rothke believed that Petitioner was so incapable of employment. Mr. Gustafson, upon cross-examination, agreed that Dr. Rothke never stated that Petitioner could not work. (PX 2 at 49-50, 63-64).

Respondent retained Julie Bose as its vocational rehabilitation expert. Ms. Bose indicated that Petitioner was of average intelligence and had some mild deficit in memory and processing speed. Ms. Bose also noted that Dr. Alper, Dr. Warren, and Dr. Obolsky all questioned whether Petitioner's symptoms were exaggerated and whether the tests represented an accurate measure of her abilities. Ms. Bose opined that Petitioner would be employable in more unskilled, routine types of positions that do not require a high level of socialization and did not involve skilled and multistep tasks such as a housekeeping cleaner, a laundry worker, or a janitor. (RX 6). Arbitrator Pulia found Ms. Bose's opinion credible in her determination that Petitioner was no longer totally disabled as of June 24, 2015, the date of Ms. Bose's evaluation of Petitioner. (Arb. Pulia's decision at 25).

Regarding Petitioner's efforts to find employment, they have been unsuccessful to date. According to her husband, she had applied to employers including a gas station. However, no employer would call her back (even for unpaid volunteer positions) because Petitioner would be "truthful" to the potential employers when making employment inquiries, reveal that she had a head injury, and advise them that her migraines might prevent her from showing up for work. (Tr. 47-49). Petitioner even testified that her friends, owners of a local restaurant, had offered her a part-time job as a waitress. However, she declined this offer because symptoms of her condition -- her aversion to noise and crowds, and her frequent headaches -- would make her an unreliable employee. (Tr. 88-89).

DISCUSSION

A. The Arbitrator Erroneously Invoked "Law of the Case" Doctrine Regarding Causation

At the outset, the Commission notes that it is apparent that Arbitrator Pulia was invoking the doctrine of the law of the case in her summary disposition of the causation issue, where she wrote:

> This claim was previously tried pursuant to Section 19(b) of the Act on 9/10/10. One of the issues in dispute was causal connection. With respect to this issue, Arbitrator White found that petitioner's cognitive difficulties, memory impairment, daily headaches, depression, and anxiety, as well as her post-concussion syndrome are all directly related to her February 13, 2009 work related injury. Respondent did not appeal Arbitrator White's decision. Petitioner

> is not claiming any new injuries or conditions as a result of her work injury. As such, this arbitrator finds the conditions Arbitrator White found causally related to the work injury, are still causally related to the work injury.

(Arb. Pulia's decision at 18-19). Arbitrator Pulia then stated that she would proceed to "address whether or not the treatment petitioner has received for these conditions since the 19(b) hearing on 9/10/10 was reasonable and necessary, and the impact these conditions now have as they relate to the nature and extent of petitioner's injury." (Arb. Pulia's decision at 19).

The Arbitrator has erred insofar as she decided that the law of the case doctrine relieved Petitioner of her burden to prove, at the permanency hearing, that any purported ill-being as may be extant after the date of the earlier §19(b) hearing is causally related to her accident. The Commission is allowed in a subsequent hearing to find that a previously causally connected condition has resolved and to deny a current causal connection without reversing the prior §19(b) decision. *See Weyer v. Illinois Workers' Compensation Comm'n*, 387 Ill. App. 3d 297 (2009). Each §19(b) hearing is a separate and appealable proceeding, limited to a determination regarding the compensability of a claim up to the date of hearing. *See R.D. Masonry, Inc. v. Illinois Workers' Compensation Comm'n*, 215 Ill.2d 397 (2005). And while Arbitrator White's §19(b) decision became a final decision when not appealed, her causation finding regarded, and was limited to, Petitioner's condition *up to the time of the §19(b) hearing.*

Petitioner still had the burden of proving that her current ill-being, i.e., the ill-being as it was alleged to exist post-§19(b) and up to the time of the permanency hearing, was causally connected to her accident. The evidence shows that Petitioner has failed to carry her burden. The evidence presented at hearing showed that Petitioner is malingering and exaggerating her symptoms, in particular her cognitive problems. Extensive testing done by three doctors, including two of her own treating doctors (Dr. Warren and Dr. Alper), are consistent with symptom exaggeration and malingering.

The evidence shows that Petitioner's post-concussion syndrome and any other effects from her February 2009 fall resolved to the point of maximum medical improvement not long after the §19(b) decision. Specifically, maximum medical improvement as to her work-related condition was achieved no later than May 18, 2011, when Dr. Warren found evidence of "frank malingering" and concluded that Petitioner's dysfunction at that time was related not to traumatic brain injury but to underlying depression and anxiety. Petitioner's history since that day has further suggested the validity of Dr. Warren's assessment of malingering and symptom magnification.

B. The True Nature and Extent of Petitioner's Mild Disability Is Best Shown in the Testing Done By Dr. Rothke

Although Arbitrator White found that Petitioner suffered from compensable ill-being at the time of the September 2010 hearing, it should be noted that, as early as a year prior to that hearing, symptom magnification was an issue raised by Dr. Alper. It is true that Dr. Alper eventually made diagnoses and recommendations, endorsed by Dr. Catt, that Petitioner was impaired and in need of treatment. It is true that Arbitrator White cited Dr. Catt's opinions favorably in her §19(b) decision. And, as noted above, the Commission is bound by Arbitrator White's determination regarding the cause of Petitioner's symptoms up to that time. However,

post-§19(b), other providers and experts – including Dr. Warren, Dr. Obolsky, and even her own independent medical examiner, Dr. Rothke – have noted symptom magnification and malingering.

It should be borne in mind that symptom magnification and actual impairment are not mutually exclusive. "Failing" a symptom validity test only means that the true nature and extent of the individual's condition cannot be determined (by that test), since that individual has purposefully exaggerated or otherwise obscured her real condition. In the instant case, the Commission finds that Petitioner currently suffers some condition of impairment. However, when her condition is broken down into its constituent symptoms, the following conclusions must be made: (1) Petitioner's current emotional symptoms (depression and anxiety) are not related to any brain injury sustained on February 13, 2009; (2) her current physical symptoms (chronic headaches) are not related to any brain injury sustained on February 13, 2009 (and are likely being over-reported by her); and (3) her current cognitive impairment (memory problems and other difficulties with information processing) is mild and does not render her incapable of working. With regard to symptoms of cognitive impairment, these symptoms have been considerably exaggerated by Petitioner.

Ironically, these conclusions are supported by Dr. Rothke's findings. It is apparent that Petitioner made her most honest efforts when being tested by her own independent medical examiner. Regarding emotional symptoms, it does appear that Petitioner is mostly convinced of her extreme disability and experiences genuine distress from this conviction. However, as to cognitive disability, there is ample evidence that she had significantly exaggerated such limitations when being tested by all doctors other than Dr. Rothke. And even as to the tests administered by Dr. Rothke, yielding results of mild impairment at worst, Dr. Rothke was obliged to note "over-reporting" of cognitive difficulties.

Lastly, it bears emphasizing that not even Dr. Rothke believed that Petitioner was totally disabled. As he testified, Petitioner's mild memory difficulties were not so severe that she was rendered incapable of working in some capacity. The evidence shows that Petitioner's lack of success in finding employment is due to her own desultory job search efforts and self-defeating behavior. In short, Petitioner's alleged un-employability is illusory. Her stated desire to return to health and gainful employment is to be questioned. [3]

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 25, 2016 is hereby modified.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner the sum of $ 482.63 per week commencing September 11, 2010 through May 18, 2011 (35 and 4/7 weeks), that being the period of temporary total incapacity for work under Section 8(b) of the Illinois Workers' Compensation Act. Respondent shall receive a credit of

[3] At hearing, when asked whether she is asking the Arbitrator to find her permanently unable to work, she answered, "That's not my hope honestly, but I don't know what other choice I have, so it's not looking too good for the home team." (Tr. 89-90).

17IWCC0482

$19,305.20, that being the sum of temporary total disability benefits from September 11, 2010 through June 17, 2011, already paid.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall pay the reasonable and necessary charges for medical services provided to Petitioner through May 18, 2011, subject to the limits of Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $ 434.36 per week for a period of 75 weeks, as the injury sustained caused permanent partial disability to the extent of 15% loss of use of the person as a whole under Section 8(d)2 of the Act.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $ 31,000.00. 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: AUG 2 - 2017

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

o-06/06/17
jdl/ac
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

Q-Dex On-Line
www.qdex.com

HARTNELL, KIM
Employee/Petitioner

Case# **09WC024716**

JC PENNY CORP
Employer/Respondent

17IWCC0482

On 2/25/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.45% shall accrue from the date listed above to the day before the 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
KEVIN ELDER
4242N KNOXVILLE AVE
PEORIA, IL 61614

5074 QUINTAIROS PRIETO WOOD & BOYER
MICHAEL SCULLY
233 S WACKER DR 70TH FL
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF MCLEAN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

KIM HARTNELL,
Employee/Petitioner

v.

JC PENNY CORP.,
Employer/Respondent

Case # 09 WC 24716

Consolidated cases: _____

17IWCC0482

An *Application for Adjustment 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 **Bloomington**, on **1/27/16**. After reviewing all of the 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 _____

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FINDINGS

On **2/13/09**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**37,644.88**; the average weekly wage was $**723.94**.

On the date of accident, Petitioner was **51** years of age, ***married*** with **no** dependent children.

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

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

Respondent shall be given a credit of $**19,305.20** for TTD, $**00** for TPD, $**00** for maintenance, and $**00** for other benefits, for a total credit of $**19,305.20**.

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

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $3,310.00 to Dr. Warren, $115.00 to Dr. Moody, and $835.00 to petitioner for out of pocket expenses, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $482.63/week for 249-4/7 weeks, commencing 9/11/10 through 6/24/15, as provided in Section 8(b) of the Act. Respondent shall receive credit for the $19,305.20 it has already paid.

Respondent shall pay Petitioner permanent partial disability benefits of $434.36/week for 150 weeks, because the injuries sustained caused the 30% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

2/14/16
Date

FEB 25 2016

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 51 year old, retail clerk, sustained an accidental injury that arose out of and in the course of her employment by respondent on 2/13/09, when she fell off a ladder approximately 12 feet onto a concrete floor. This case was previously heard before Arbitrator White pursuant to Section 19(b) of the Act on 9/10/10. The issues in dispute were causal connection, medical, prospective medical, and temporary total disability. On 11/2/10 Arbitrator White issued her Arbitration Decision. Arbitrator White found that petitioner's cognitive difficulties, memory impairment, daily headaches, depression and anxiety, as well as her post concussion syndrome are all directly related to her February 13, 2009 work related injury. Arbitrator White found respondent shall pay reasonable and necessary medical services of $10,085.00, as provided in Section 8(a) of the Act; respondent shall pay petitioner temporary total disability benefits of $482.63/week for 81-6/7 weeks, commencing 2/14/09 through 9/10/10 as provided in Section 8(b) of the Act; that respondent is entitled to a credit of $31,370.95; and that respondent shall pay all reasonable costs subject to the Fee Schedule for the psychotherapy and psychiatry that Dr. Catt recommended.

On 4/5/11 petitioner underwent an evaluation performed by Dr. Pamela Warren, Licensed Clinical Psychologist. Petitioner was referred to Dr. Warren by respondent's insurance carrier nurse, based on Arbitrator White's order that petitioner undergo psychotherapy and psychiatry as recommended by Dr. Catt. Dr. Warren interviewed petitioner, took a medical history, education and social history, and performed a mental status evaluation. Dr. Warren's diagnostic impressions were:

AXIS I:
1. Rule out major depression disorder and any of the anxiety -spectrum disorders.
2. Rule out symptom exaggerations.
3. Rule out malingering.

AXIS II: Diagnosis deferred.
AXIS III: Please review Ms. Hartnell's medical chart for full medical disclosures.
AXIS IV: Social withdrawal and ongoing self-report of cognitive problems.
AXIS V: Global Assessment of Functioning: 60

Dr. Warren's treatment recommendation had been for cognitive-behavioral therapy, but she noted that it was also important, because of some of the issues raised, that petitioner was going to mostly likely need to complete some additional psychological testing. Dr. Warren noted concerns because petitioner had clear evidence of symptom exaggeration, and in some cases malingering with Dr. Alper, that an update of these tests would be dictated in another report.

On 5/18/11 petitioner underwent 145 minutes of psychological testing. For the total test, any score greater than 14 is indicative of malingering and petitioner's score was 26. The results showed that in multiple scales

petitioner was likely to be greatly exaggerating any cognitive concerns that she has. Evidence of frank malingering was also found. It was noted that these results were going to be reviewed at her next appointment. Dr. Warren was of the opinion that if petitioner has underlying depression it is far more likely that the issues are related to anxiety and depression as opposed to any type of brain injury and any sustained effects from the fall that she reported to have experienced.

On 11/8/11 petitioner first presented to Dr. Virginia Moody, at Central Illinois Psychiatric Associates, for medicine management and therapy. Petitioner followed-up with Dr. Moody on 7 occasions from 11/8/11-6/26/12. Petitioner paid for this treatment "out of pocket". On 11/8/11 Dr. Moody had petitioner take the Self Administered Gerocognitive Examination (SAGE). Petitioner provided Dr. Moody with a history of the injury on 2/13/09. She stated that she was unconscious for an unknown amount of time. Petitioner could not recall clear details of what happened and only remembered walking out of the stockroom and the customer being angry that it took so long. She stated that several days she developed post-concussive syndrome, and was referred, by her current neurologist, who she had been seeing for prior TMJ pain and migraine headaches, to Dr. Alper for a neurological testing. She reported that her cognitive deficits have not improved significantly, but her dizziness and headaches had improved somewhat. She reported significant anxiety with catastrophizing ideations, when she feels she is not contributing to the family. She stated that too noisy environments cause her to shut down. She denied panic attacks, specific phobias, or PTSD. She stated that she felt avoidant of people, because they will notice her deficits and judge her. She denied any past psychiatric history, but Dr. Moody noted that a review of her records showed that she had been on Cymbalta, and perhaps Celexa and Ambien. She stated that she takes Maxalt for her migraines. She stated that her headaches have improved somewhat since the initial trauma.

Following her examination Dr. Moody diagnosed that petitioner was suffering a significant degree of anxiety; displaying some difficulties with hyper-sensitivity of hearing, tactile and visual; post-concussion syndrome; and has some difficulties with memory and judgment. Dr. Moody noted that prior psychological testing indicated that some of petitioner's dysfunction might be due to anxiety or depression and not completely due to her underlying brain damage, such as Alzheimer's or tissue damage from the fall. Dr. Moody diagnosed Generalized Anxiety Disorder, Post-concussive Syndrome, Financial and ADL difficulties, and GAF+35. Dr. Moody did not know if petitioner could handle finances. She noted that petitioner is capable of handling most, if not all in-house ADL's, and has some limited function in the community, due to restrictions on her driving and getting lost when she leaves her home at times. Dr. Moody recommended a trial of Gabapentin for sleep.

On 11/12/11 Wilma McLaughlin, MA, LCPC, and petitioner's counselor at Apage Counseling, drafted a letter to petitioner's attorney, Kevin Elder, regarding her observations and professional opinion related to petitioner. McLaughlin noted that she had seen petitioner 6 times for individual psychotherapy from 6/30/11 through 11/3/11. She noted petitioner's presenting concerns were loss of cognitive function and depressive symptoms since suffering a fall from a ladder in February 2009. Petitioner reported that prior to the fall she had been an outgoing, confident and social individual; worked five years at State Farm Insurance with increasing degrees of responsibility and multitasking as part of her position; and full time before that for a number of years elsewhere. These statements were corroborated by her husband, Chris Hartnell. Petitioner reported that since the fall she has experienced difficulty focusing and staying focused, is highly anxious when in crowds or social situations, cannot multitask, is forgetful, has difficulty with memory retrieval, has difficulty with simple tasks, easily gets overwhelmed and confused, and believes her judgment is at times unsound. Petitioner also reported that she easily fatigues, has difficulty sleeping, and has had an increase in the frequency and severity of headaches since the fall. McLaughlin noted that petitioner's goals were to return to some kind of gainful employment and be able to function more fully in household tasks and socially. McLaughlin recommended that petitioner consult with a psychiatrist for a medication evaluation and apply for services from the Department of Rehabilitation Services of the Illinois Department of Human Services. She also instructed her to complete a daily mood log and provide it to her each week. McLaughlin noted that petitioner followed her recommendations. In conclusion, McLaughlin was of the opinion that based on petitioner's presentation, self reporting, corroborating statements by her husband, and medical records substantiating a closed head injury, i.e., concussion, she assigned the diagnosis of Cognitive Disorder Not Otherwise Specified; Post-concussional Disorder with associated depression. Her treatment plan was for petitioner to alleviate symptoms of depression through cognitive behavior intervention and referral for psychiatric evaluation for possible medication intervention.

On 12/13/12 petitioner underwent a Section 12 examination performed by Dr. Steven Rothke, a clinical psychologist with a subspecialty in neuropsychologist, at the request of her attorney. In addition to his interview and testing of petitioner, Dr. Rothke spoke with her husband, Chris Hartnell. Dr. Rothke also reviewed medical records sent to him by petitioner's attorney that included records from Bromenn Healthcare, OSF St. Joseph Medical Center, Carle Clinic, the Illinois Department of Rehabilitation Services, Central Illinois Psychiatric Associates, and an independent medical exam by Dr. David Gelber. Dr. Rothke opined that the majority of the diagnostic tests of petitioner's he reviewed were largely negative. Dr. Rothke testified that during his interview of petitioner there was not anything significant in her past that he thought was having an impact on her current condition. However, he did learn some issues in her background that might make her more susceptible to the

effects of future trauma, including the emotional abuse by her first husband, and the fact that she was adopted at the age of nine. Dr. Rothke noted that when he tested petitioner she showed some improvement in her attention and concentration, and effort, as compared to when she was tested a year prior.

Dr. Rothke summarized that the results of the two Wechsler tests support some memory difficulties, and that they did not rise to a level that she could not function or could not learn to work around in some way, given the right interventions. With respect to the Stroop test, petitioner performed in the low average range as it applies to performing tasks or multi-tasking. Dr. Rothke opined that it is extremely unlikely that petitioner's Stroop test results would have been the same before the accident, because he did not believe petitioner could have held down two jobs if the results were the same. Dr. Rothke opined that when looking at both the Grooved Pegboard test and the Trail Making test, which also looks at visuomotor speed, that petitioner's sequencing ability was good and intact, which was good with respect to her driving ability. He opined that although her motor ability seemed to be impaired, some of it could be related to the right arm injury she sustained at the time of her fall. He opined that motorically, petitioner was slower than she probably was in the past, beyond any effect of aging. On the NAB Mazes Test and NAB Categories test, Dr. Rothke opined that petitioner performed in the average range for women of her age and level of education. He found no deficiencies. He further opined that this means that petitioner is able to still think in concepts, can think abstractly at least at an average level, and can be adaptive in coming up with solutions to tasks that are not typical everyday tasks. Dr. Rothke opined that on the Clock Drawing Test, that looks at planning, judgment, and spatial reasoning, petitioner's spatial reasoning was good. He also opined that the Famous Faces test, is usually not affected by the kind of injury that petitioner had. He opined that petitioner did well on this test. On the BHI-2 Test, that looks at the extent of pain someone is experiencing in different regions of the body, psychological reactions to pain or functional limitations, and role of pain or physical limitations on physiological status, Dr. Rothke opined that petitioner showed the profile of an individual who likely, at least to some degree develops physical problems in response to stress, as well as feelings of helplessness and powerless to change her current circumstances and difficulty coping with stress. On the MMPI test, petitioner's findings were similar to those on the BHI-2 test. It showed that petitioner was very worried about her overall health and physical functioning; experiences difficulties with memory and concentration, anxiety and obsessive worrying; and often worries about her finances and loss of job. He opined that petitioner is prone to developing physical symptoms in response to stress. He also opined that the results show she has lost or has low self confidence, is feeling helpless in terms of making changes in her life and more introverted and shy than she was in the past, and is somewhat passive and has difficulty directly expressing feelings of displeasure or anger. Overall though, Dr. Rhotke opined that petitioner may have some over-reporting of cognitive and somatic difficulties (physical problems).

Based on all the records he reviewed, and the results of all the tests he performed, Dr. Rhotke's diagnoses were major depressive disorder, moderate and generalized anxiety disorder. He opined that these diagnoses are in response or reaction to the accident of 2/13/09, and in response to the subsequent difficulties she has had since that time. Dr. Rhotke opined that petitioner had not yet reached maximum medical improvement. He recommended an updated psychiatric consultation to evaluate medications for her depression, anxiety, and sleep disruption. He recommended a more active course of individual rehabilitation psychotherapy specific to working with an individual who has had an injury or a disabling condition. He recommended treatment with a rehabilitation psychologist. He agreed that counseling can be a form of psychotherapy. He recommended that she engage in volunteer work to give her life some structure so she is not just sitting at home. He noted that this would provide activity to organize he life around, and get her back into somewhat of a work routine. He was of the opinion that this would combat social isolation, enable her to do things that are useful to other people and improve self-esteem, and rebuild or sharpen skills that could eventually be applied to some form of gainful employment. Dr. Rhotke's last recommendation was that after she underwent the recommended psychiatric and psychological care, she should work with a vocational rehabilitation counselor to help her put a resume together, do a job search, learn how to interview and deal with questions of why she has been out of the workforce for four years.

On cross-examination Dr. Rhotke believed Dr.Moody was primarily providing medication management, and Wilma McLaughlin, the Counselor was performing psychotherapy. Dr. Rhotke testified that "The occurrence of the accident was very upsetting; so her depression and anxiety is her reaction to the accident, itself, and, more importantly, what it led to, whatever functional or physical problems she had that led to her inability to return to work, to pain, to distractibility and thinking difficulties." He testified that the difficulties stem from the accident, and that is what she is reacting to. He opined that this is what the depression and anxiety is in response to. Dr. Rhotke opined petitioner's depression or anxiety are not directly due to brain changes. Dr. Rhotke opined that petitioner's depression and anxiety had been present for the majority of time from the date of accident until his examination , and probably got somewhat worse over that time, in part due to her difficulties, her failure to return to work, and her financial difficulties. He further opined that depression can wax and wane depending on what else is going on in her life, or dependent on what treatment she is getting. He noted that petitioner had no problems performing the computer part of the testing.

Dr. Rhotke acknowledged that Dr. Alper performed some of the same testing in 2009 that he performed in 2012, and found that petitioner was possibly malingering and had symptoms of magnification. He believed that Dr. Alper believed his assessments and impressions did not give an accurate picture of petitioner's strengths and

weaknesses. He noted that Dr. Alper indicated that petitioner was unable to sustain consistent attention and effort, which is needed for an accurate picture of somebody. Dr. Rothke opined that his findings/opinions in 2012 more accurately portray her current functioning, than those of Dr. Alper in 2009. Dr. Rhotke opined that some of her results could in part be based on the fact that she was not working or not performing a function or volunteering when she was examined. Dr. Rhotke noted that petitioner reported that on a day to day basis she does light cooking, laundry at home, grocery shopping, and drives.

On 6/27/12 petitioner last followed-up with Dr. Moody. She reported that her headaches were worse, and that made her feel more depressed. She stated that her sleep was off, and she had decreased energy. Petitioner told Dr. Moody that she was disappointed that she was not more cooperative with her lawyer. Dr. Moody told petitioner and her lawyer that she cannot make predictions or correlations her lawyer asked for. Dr. Moody stated that she does not want to do depositions. Dr. Moody noted that petitioner told her she was frustrated with her and her worker compensation claim. Dr. Moody recommended that petitioner discontinue Gabapentin and consider another drug. Dr. Moody noted that if petitioner decides to transfer care she would forward her records.

Petitioner offered into evidence her Job Search records that included 3 or 4 applications. These included an Application for Employment to Funks Grove Library. The date she completed it was left blank. Petitioner also completed and withdrew her submission to Teltech for a Customer Service Representative. She also applied for a Customer Service Representative at Randstad, and Assistant Store Manager at Family Dollar.

On 5/24/13, the evidence deposition of Dr. Rothke was taken at the request of the petitioner. The vast majority of Dr. Rothke's work involves individuals who have sustained some type of injury or disabling condition, most commonly individuals with a head injury. He spends the majority of his time performing evaluations and consultations. Following the evaluation/consultation Dr. Rothke then makes referrals based on that treatment plan. Dr. Rothke is not a medical doctor. Psychologists are eligible for consulting privileges. Dr. Rothke testified that he does most Section 12 evaluations for the respondent.

On 10/14/13 Dr. Alexander Obolsky drafted a report regarding his forensic psychiatric evaluation, performed at the request of the respondent. The evaluation was performed in order to assess petitioner's reported mental health consequences of the fall on 2/13/09. The forensic psychiatric evaluation was comprised of a record review, forensic psychiatric interview, forensic psychological and cognitive testing, and data analysis. Dr. Obolsky reviewed records from Bromenn Healthcare Emergency Room, Carle Clinic, Mayo Clinic, Digestive Disease Consultants, Dr. Gelber, Health Direct, Dr. Catt. Dr. Frank, Dr. Moody, Health and Law Resources, Dr, Bailey, and Wilma McLaughlin, for treatment both before and after the injury on 2/13/09. Based on the evidence and his reasoning, Dr. Obolsky opined that petitioner was malingering her cognitive and

emotional symptoms and had reached MMI in May of 2009. He opined that petitioner is mentally fit for full time employment. He found no evidence of any impairing mental condition and was of the opinion no mental health treatment is required. Dr. Obolsky opined that petitioner's current mental health treatment is not related to her injury on 2/13/09. He opined that at worst, petitioner experienced a mild traumatic brain injury, and her expected course of recovery to her pre-existing level of functioning would have been 3 months.

Dr. Obolsky found it significant that following the injury petitioner made several visits to the mall and reported lack of avoidance, anxiety, or emotional distress when exposed to reminders of her fall. He opined that this indicates that she did not develop posttraumatic stress disorder. He also found it significant that in August of 2009, when she underwent neuropsychological testing, she exhibited memory impairment as severe as that seen in Alzheimer patients, and inconsistent effort on several cognitive tests. He noted that Dr. Alper found petitioner did not put forth the best effort. Dr. Obolsky saw this as indicative of purposeful behavior to present oneself as being sick. Dr. Obolsky believed petitioner's trip to Mexico in October of 2009 and her ability to enjoy herself as documented in Facebook posts were discrepant with her complaints to various physicians before and after the trip. (The Arbitrator notes that Petitioner's trip to Mexico was on 3/28/09, and not in October of 2009, as verified by her passport.) Dr. Obolsky also relied on the opinions of Dr. Bhosale in November of 2009 when he reported "It is also apparent to me that the patient and her husband are grappling with having difficulty accepting the fact that her symptoms are not related to any structural or physiological injury to the brain. They are less inclined to believe this is all a psychological issue." He noted that Dr. Bhosale believed petitioner's cognition was intact, and that "he is not completely convinced the patient meets criteria for major depression and anxiety disorder." Dr. Obolsky was also of the opinion that Facebook posts with petitioner having drinks at a bar on 12/7/09 contradict a diagnosis of depression and anxiety. He further opined that her ability to enjoy herself with friends and on vacation disproves the presence of a current disorder. Dr. Obolsky also relied on Dr. Frank's opinion that petitioner's current examination was "entirely within normal limits," that she has a lot of subjective complaints," and appeared to have some somatoform type of disorder in 2004. He also relied on Dr. Frank's opinion that he could see no reason that petitioner could not function in her previous capacity working with computers and with the telephone at State Farm.

Dr. Obolsky also relied on the opinions of Dr. Warren on 5/18/11, that showed petitioner purposely feigned cognitive and emotional symptoms. Whereas, Dr. Obolsky was of the opinion that Dr. Rothke's opinions that petitioner's reported symptoms "suggest" authenticated major depression and generalized anxiety disorders causally connected to the work event on 2/13/09, and authentic cognitive complaints, were in contradiction to the totality of the available data. Dr. Obolsky also found it significant that petitioner was

frequently non-compliant with prescribed treatment, in that she missed 2/3 of her physical therapy appointments. He found such behavior inconsistent with factitious disorder.

After reviewing petitioner's medical records that preceded the accident, Dr. Obolsky's opined that petitioner did not have a prior head or brain injury, but an MRI on 6/11/04 showed white matter lesion on her brain. Additionally, before her injury, petitioner treated for chronic migraines and headaches, as well as chronic pain in her neck and head. No mental, emotional, or cognitive deficits were noted before 2/13/09.

Dr. Obolsky opined that there is no objective evidence to support petitioner's complaints of cognitive pathology. He found solid evidence that petitioner purposely feigns cognitive deficits and symptoms of emotional distress. He opined that the results of the forensic psychiatric evaluation show that petitioner is malingering both her cognitive and emotional symptoms, psychological dysfunction, mental and physical symptoms, moderate depression, and self reported anxiety.

Dr. Obolsky opined that his diagnosis of malingering is robust and extensive and was based in part on the course, severity, and nature of the alleged symptoms are inconsistent with the nature, severity, and duration of the reported 2/13/09 work event; the course, severity, and nature of the alleged symptoms are inconsistent with petitioner's pre-morbidity history; discrepancies between test data and observed behaviors; discrepancies between various test data and known patterns of brain functioning; discrepancy between self-reported symptoms and observed behaviors; discrepancy between self-reported symptoms and evidence from non-clinical sources; evidence of exaggerated distress on various tests of psychological function; and multiple tests indicating that petitioner malingered emotional and cognitive symptoms.

On 3/13/14 the evidence deposition of Dr. Obolsky, board certified in general and forensic psychiatry, was taken on behalf of the respondent. Dr. Obolsky testified that his areas of expertise are the emotional, cognitive and mental consequences of severe emotional and physical injury to individuals. He opined that petitioner's complaints of mental symptoms are not related to the work event of 2/13/09. He opined that the treatment provided was reasonable as to the degree that the treating physicians and other professionals were not aware of the fact that petitioner was malingering her symptoms. He further opined that no treatment provided subsequent to the first three to four months after the injury was related to the injury on 2/13/09. He found it significant that two months before her appointment with him, her 31 year old son died in his sleep due to myocardial infarction. He also found it significant that when he talked to her about the fall she demonstrated no evidence of any emotional distress, but did demonstrate emotional distress when talking about her finances and where she was going to live. Dr. Obolsky opined that as of the date he examined petitioner she was mentally fit for full-time competitive employment consistent with her education, skills and experience.

On cross-examination, Dr. Obolsky testified that Dr. Rothke is not a physician. He also testified that Dr. Rothke did not address the issue of malingering. He opined that the published ethical guideline is that no neuropsychological testing can be done without a thorough evaluation of a person's effort and exaggeration of symptoms. He opined that neuropsychologists in the U.S. have different specialty-specific guidelines as to how to evaluate patients, which is different than that of physicians. Dr. Obolsky testified that when Dr. Alper compared the results of one or more testings of petitioner to that of somebody that had a degenerative dementia of an Alzheimer type rather than a mild traumatic brain injury, Dr. Obolsky was of the opinion that moderate to severe memory impairment is the definition of moderate to severe Alzheimer's. Dr. Obolsky did not diagnose Alzheimer's for petitioner. Dr. Obolsky testified that 99% of his worker's compensation cases are referred to him by insurance companies.

On 4/15/15 petitioner underwent a Vocational Assessment performed by Dennis Gustafson, M.S. CRC., at the request of petitioner's attorney, Kevin Elder. This assessment included education and work history, a review of medical information relative to the work related injury on 2/13/09, face to face interview with petitioner performed on 9/8/14, and a 20 minute telephone conversation with Chris Hartnell, petitioner's husband. Gustafson noted that petitioner exhibited a great deal of difficulty remembering prior jobs and dates of employment, and transitioning from one answer to the next during the interview. Petitioner told Gustafson that she was unable to focus on more than one thing at a time, and if she does not complete a task before going on to another task she forgets to return and finish it. She complained of headaches on 6 days of the week, with them being most severe on 2-3 days and she must lie down in a darkened room. She told Gustafson that the more severe headaches have improved over time. She reported that she could not recall how to use Microsoft Office, despite having successfully completed the computer testing done by Dr. Rothke. Chris Hartnell reported that petitioner can no longer multitask, and does not remain focused. He said it appears that she lost all her knowledge of insurance, and computer knowledge, despite Dr. Rothke's finding to the contrary. He noted that she is frustrated and depressed on a daily basis over her inabilities and suffers considerable social anxiety. He noted that petitioner has a fear of interstate driving, and exhibits high anxiety with the proximity of trucks or other large vehicles. Mr. Hartnell told Gustafson that he did not believe petitioner could work even in a simple job due to her focus concentration and memory issues, and if she did work she would miss 2-3 days per month due to severe headaches and anxiety.

Based on his interview with petitioner and her husband, and his review of petitioner's medical records that included Dr. Rothke's neuropsychological evaluation, labor market survey done by Coventry Worker's Compensation, SSDI award letter, Gustafson concluded that petitioner is unable to meet the productivity

requirements and overall employment expectation of any employer in any job as normally performed within the economy. He noted that this is the reason she was awarded SSDI. Gustafson was of the opinion that nothing seems to have improved with petitioner in the 2 years since her neuropsychological evaluation with Dr. Rothke, and may have worsened. Gustafson noted that petitioner tried to attempt volunteer work at Bromenn, but her failure to perform the expected requirements of the job resulted in further reduction of her self-esteem and sense of competency. He was also of the opinion that her inability to perform simple clerical tasks clearly points to the expectation that she would be unable to meet the more rigorous and detailed demands of her prior State Farm job or any other clerical type task consistent with prior work experience. He opined that her prior expertise in customer service was unlikely unable to be used for employment based upon current social anxieties and tendency toward people avoidance. Gustafson also ruled out repetitive task jobs because of petitioner's wandering focus of attention , and inability to efficiently mow her yard, which is a highly repetitive and simple task. Gustafson was of the opinion that petitioner was incapable of productive performance in any current job situation as normally performed. He also believed petitioner would not be a successful candidate for either further vocational education/training or vocational rehabilitation services.

On 6/24/15 petitioner underwent an Initial Vocational Rehabilitation Evaluation performed by Julie Bose, M.S.CRC at Medvoc. Ms. Bose received the file of petitioner for a limited assignment, to conduct a file review and vocational rehabilitation assessment. She reviewed numerous documents including vocational assessment conducted by Gustafson, neuropsychological examination by Dr. Rothke, neuropsychological evaluation from Dr. Obolsky, psychiatric records from Dr. Moody, neuropsychological evaluation from Dr. Warren, neuropsychological evaluation by Dr. Alper, and facebook entries from petitioner. Bose collected Behavioral/Biographical Data, Medical Data, Vocational History, and Current Vocational Rehabilitation Status from petitioner. Based on this information Ms. Bose made her rehabilitation impressions and recommendations. She noted that petitioner was of average intelligence and has some mild deficit in memory and processing speed. However, she also noted that Dr. Alper, Dr. Warren, and Dr. Obolsky all questioned whether petitioner's symptoms were exaggerated and whether the tests represented an accurate measure of her abilities.

Bose found no medical or psychological opinions that petitioner was permanently and totally disabled from work. She noted that petitioner's neuropsychological testing only reflects minimal deficits which should be factored into her vocational plan. Based on petitioner's self-reported activities of daily living, results of neuropsychological testing, and review of petitioner's presentation on social media, Bose was of the opinion that petitioner would be a candidate for a wide range of simple unskilled occupations. She was of the opinion that given petitioner's difficulty with coping with stress, she would not recommend that petitioner be placed in a job

with rigid production rates. Also, given petitioner's concern about the ability to interact appropriately on a social basis, Bose recommended that petitioner search for employment with limited social interaction. Bose was also of the opinion that petitioner would be an appropriate candidate for jobs such as that of a janitor, housekeeping cleaner, or laundry worker. She noted that these positions are self to moderately paced, involve no tandem work with co-workers, and are simple and routine in nature. Bose pointed out that the records reflect that petitioner also has poor self-esteem, and that reentry into the workplace would be helpful in improving her self-esteem, and making her a productive member of society.

On 8/17/15 the evidence deposition of Gustafson, was taken on behalf of petitioner. He believed petitioner was making an effort to respond to what he was asking her during her interview. He noted a lot of problems in petitioner's focus and general understanding of what was going on during the interview. Gustafson testified that petitioner worked as a receptionist and performed clerical work in a doctor's office, OSF Healthcare, and Mitsubishi for 10 years, and did customer service work on the phone at State Farm and eventually worked her way up to underwriter assistant with State Farm, performing clerical support to underwriter. Gustafson testified that petitioner told him she only volunteered at Bromenn for 4 hours every two weeks, but had a great deal of difficulty remembering when she could go back, how to access the info on the computer, or the duties she was to perform. He noted that she developed a feeling of being uncomfortable and anxious in an environment where a lot of people were present, and this caused additional headaches. Gustafson was under the belief that the injury caused her headaches. He did not believe she had migraines and had not been diagnosed with them. However, petitioner's medical records prior to her work injury showed that petitioner had severe migraine headaches and facial numbness as far back as at least 2004. Gustafson testified that he relied only on Dr. Rothke's recommendations that included deficits in new learning and recall of verbally and visually presented information; mental efficiency; visual motor speed; and right handed manual dexterity when he determined that she was unable to meet productivity requirements and employment expectations of any employer in any job. He did not believe vocational retraining would work due to her memory deficit, and was of the opinion that new learning would be needed and she has problems learning things. Gustafson agreed that Dr. Rhotke did not give petitioner any formal restrictions.

On cross-examination Gustafson testified that 99% of the workers' comp work he does is for petitioners. He testified that he only does evaluations. He does not do job placement. Gustafson testified that the only medical records he reviewed with respect to petitioner were the records of Dr. Rothke, the doctor petitioner's attorney sent her to. He testified that he did not review the records of Dr. Warren, Dr. Alper or Dr. Obolsky, all of which showed symptom magnification and malingering. He also did not review any of her treating records,

or social media, that showed some malingering, and petitioner in Mexico and in a bar with a group of friends having a great time, respectively. Gustafson attributed the symptom magnification that Dr. Rothke found to petitioner' s anxiety. He testified that it was his understanding that petitioner's forgetfulness, memory problems, and stress at work did not occur until after her injury. He was not aware that she had headaches and treatment for her headaches prior to the injury. He also did not know when petitioner voluntarily left her employment with State Farm, she was asked to leave, or left because she was moving from Bloomington. Gustafson admitted that he has no training in neuropsychological testing. He also agreed that Dr. Rothke never said petitioner could not work. Gustafson was of the opinion that because of petitioner's cognitive problems, she would likely fail at work and that failure would exacerbate her depression and anxiety. He noted that petitioner never looked for any work after leaving State Farm, but attributed it to her cognitive problems, even though some of those issues resolved over time.

The evidence deposition of Bose was taken on behalf of respondent on 9/28/15. Bose has been a certified vocational rehabilitation counselor for 32 years. Bose testified that she has a background in neuropsych training, as it relates to a semester long three-hour credit class in neuropsych assessment while in her master's degree program. She also worked as a contract provider for New Medico doing job placement. Bose does a wide variety of tasks that include medical management, creates vocational rehabilitation plans, coordinates training programs, performs job placement services and labor market surveys, performs ergonomic studies, and a fair amount of supervision of staff. Bose performs these activities on behalf of both the petitioner and respondent.

Bose testified that petitioner was late to her appointment because she was in a minor traffic accident on her way to see her. Petitioner drove herself to the appointment. Bose testified that she did not see petitioner's slow responses to be based on anything that she saw in the records from the neuropsych assessment. She attributed petitioner's slow response to her being rattled after having the traffic accident and being pretty shook up. She believed petitioner's response was more of an emotional response than a brain injury response. Bose noted that Dr. Alper felt that petitioner's sensory perceptional and motor functions were all predominantly normal, that she had an average IQ, and that her memory test, although reduced, was an underestimation of her true potential, that she had mild impairment in processing speed, and that her verbal ability was average. She further noted that Dr. Alper, based on validity testing, was of the opinion that there were inconsistencies in petitioner's responding, in both verbal and nonverbal measurements of domain. She noted that Dr. Alper was of the opinion that petitioner had some mild abnormalities, but did not feel that they were consistent with a brain injury, but rather more consistent with depression and anxiety. Bose noted that Dr. Frank indicated that

petitioner was already diagnosed in 2004 as having some type of somatoform disorder, and was of the opinion that petitioner could go back to work at State Farm. Bose also noted that Dr. Warren was of the opinion that petitioner gave poor effort on the TOMMS test, questionable engagement in the VSVT assessment, malingering range on the SIMS test, and basically concluded that petitioner's symptoms appeared to be more due to anxiety and depression than a brain issue. Bose noted that when petitioner saw Dr. Moody her complaints were more headache related than specific symptoms of TBI and anxiety and depression. She further noted that Dr. Moody indicated that petitioner reluctantly agreed to take the psychotrophic medication, but there was limited success. She noted that Dr. Moody also indicated that petitioner appeared to be preoccupied with the headaches, negative thinking, and eventually petitioner just discontinued treatment with Dr. Moody. She noted that Dr. Rothke diagnosed a mild impairment based on an average IQ, high average of attention span for digits and math, average recall for basic personal information and current events, mild impairment in immediate recall and call processing speed, and mild limitations. She noted that Dr. Rothke recommended that petitioner undergo voc rehab services and volunteer work because petitioner had some issues regarding self-esteem as well. She noted that the results of Dr. Obolsky's testing were consistent with those of Dr. Alper and Dr. Warren, who also noted malingering.

Bose testified that petitioner told her that most activities she could not do were limited primarily by her headaches, which she had prior to the work injury. She testified that petitioner was not under any current medical care and was not taking any medications for her headaches. She testified that petitioner told her she was treating her headaches with fountain Dr. Pepper, and it had been somewhat successful. Bose testified that petitioner told her that most of her problems driving, and her ability to socialize were caused by her headaches.

Bose testified that petitioner told her that she had not been looking for work because she believed she would not be able to be productive or reliable, primarily due to the headaches. Bose opined that petitioner would be employable in more unskilled routine types of positions that don't require a high level of socialization and positions that did not involve skilled tasks and multistep tasks such as that of a housekeeping cleaner, a laundry worker, or a janitor. She opined that a return to work could also be beneficial for her in terms of self-esteem. She opined that it would have been more beneficial if petitioner had attempted to return to work instead of trying a volunteer position.

On cross-examination, Bose opined that it would have benefitted Gustafson to review Obolsky's neuropsych report, Warren's neuropsych report, Alper's report, and review the actual test results, which were an objective measure. She noted that in all of them there was consistency with intellectual functioning, consistency in the area in the resting where there was impairment between all 3 of them, and consistent findings of

malingering or concerns about validity in all three of them. She also believed there was benefit to reviewing the neuropsych eval performed by Dr. Rothke.

Bose testified that she did not speak to petitioner's husband. She testified that when working with a person with a disability, she looks at the physicians restrictions to determine their work abilities, and none of the doctors opined that petitioner was unable to work, although some thought certain restrictions would be necessary.

On redirect examination Bose testified that the neuropsychologists did not feel that her mild impairment shown on testing was related to a brain injury, but was related to depression and anxiety, which no doctor opined was related to her fall at work.

Prior to petitioner's injury on 2/13/09 petitioner treated at Carle Clinic. In April of 2004 petitioner treated for numbness to the right side of her face, and her head. She reported that the "top of head hurts bad!" She was diagnosed with migraines and face numbness. It was also noted that petitioner had a history of migraines, unilateral face numbness, and focal symptoms. An MRI of the brain was ordered. She went to a neuro in May of 2004, who reviewed her extensive old records and noted that he needed her actual MRI brain films. Very small WM lesions were seen. In June of 2004 she was scheduled for a TEE for her facial numbness. The TEE showed a slight leaky valve, which was nothing to worry about, and was not causing her symptoms. Petitioner was prescribed Topamax.

In July 2004 petitioner told her doctor that her headache was not a problem at that time and she would rather not take any medication since it is a problem for her to remember to take the medication. On 7/27/04 petitioner reported that she "is like in a fog," "not understanding things that are going on, and has been this way for at least 4 days." Petitioner was scared about symptoms she was experiencing. "Feels out of it." She complained of dizzy, blurred vision. She said she was taking Tylenol 1500mg daily for pain at the base of her skull. On 9/3/04 she underwent a spinal fluid test. No sign of multiple sclerosis was noted. On 9/24/04 it was suspected that she had occipital neuralgia. On 10/12/04 she complained of left jaw, neck and shoulder pain, and pain burning at the base of her skull that radiates to the left jaw, neck and shoulder for the past 8 years. She stated that she was extensively evaluated at Mayo for these conditions, and the pain was felt to be related to facial pain of unknown etiology. Petitioner underwent some injections that provided no relief for her headaches. Dr. Catt felt there could be some occipital neuralgia or irritation of the occipital nerve contributing to her discomfort.

On 1/10/05 petitioner presented to the emergency room with facial numbness and burning unilaterally in the occiput/temple. Petitioner was prescribed Trileptal to help with the burning pain. On 11/8/08 petitioner had recurring symptoms of neuralgia.

Petitioner's husband, Christopher Hartnell, was called as a witness on behalf of petitioner. He testified that for her job at State Farm in the office she needed 11-13 licenses to sell insurance. On or about 2008 petitioner bid up to an underwriter assistant position. She was in that position for 1-1/2 years, and her husband testified this job was a bit of a struggle for her. Mr. Hartnell testified that before the accident she would go to dinner with friends, and had people over. She also drove without difficulty. At home she helped with the checkbook, did laundry, shopped, cleaned and kept the house clean. He observed no memory or focus issues, despite the fact that petitioner had reported these type of problems prior to the injury.

After the injury, he stated that she only worked for State farm for a few days. Mr. Hartnell testified that petitioner recently got SSDI. He testified that if a weather front comes in she cannot deal with people and shuts herself in. He stated that she also gets migraine headaches. Mr. Hartness testified that petitioner does not go out much. He stated that her memory is spotty, and she get distracted easily. He also testified that she is more emotional now. He stated that she only has 7-8 good days a month. Petitioner does a fairly good job with the checkbook. Mr. Hartnell testified that petitioner stopped seeing Dr. Moody due to financial reasons.

Mr. Hartnell testified that petitioner tried to volunteer at Advocate Bromenn and the McLean library, but could not always show up when scheduled. He testified that petitioner has searched for jobs, but found none. He testified that petitioner cannot multitask very well.

On cross-examination he admitted that petitioner had a history of headaches/migraines, and jaw injury prior to the work injury. In August of 2011 petitioner drove with her husband and grandkids to Florida for a vacation. They travelled on the highway with trucks.

Petitioner testified that she had problems with the noise and crowds when she volunteered at Advocate Bromenn. However, her facebook page shows her in a bar drinking with her friends. Petitioner testified that since 2/16/09 she has not worked in any paying job.

Today, petitioner testified that she experiences a lot of confusion and can't stay focused. She complained of headaches, anxiety and depression every day. She testified that she has 1-2 good days a week, but it varies depending on the weather. She testified that the bariatric pressure affects her, and she gets debilitating migraines. She testified that she can drive up to 15 miles, but concentration is an issue. The arbitrator notes that petitioner's trip to see Bose was further than 15 miles and she drover herself there. She testified that since

September of 2010 her headaches have improved, and they are not so severe all the time. She testified that she has breakthrough of memory. Petitioner also testified that she applied for jobs but never got none.

Petitioner testified that in September of 2013 she was in the car with her grandson, with someone else driving, and got into a motor vehicle accident. She testified that they were hit on the left side, and spun and hit a tree. She did not treat for these injuries. Petitioner testified that she was not in Mexico in October of 2009. Her passport shows her and her husband were there in March of 2009, one month after the work injury.

Hillary Sand, a friend of petitioner's for 25 years was called as a witness. She testified that before the accident petitioner was happy, fun loving, energetic, a party planner, went camping, was always ready to jump in, was busy with the kids, and worked 2 jobs. In 2015 Sand saw petitioner 6 times, because they do not live as close as they used to since petitioner moved to Atlanta. She testified that noise and commotion affect her. She stated that petitioner gets scattered, can't function, and is low key. Sand does not find petitioner full of life today.

Paula Degaramo Short, a friend of petitioner's for 28 years, was called as a witness on behalf of petitioner. She testified that in 2008 she saw petitioner every or every other weekend, and they did everything together. Currently, she sees petitioner about 5-6 times a year. She testified that petitioner is not as involved in doing things as she used to be. She testified that petitioner's memory does not seem the same, and she does not have memory of what they did they together. She testified that weather changes are almost crippling to petitioner.

Amanda Gibson, petitioner's daughter, was called as a witness on behalf of petitioner. She testified that she saw her mom every day before the accident, and close to every day now. She testified that before the accident she was always on the go and on the ball. She never sat down, ran everywhere, and was happy. She had great friends and did a lot with them. She testified that currently her mother does not work and stays home. She stated that she is not as kept as she used to be, and that her mom has difficulty getting tasks done. She testified that her mom is not involved in as many social things as before. She gave a specific situation where her mother forgot to buckle her daughter in the stroller and she fell out, but was not seriously injured. She testified that her mother watches her 4 year daughter after school, since that is where the bus drops her off. Sometimes, when she is not up to it, Gibson will pick up Amanda at the bus.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

This claim was previously tried pursuant to Section 19(b) of Act on 9/10/10. One of the issues in dispute was causal connection. With respect to this issue, Arbitrator White found that petitioner's cognitive difficulties, memory impairment, daily headaches, depression, and anxiety, as well as her post concussion syndrome are all

directly related to her February 13, 2009 work related injury. Respondent did not appeal Arbitrator White's decision. Petitioner is not claiming any new injuries or conditions as a result of her work injury. As such, this arbitrator finds the conditions Arbitrator White found causally related to the work injury, are still causally related to the work injury. However, the arbitrator will address whether or not the treatment petitioner has received for these conditions since the 19(b) hearing on 9/10/10 was reasonable and necessary, and the impact these conditions now have as they relate to the nature and extent of petitioner's injury.

J. WERE THE MEDICAL SERVICES THAT WERE PROVDED TO PETITIONER REASONABLE AD NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

Per the Request for Hearing, the medical bills petitioner is alleging were reasonable and necessary were offered as PX10. Petitioner offered into evidence 4 bills from Bloomington Radiology. The first one is for a CT of the head and chest x-ray performed on 10/26/09, in the amount of $215.00. Since these diagnostic tests were performed nearly one year before the first 19(b) hearing and sent to collections prior to the 19(b) hearing, the arbitrator has no credible evidence to support a finding as to who ordered these tests and the purpose of these tests, especially given the fact that prior to the injury on 2/13/09 petitioner had multiple tests ordered and performed for her preexisting migraines and facial numbness. The proper time to offer these bills was at the hearing on 9/10/10 with the proper supporting medical evidence. As such, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that these diagnostic tests were reasonable and necessary to cure or relieve her from the injuries she sustained on 2/13/09.

The second bill from Bloomington Radiology is for a duplex scan extreme vein LM performed on 10/26/09, in the amount of $97.00. Again, the arbitrator finds that since this diagnostic test was performed nearly one year before the first 19(b) hearing and sent to collections prior to the 19(b) hearing, the arbitrator has no credible medical evidence to support a finding as to who ordered this test and the purpose of this test, especially given the fact that there is no credible medical evidence in the credible record to support this type of diagnostic test. The proper time to present this bill was at the hearing on 9/10/10 with the proper supporting medical evidence. As such, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that this diagnostic test was reasonable and necessary to cure or relieve her from the injuries she sustained on 2/13/09.

The third bill from Bloomington Radiology is for 2 chest views in the amount of $46.00. These x-rays were performed on 2/15/11. Petitioner offered no credible medical evidence to support a finding that these x-rays were reasonable or necessary for her causally related conditions. Additionally, petitioner failed to offer into evidence any order by any treating doctor for these x-rays. As such, the arbitrator finds the petitioner has failed

to prove by a preponderance of the credible evidence that this diagnostic test was reasonable and necessary to cure or relieve petitioner from the effects of her injury on 2/13/09.

The fourth and final bill from Bloomington Radiology is for another chest x-ray on 9/3/11, in the amount of $38.00. Again, the arbitrator finds the petitioner offered no credible medical evidence to support a finding that this x-ray was reasonable or necessary for her causally related conditions. Additionally, petitioner failed to offer into evidence any order by any treating doctor for this x-rays. As such, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that this diagnostic test was reasonable and necessary to cure or relieve petitioner from the effects of her injury on 2/13/09.

Petitioner offered into evidence a report from Financial Recovery Services for services on 9/3/11 at Bloomington Medical Lab Phys in the amount of $137.00; services at Bloomington Medical Lab Phys on 2/15/11 in the amount of $62.40; services at OSF St. Joseph Medical Center on 2/15/11 in the amount of $871.31; services at OSF St. Joseph Medical Center on 2/24/11 in the amount of $214.05; and services at OSF St. Joseph Medical Center on 1/10/12 in the amount of $1,119.55. Given that the petitioner offered no credible medical evidence that identifies what these charges are for, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that this diagnostic test was reasonable and necessary to cure or relieve petitioner from the effects of her injury on 2/13/09.

Petitioner offered into evidence a bill from OSF Medical Group in the amount of $106.00 for services on 10/20/09 related to a contusion of her upper arm. Given that petitioner's injury was 2/13/09, and her 19(b) hearing was on 9/10/10, the proper time to present these bills for payment would have been at the hearing on 9/10/10. Additionally, the arbitrator finds no credible medical evidence to support the reasonableness and necessity of this service as it relates to her injury on 2/13/09. The credible medical records offered into evidence include no records from Sam Moore. For these reasons the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that these medical services were reasonable or necessary to cure or relieve petitioner from the effects of her injury on 2/13/09.

Next, petitioner offers into evidence a bill from Carey Harris for an office visit on 2/17/11 in the amount of $115.00; a bill from Caisus2 for an ultrasound of the abdomen on 2/24/11 in the amount of $133.00; a bill from Carey Harris for an office visit on 2/28/11 in the amount of $115.00; and a bill from Pamela Harris for an office visit on 10/6/13 in the amount of $222.00. The arbitrator finds the petitioner has offered no credible medical evidence to support a finding that these services were reasonable and necessary to cure or relieve petitioner from the effects of her injury on 2/13/09. Additionally, the arbitrator notes that the balance due on all these bills is $0. For these reasons the arbitrator finds the petitioner has failed to prove by a preponderance of

the credible evidence that these medical services were reasonable or necessary to cure or relieve petitioner from the effects of her injury on 2/13/09.

Petitioner then offered into evidence bills with service dates of 5/4/09 for a PT evaluation and service dates of 5/4/09, 6/9/09, 7/8/09, 7/15/09, 8/13/09 for neuromuscular re-education, and service date of 9/10/09 for therapeutic exercise. The service provider is not identified for any medical service on the bill offered into evidence. Given that these services were incurred before the 19(b) hearing on 9/10/10, and petitioner offered no credible medical evidence related to these bills to show that these services were reasonable and necessary and related to the accident on 2/13/09, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that these medical services were reasonable or necessary to cure or relieve petitioner from the effects of her injury on 2/13/09.

The petitioner also offered into evidence a printout of charges from 02/18/09 through 09/17/09 for various exams, blood tests, and other medical services not fully described, or associated with any specific healthcare provider. Additionally, the reason for these services is not documented. For these reasons the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that these medical services were reasonable or necessary to cure or relieve petitioner from the effects of her injury on 2/13/09.

Petitioner then offered into evidence another printout of charges from Carle Clinic from 2/25/09 through 3/22/11 for various services that are not fully described, or associated with any specific healthcare provider. Additionally, the reason for all of these services is not documented. For these reasons the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that these medical services were reasonable or necessary to cure or relieve petitioner from the effects of her injury on 2/13/09.

Petitioner offered into evidence a bill for services rendered by Dr. Warren from 4/1/10 to 5/15/14 in the amount of $3,310.00. Given that petitioner was referred to Dr. Warren by respondent's insurance carrier's nurse, in response to Arbitrator White's order that petitioner undergo the psychotherapy and psychiatry recommended by Dr. Catt, the arbitrator finds respondent shall pay, pursuant to Section 8(a) and Section 8.2 of the Act, the $3,310.00 for the services rendered by Dr. Warren.

Petitioner offered into evidence a bill from OSF St. Joseph Medical Center for emergency room services on 9/3/11 in the amount of $2,210.30. Given that petitioner offered no medical records regarding the services rendered this day, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that these medical services were reasonable or necessary to cure or relieve petitioner from the effects of her injury on 2/13/09.

Petitioner offered into evidence a bill from OSF St. Joseph Medical Center for an ultrasound of petitioner's abdomen on 2/24/11 in the amount of $415.00. Given that petitioner offered no medical records regarding the services rendered this day, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that these medical services were reasonable or necessary to cure or relieve petitioner from the effects of her injury on 2/13/09.

Petitioner offered into evidence a bill from OSF St. Joseph Medical Center for medical services on 2/15/11 in the amount of $1,688.20. Given that petitioner offered no medical records regarding the services rendered this day, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that these medical services were reasonable or necessary to cure or relieve petitioner from the effects of her injury on 2/13/09.

Petitioner offered into evidence the bill of Dr. Moody from Central IL Phys. Assc. for services rendered on 11/8/11, 1/11/12, 1/25/12, 3/5/12, 4/4/12, 5/15/12 and 6/27/12, in the amount of $950, of which petitioner paid $835.00 directly to Dr. Moody. Given the fact that the arbitrator finds the treatment rendered by Dr. Moody was reasonable and necessary to cure or relieve petitioner from the effects of her injury on 2/13/09, given that this treatment was ordered by Arbitrator White, the arbitrator finds the respondent shall reimburse petitioner for her $835 in out of pocket expenses, and pay the remaining $115 pursuant to Sections 8(a) and 8.2 of the Act.

K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Petitioner is claiming that she is entitled to temporary total disability benefits from 9/11/10 through 1/27/16. Respondent paid petitioner temporary total disability benefits from 9/11/10 through 6/17/11 in the amount of $19,305.20. Respondent is claiming that they are entitled to reimbursement of these temporary total disability benefits paid.

As a result of the 19(b) hearing on 9/10/10 Arbitrator White found that petitioner's cognitive difficulties, memory impairment, daily headaches, depression and anxiety, as well as her post concussion syndrome were all directly related to her February 13, 2009 work related injury, and that petitioner was temporarily totally disabled from 2/14/09 through 9/10/10 as provided in Section 8(b) of the Act. In response to Dr. Cattt's recommendation that petitioner undergo psychotherapy and psychiatric treatment petitioner presented to Dr. Pamela Warren. Dr. Warren then referred petitioner for medicine management. Petitioner sought treatment from Dr. Moody.

Following the hearing on 9/10/10, petitioner offered into evidence medical records beginning on 4/5/11. On 4/5/11 petitioner presented to Dr. Warren, a therapist respondent's insurance company nurse sent petitioner

to in response to Arbitrator White's order that petitioner be referred for psychotherapy and psychiatry that Dr. Catt's recommended.

Following her interview of petitioner; medical, educational, and social history; and mental status evaluation, Dr. Warren was of the opinion that petitioner was most likely going to need some additional psychological testing due to her concerns that petitioner showed clear evidence of symptom magnification, and in some cases some malingering with Dr. Alper. After 145 minutes of psychological testing, Dr. Warren opined that the results showed that in multiple scales petitioner was likely greatly exaggerating any cognitive concerns that she had. Dr. Warren found frank evidence of malingering. Dr. Warren assessed underlying depression related to anxiety and depression, and not related to any type of brain injury or any sustained effects from the fall on 2/13/09. On 6/7/11 Dr. Warren recommended medication and cognitive-behavioral psychotherapy, and a referral to a psychiatrist for bio-feedback therapy.

Following this treatment by Dr. Warren, respondent terminated petitioner's temporary total disability benefits. The arbitrator finds this termination of benefits not supported by the findings of Arbitrator White and the recommendations of Dr. Catt.

From 6/30/11 through 11/3/11 petitioner underwent counseling and psychotherapy with Wilma McLaughlin at Agape Counseling. McLaughlin recommended that petitioner consult with a psychiatrist for medication evaluation and apply for services from the Department of Rehabilitation Services of the Illinois Department of Human Services. The arbitrator finds these services consistent with the recommendation of Dr. Catt, as ordered by Arbitrator White. McLaughlin did not return petitioner to work.

On 11/8/11 petitioner next presented to Dr. Moody at Central Illinois Psychiatric Association for medicine management and therapy. Petitioner saw Dr. Moody seven times through 6/26/12. Following her testing and examination, as well as review of prior medical records, Dr. Moody noted that petitioner, despite her denial of any past psychiatric history, had been on Cymbalta, and perhaps Celexa and Ambien. She also noted that petitioner had been seen by a neurologist before the work injury for TMJ and migraine headaches. Petitioner reported that her headaches and dizziness had improved somewhat. Dr. Moody diagnosed petitioner as suffering a significant degree of anxiety; displayed some difficulties with hyper-sensitivity of hearing, tactile and visual; post-concussion syndrome; and difficulties with memory and judgment. She was also of the opinion that prior psychological testing indicated that some of petitioner's dysfunction might be due to anxiety and depression, and not completely due to her underlying brain damage. She opined that petitioner was capable of handling most, if not all in-house ADL's, has some limited function in the community due to her restrictions on

driving and getting lost sometimes when she leaves home. Based on these opinions the arbitrator does not find petitioner had yet reached maximum medical improvement or was able to return to her regular duty job.

On 12/13/12 petitioner underwent a Section 12 examination performed by Dr. Rothke, at the request of her attorney. Dr. Rothke performed extensive psychological testing, performed a record review, and interviewed petitioner and her husband. Overall, he opined that petitioner may have some over-reporting of cognitive and somatic difficulties. His diagnoses were major depressive disorder, and moderate and generalized anxiety disorder related to her fall at work. Dr. Rothke further opined that petitioner's depression or anxiety are not directly related to brain changes. He noted that petitioner had no trouble performing the computer part of the testing.

On 10/14/13 petitioner underwent a Section 12 examination performed by Dr. Obolsky, at the request of the respondent. Dr. Obolsky performed a forensic evaluation and psychiatric evaluation which was comprised of a record review, forensic psychiatric interview, forensic psychological and cognitive testing, and data analysis. Based on this evidence and his reasoning, Dr. Obolsky opined that petitioner was malingering her cognitive and emotional symptoms and had reached MMI in May of 2009. He opined that petitioner is mentally fit for full time employment. He opined that no mental treatment was required. He opined that at worst, petitioner experienced a mild traumatic brain injury, and her expected course of recovery to her preexisting level of functioning would have been 3 months. Dr. Obolsky reviewed petitioner's Facebook posts. He also noted that Dr. Bhosale in November of 2009 was of the opinion that petitioner and her husband were grappling with having difficulty accepting the fact that her symptoms are not related to any structural or physiological injury to the brain. He opined that her Facebook posts that show her having drinks in a bar on 12/7/09 contradict a diagnosis of depression and anxiety. He also found it significant that Dr. Frank opined that his examination of petitioner was "entirely within normal limits" and "she has a lot of subjective complaints" and appeared to have some somatoform type of disorder in 2004. He also relied on Dr. Frank's opinion that petitioner could function in her previous capacity with computers and telephone at State Farm.

On 4/15/15 petitioner underwent a Vocational Assessment performed by Dennis Gustafson, at the request of her attorney. The only medical records of petitioner that Gustafson relied on were the findings and opinions of Dr. Rothke. He also relied on an interview with petitioner and her husband, a labor market survey performed by Coventry Worker's Compensation, and petitioner's SSDI award letter. Based on this, Gustafson concluded that petitioner was unable to meet the productivity requirements and overall employment expectation of any employer in any job as normally performed within the economy. He also believed she would not be a candidate for vocational educational/training. The arbitrator finds it significant that Gustafson did not review any other

medical records other than those of Dr. Rothke. For this reason the arbitrator gives little weight to Gustafson's opinions.

Lastly, petitioner underwent a Vocational Rehabilitation Evaluation by Bose on 6/24/15. Bose, unlike Gustafson, reviewed numerous documents including those of Gustafson, Dr. Rothke, Dr. Moody, Dr. Obolsky, Dr. Warren, Dr. Alper, and petitioner's Facebook entries. She also collected behavioral and biographical date from petitioner, vocational history, and current vocational rehabilitation status. She found it significant that Dr. Alper, Dr. Warren and Dr. Obolsky all questioned whether petitioner's symptoms were exaggerated, and whether the tests represented an accurate measure of her abilities. In conclusion, Bose found no medical or physiological opinions to support a finding that petitioner was permanently and totally disabled from work. Although she did note that petitioner did have neuropsychological testing that only reflected minimal deficits which should be factored into her vocational plan. Based on petitioner's self reported activities of daily living, results of her neuropsychological testing, and petitioner's presentation on social media that was inconsistent with her claims that she could not drive on the highway with trucks around her, and that she could not be in crowds, or where it was loud. Petitioner herself stated that she drove to Florida with her husband on the highway where there were trucks. Also petitioner posted pictures of her in a bar drinking and having a good time with a group of people. She also had a lot of people over to her house for the July 4th weekend and they all camped out, and hung out in her yard/house.

The reason petitioner gave Bose for not looking for work was that she did not think she would be able to be productive or reliable primarily due to her headaches, which the arbitrator notes were preexisting as far back as at least 2004 when she received extensive treatment for her migraines and facial numbness, that included an MRI of the brain, a spinal fluid test, and visits to a neurologist. At that time, petitioner also complained of left jaw pain, and neck and shoulder pain radiating from the base of her skull for the past 8 years. Petitioner also underwent injections that provided no relief of her headaches. These symptoms continued up until the time of her injury on 2/13/09.

Based on the above, as well as the credible evidence, the arbitrator finds that petitioner was no longer temporarily totally disabled, and had reached MMI, when she underwent her Vocational Assessment by Bose. Bose had outline various positions that petitioner was capable of performing. Given the fact that each and every medical doctor was of the opinion that petitioner was capable of performing some type of work, and Bose outlined what these positions might be, the arbitrator finds the only obstacle to petitioner partaking in a vocational program at that point was her own belief that she was unable to be productive or reliable due to her headaches. Given that a fact that petitioner had severe headaches for years prior to the work injury, and a

number of medical doctors diagnosed petitioner with some level of malingering, the arbitrator finds the petitioner had an obligation to at least try vocational rehabilitation at that time. Given the fact that she did not, the arbitrator finds the petitioner was no longer temporarily totally disabled after 6/24/15, based on the opinions of Bose that petitioner was a candidate for vocational rehabilitation. At no time prior to this date did the respondent offer vocational rehabilitation for petitioner. The arbitrator finds that despite the opinion of a lot of petitioner's treating and examining doctors that petitioner is a malinger, most of them believed petitioner's current condition of ill-being following her injury may prevent her from returning to her regular duty job, but did not prevent her from returning to some type of work.

The arbitrator finds the petitioner was temporarily totally disabled from 9/11/10 through 6/24/15, a period of 249-4/7. As such, the arbitrator finds the respondent shall pay petitioner temporary total disability benefits of $482.63/week for 249-4/7 weeks. Respondent is also entitled to a credit of $19,305.20 for temporary total disability benefits paid after 9/10/10.

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

Although petitioner reported to various healthcare providers that she had no problems with her head prior to the injury on 2/13/09, the arbitrator finds there is at least an 5 year history of headaches and facial numbness that petitioner had prior to the injury on 2/13/09. This is documented in her medical records prior to 2/13/09 that show petitioner treated for numbness to the right side of her face and head. Petitioner complained of a history of migraines and facial numbness. For these conditions she underwent an MRI of the brain, a referral to a neurosurgeon, a spinal fluid test, and complained of left jaw pain, and neck and shoulder pain for the past 8 years. She also reported that she underwent some injections to relieve her pain, but they did not work.

Of all the medical doctors petitioner treated with, many found signs of malingering. These doctors included Dr. Alper, Dr. Rothke, Dr. Frank, Dr. Moody, Dr. Warren and Dr. Oblosky. Additionally, there is not one doctor that felt petitioner could not return to some kind of work. The only one who believed petitioner could not return to any type of work was Gustafson, who was hired by petitioner's attorney, and only reviewed the medical records of one doctor, Dr. Rothke, who even opined that petitioner was not permanently totally disabled. In fact, petitioner had no problems performing the computer part of Dr. Rothke's testing, and no problem accessing and posting on social media, and performing a very limited online search for jobs.

The arbitrator also questions some of petitioner's claims of needing to be away from crowds and loud noises given her facebook posts that showed her in Mexico with her husband having a good time, and in a bar drinking with her friends. The petitioner also went to a hockey game. The petitioner also claimed she could not drive on the highway near trucks, but drove all the way to Florida and back with her husband. She also drove

herself from Atlanta, IL to Steger, IL for her appointment with Bose, which was more than the 15 miles she claimed she could drive. She also had a group of people come and spend the 4th of July weekend with her and her family camping in her yard and spending time together. The arbitrator finds petitioner's, her husband's, and her friends testimony regarding what she can and cannot do often inconsistent with what she actually did.

Based on the credible medical record, the arbitrator finds the petitioner sustained minimal deficits which should be factored into her vocational plan. However, since petitioner refused any vocational plan due to her beliefs that she was unable to be productive or reliable primarily due to her headaches, absent any such opinion from a medical doctor, the arbitrator finds the petitioner sustained a 30% loss of use of her person as a whole pursuant to Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Wiegers,

Petitioner,

vs.

NO: 12WC 40446

State of Illinois/Illinois State Police,

17IWCC0532

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by both parties and proper notice given, the Commission, after considering the issues of accident, temporary disability, causal connection, permanent disability, medical expenses, motion in limine, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 27, 2017 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.

17IWCC0532

Pursuant to §19(f)(1) of the Act, this Decision and Opinion on Review of a claim against the State of Illinois is not subject to judicial review.

DATED: AUG 30 2017

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

SJM/sj
d-8/3/2017
44

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WIEGERS, MICHAEL
Employee/Petitioner

Case# **12WC040446**

ST OF IL/ILLINOIS STATE POLICE
Employer/Respondent

17IWCC0532

On 2/27/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.67% shall accrue from the date listed above to the day before the 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:

1780 JOHNSON & JOHNSON PC
ANDREWE W JOHNSON
212 E CHESTNUT ST
CANTON, IL 61520

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

5300 ASSISTANT ATTORNEY GENERAL
CODY KAY
500 S SECOND ST
SPRINGFIELD, IL 62706

2202 ILLINOIS STATE POLICE
801 S 7TH ST
SPRINGFIELD, IL 62794

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

FEB 27 2017

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

17IWCC0532

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

Michael R. Wiegers
Employee/Petitioner

v.

State of Illinois/Illinois State Police
Employer/Respondent

Case # 12 WC 40446

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 Peoria, on January 19, 2017. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0532

FINDINGS

On October 1, 2010, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $78,825.00; the average weekly wage was $1,505.48.

On the date of accident, Petitioner was 59 years of age, married with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services as related to Petitioner's bilateral carpal tunnel syndrome condition, as identified in Petitioner's Exhibit 9, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $1,003.65 per week for three and three-sevenths (3 3/7) weeks commencing December 10, 2013, through December 18, 2013, and December 16, 2014, through December 30, 2014, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $669.64 per week for 25.625 weeks because the injuries sustained caused the five percent (5%) loss of use of the right hand and seven and one-half percent (7 1/2%) 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

William R. Gallagher, Arbitrator
ICArbDec p. 2

February 16, 2017
Date

Preliminary Ruling

This case was tried in Peoria on January 19, 2017. Petitioner's counsel previously filed a Motion in Limine wherein he moved the Arbitrator exclude the deposition testimony of Respondent's Section 12 examining physician, Dr. James Williams. In that motion, Petitioner's counsel argued the Dr. Williams committed perjury when he was deposed in regard to the percentage of examinations he performed at the request of Respondent. Further, Petitioner's counsel represented that Dr. Williams had a financial bias based upon the income he derived from performing examinations at the request of Respondent. Because of the preceding, Petitioner's counsel argued that Dr. Williams' testimony be excluded, in its entirety, because it was unreliable and prejudicial to be admitted into evidence (Petitioner's Exhibit 3).

Respondent's counsel filed a Response to Petitioner's Motion in Limine wherein he stated that Dr. Williams did not perjure himself when he was deposed. Further, Respondent's counsel stated that excluding Dr. Williams' testimony would violate Respondent's rights of due process (Respondent's Exhibit 4).

Petitioner's Motion in Limine was previously argued before the Arbitrator in October, 2016. At that time, the Arbitrator denied the motion because the issues raised by Petitioner's counsel related to the credibility of the witness and what probative value should be given to his testimony. The Arbitrator found this was not a basis to exclude, in its entirety, Dr. Williams' testimony. When this case was tried on January 19, 2017, the Arbitrator reaffirmed this ruling on the record.

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained a repetitive trauma injury arising out of and in the course of his employment for Respondent. The Application alleged a date of accident (manifestation) of October 1, 2010, and that Petitioner sustained repetitive trauma to bilateral hands and arms (Petitioner's Exhibit 1). Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibit 1).

Petitioner began working for Respondent in October, 1986, and worked up until he retired on December 31, 2016. For approximately 25 years, Petitioner was an Intelligence Analyst. Petitioner claimed he sustained bilateral carpal tunnel syndrome as a result of typing/keyboarding. Petitioner testified he was right hand dominant and used both of his hands for typing for virtually 95% of every workday.

At trial, Petitioner's counsel tendered into evidence eight photographs of Petitioner's workstation which included two separate keyboards and pads Petitioner rested his hands on when he was typing (Petitioner's Exhibit 10). Petitioner testified he would generally hold his hands at about a 45° angle when he was typing. Petitioner would hold his hands at the same angle on both keyboards. Petitioner's other duties at work included answering the telephone, handwriting and filing.

Petitioner initially sought medical treatment on October 1, 2010 (the date of manifestation alleged in the Application) from Dr. Michelle Reeves, his family physician. At that time, Dr. Reeves' findings on examination were consistent with bilateral carpal tunnel syndrome. Dr. Reeves indicated she was going to order EMG/nerve conduction studies. Dr. Reeves stated in her record she considered the condition to be work-related, but did not explain the basis for her opinion (Petitioner's Exhibit 7).

EMG/nerve conduction studies were performed on October 12, 2010. The studies were consistent with mild bilateral carpal tunnel syndrome as well as chronic moderate cubital tunnel syndrome and bilateral C6-C7 radiculopathy (Petitioner's Exhibit 6).

Petitioner was subsequently seen by Dr. Edwin Card, a general surgeon, on November 8, 2010. Dr. Card examined Petitioner and noted Petitioner had recently undergone nerve conduction studies which were positive for carpal tunnel syndrome. He also indicated Petitioner worked for the State Police, did a significant amount of typing and that Petitioner's complaints were significantly worse when involved in those activities (Petitioner's Exhibit 5).

Petitioner was again seen by Dr. Reeves on May 4 and July 13, 2011, and Petitioner's symptoms had worsened. Dr. Reeves ordered new EMG/nerve conduction studies to be performed (Petitioner's Exhibit 7).

EMG/nerve conduction studies were performed on August 2, 2011. The EMG/nerve conduction studies were positive for moderate chronic bilateral carpal tunnel syndrome as well as suggestive of bilateral C6-C7 radiculopathy (Petitioner's Exhibit 4; Deposition Exhibit B).

At the direction of Respondent, Petitioner was examined by Dr. James Williams, an orthopedic surgeon, on October 3, 2012. In connection with his examination of Petitioner, Dr. Williams reviewed medical records provided to him by Respondent. Dr. Williams agreed Petitioner had bilateral carpal tunnel syndrome; however, he opined that it was not related to Petitioner's work activities of typing. Dr. Williams referenced literature in *The Journal of Hand Surgery* which stated there was no relationship between typing and the development of carpal tunnel syndrome. He also noted Petitioner had hypertension, but opined it was more likely the carpal tunnel syndrome was of idiopathic origin (Respondent's Exhibit 4; Deposition Exhibit 2).

Dr. Reeves continued to treat Petitioner primarily for his neck condition, which was not alleged to be work-related, for several months. When Dr. Reeves saw Petitioner on December 5, 2012, she referred him to Dr. Christopher Wottowa, an orthopedic surgeon, for the bilateral carpal tunnel syndrome (Petitioner's Exhibit 7).

In regard to the bilateral carpal tunnel syndrome condition, Petitioner was initially evaluated by Dr. Wottowa on February 18, 2013. Dr. Wottowa had previously treated Petitioner in 2006 and 2007 for bilateral cubital tunnel syndrome and performed ulnar transposition surgeries. Dr. Wottowa released Petitioner from treatment and authorized him to return to work in March, 2007, following those surgeries (Petitioner's Exhibit 4; Deposition Exhibit B).

When Dr. Wottowa saw Petitioner on February 18, 2013, Petitioner advised he had numbness/tingling in both hands which he associated with typing at work. Dr. Wottowa reviewed the prior EMG/nerve conduction studies and opined Petitioner had bilateral carpal tunnel syndrome. Prior to making a decision about whether to proceed with carpal tunnel release surgeries, Dr. Wottowa ordered further EMG/nerve conduction studies. Petitioner had EMG/nerve conduction studies performed on June 13, 2013, which were positive for bilateral carpal tunnel syndrome (Petitioner's Exhibit 4; Deposition Exhibit B).

Dr. Wottowa subsequently performed carpal tunnel release surgeries on Petitioner's left and right hands on December 10, 2013, and December 16, 2014, respectively (Petitioner's Exhibit 4; Deposition Exhibit B). Following both surgeries, Petitioner was able to return to work to his regular job without restrictions.

Dr. Williams was deposed on March 10, 2016, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Williams testified Petitioner had bilateral carpal tunnel syndrome, but that the duties of typing did not cause or aggravate the condition. He based this opinion on an article contained in *The Journal of Hand Surgery* that he referenced in his report and stated the condition was likely idiopathic. Dr. Williams testified Petitioner did not have any other risk factors including increased body mass, hypertension, diabetes or thyroid dysfunction (Respondent's Exhibit 3; pp 8-11). The Arbitrator notes that in Dr. Williams report he described Petitioner as having hypertension; however, when deposed he testified that this was not a risk factor.

When cross-examined, Dr. Williams agreed he did not have knowledge of the ergonomics of Petitioner's workstation and had never seen any photographs of it. He also agreed he previously opined in another case that typing for four hours could cause carpal tunnel syndrome, but that he changed his opinion about typing as being the cause of that condition (Respondent's Exhibit 3; pp 31-38).

When cross-examined, Dr. Williams was asked what percentage of his practice consisted of performing Section 12 examinations, and he testified it was less than five percent (5%). In regard to the percentage of Section 12 examinations Dr. Williams performed for Respondent, he testified it was 30% and denied that it was over 50% in prior years. Petitioner's counsel then referenced a Decision of the Commission wherein he (Dr. Williams) performed approximately one half of his IMEs for Respondent and was asked whether this was accurate. Dr. Williams responded that it was not accurate (Respondent's Exhibit 3; pp 14-20). The preceding was the primary basis of Petitioner's counsel's Motion in Limine to exclude Dr. Williams' testimony which, as previously noted herein, was denied by the Arbitrator.

Dr. Wottowa was deposed on April 25, 2016, and his deposition testimony was received into evidence at trial. In regard to his treatment of Petitioner, Dr. Wottowa's records were tendered as an evidentiary exhibit when he was deposed. In regard to the etiology of Petitioner's bilateral carpal tunnel syndrome, Dr. Wottowa testified that Petitioner's typing would not cause the carpal tunnel syndrome condition; however, he stated Petitioner's typing activities would be an "aggravating factor" of the condition (Petitioner's Exhibit 4; pp 26-28).

On cross-examination, Dr. Wottowa was questioned about other risk factors for the development of carpal tunnel syndrome. Dr. Wottowa declined to categorize the development of carpal tunnel syndrome as being "idiopathic" but described it was "multi-factorial," and that it was possible Petitioner would have developed carpal tunnel syndrome even without his job. However, Dr. Wottowa also stated Petitioner did not have any comorbidities for development of carpal tunnel syndrome, specifically, diabetes, obesity, cigarette smoking and uncontrolled hypertension. While he noted Petitioner had hypertension, he also noted it was controlled and not a risk factor (Petitioner's Exhibit 4; pp 33-35).

In regard to the postsurgical condition of Petitioner's hands, Dr. Wottowa testified Petitioner had no work restrictions, had no condition of ill-being in regard to his carpal tunnel syndrome, normal function and an excellent prognosis. When cross-examined, Dr. Wottowa agreed Petitioner had no disability as a result of the carpal tunnel syndrome (Petitioner's Exhibit 4; pp 30, 39).

When the case was tried, Petitioner's right lower arm/hand was in a cast. Petitioner testified he recently had surgery performed on his right thumb, but it was not for a work-related condition. In regard to his right wrist/hand, Petitioner stated he had virtually no symptoms at all. In regard to his left wrist/hand, Petitioner stated he still had some pain in his left wrist, but it was very infrequent.

Conclusions of Law

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

The Arbitrator concludes Petitioner sustained a repetitive trauma injury to his right and left hands that manifested itself on October 1, 2010, and that his current condition of ill-being is causally related to same.

In support of this conclusion the Arbitrator notes the following:

The date of manifestation, October 1, 2010, was when Petitioner was examined by Dr. Reeves and the findings on examination were consistent with carpal tunnel syndrome.

There was no dispute that Petitioner had bilateral carpal tunnel syndrome.

Petitioner's testimony regarding his work activities which required the daily repetitive use of both of his hands while at work was unrebutted.

Petitioner's treating physician, Dr. Wottowa, opined that while Petitioner's work activities did not cause Petitioner's bilateral carpal tunnel syndrome, the work activities were an aggravating factor.

Petitioner did not have any of the comorbidities that contribute to the development of carpal tunnel syndrome, specifically, diabetes, obesity and cigarette smoking. Petitioner did have

hypertension; however, this was controlled with medication and thereby not considered to be a risk factor.

Respondent's Section 12 examiner, Dr. Williams, opined Petitioner's bilateral carpal tunnel syndrome condition was not work-related; however, this opinion was based largely on an article he referenced contained in *The Journal of Hand Surgery*. Dr. Williams agreed he had previously opined that typing for four hours could cause carpal tunnel syndrome. Further, Dr. Williams conceded Petitioner did not have any of the other risk factors for the development of carpal tunnel syndrome including increased body mass, hypertension, diabetes or thyroid dysfunction.

Based upon the preceding, the Arbitrator finds the opinion regarding causality of Dr. Wottowa to be more persuasive than that of Dr. Williams.

In regard to Dr. Williams' alleged "perjury" about percentage of examinations he had performed at the request of Respondent, the Arbitrator is not persuaded by this. The Arbitrator notes that Section 12 examinations amount to less than five percent (5%) of Dr. Williams' overall medical practice. While Dr. Williams may have been in error regarding the percentage of Section 12 examinations he performed for Respondent, it is insignificant if was 30% or 50% of the five percent (5%) of his overall practice. In this regard, Dr. Williams' testimony regarding same should be evaluated in the context that such examinations constitute a very small percentage of his total medical practice. Accordingly, this was not a factor in the Arbitrator's finding as to which physician was a more persuasive.

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 in regard to his bilateral carpal tunnel syndrome condition was reasonable and necessary and Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as related to Petitioner's bilateral carpal tunnel syndrome condition, as identified in Petitioner's Exhibit 9, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of three and three-sevenths (3 3/7) weeks commencing December 10, 2013, through December 18, 2013, and December 16, 2014, through December 30, 2014.

In support of this conclusion the Arbitrator notes the following:

There was no dispute Petitioner was temporarily totally disabled during the aforestated periods of time.

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

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of five percent (5%) loss of use of the right hand and seven and one-half percent (7 1/2%) loss of use of the left hand.

In support of this conclusion the Arbitrator notes the following:

In regard to both hands, Dr. Wottowa opined Petitioner had no condition of ill-being, normal function, an excellent result and no disability.

In regard to the right hand, Petitioner had virtually no symptoms at all in regard to same.

In regard to the left hand, Petitioner had complaints of pain in the left wrist, but it was very infrequent.

Based upon the preceding, the Arbitrator finds Petitioner had an excellent surgical result and has minimal functional loss of use of both hands.

William R. Gallagher, Arbitrator

Preliminary Ruling

This case was tried in Peoria on January 19, 2017. Petitioner's counsel previously filed a Motion in Limine wherein he moved the Arbitrator exclude the deposition testimony of Respondent's Section 12 examining physician, Dr. James Williams. In that motion, Petitioner's counsel argued the Dr. Williams committed perjury when he was deposed in regard to the percentage of examinations he performed at the request of Respondent. Further, Petitioner's counsel represented that Dr. Williams had a financial bias based upon the income he derived from performing examinations at the request of Respondent. Because of the preceding, Petitioner's counsel argued that Dr. Williams' testimony be excluded, in its entirety, because it was unreliable and prejudicial to be admitted into evidence (Petitioner's Exhibit 3).

Respondent's counsel filed a Response to Petitioner's Motion in Limine wherein he stated that Dr. Williams did not perjure himself when he was deposed. Further, Respondent's counsel stated that excluding Dr. Williams' testimony would violate Respondent's rights of due process (Respondent's Exhibit 4).

Petitioner's Motion in Limine was previously argued before the Arbitrator in October, 2016. At that time, the Arbitrator denied the motion because the issues raised by Petitioner's counsel related to the credibility of the witness and what probative value should be given to his testimony. The Arbitrator found this was not a basis to exclude, in its entirety, Dr. Williams' testimony. When this case was tried on January 19, 2017, the Arbitrator reaffirmed this ruling on the record.

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained a repetitive trauma injury arising out of and in the course of his employment for Respondent. The Application alleged a date of accident (manifestation) of October 1, 2010, and that Petitioner sustained repetitive trauma to bilateral hands and arms (Petitioner's Exhibit 1). Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibit 1).

Petitioner began working for Respondent in October, 1986, and worked up until he retired on December 31, 2016. For approximately 25 years, Petitioner was an Intelligence Analyst. Petitioner claimed he sustained bilateral carpal tunnel syndrome as a result of typing/keyboarding. Petitioner testified he was right hand dominant and used both of his hands for typing for virtually 95% of every workday.

At trial, Petitioner's counsel tendered into evidence eight photographs of Petitioner's workstation which included two separate keyboards and pads Petitioner rested his hands on when he was typing (Petitioner's Exhibit 10). Petitioner testified he would generally hold his hands at about a 45° angle when he was typing. Petitioner would hold his hands at the same angle on both keyboards. Petitioner's other duties at work included answering the telephone, handwriting and filing.

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

Sherry Livingston,

Petitioner,

vs.

17IWCC0455

NO: 12 WC 33303

The TJX Companies, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary total disability and permanent partial disability and being advised of the facts and law, modifies the Decision of the Arbitrator, which is attached hereto and made a part hereof. After reviewing all of the evidence, the Commission finds that Petitioner's work-related condition resolved by December 21, 2010. Accordingly, we modify the Arbitrator's award of temporary total disability benefits and medical expenses as set forth below. Finally, we modify the Arbitrator's award of permanent partial disability benefits from 20% of the right foot to 12.5% of the right foot based on the credible evidence presented.

Petitioner, a 73-year-old part-time retail associate for Respondent, sustained an injury to her right medial ankle on September 21, 2010 when the corner of a mirror struck her ankle as she attempted to move the merchandise. The records in evidence show that Petitioner had a history of bilateral venous ulcers on her lower legs. Petitioner is diabetic and suffers from vascular disease; these pre-existing conditions are risk factors for the development of venous ulcers and also complicate their healing. Although a claimant can still recover for a work injury despite a pre-existing condition, the claimant must show that the injury was a causative factor. We agree with the Arbitrator's finding that the September 21, 2010 accident was causally related to the right medial ankle ulcer for which Petitioner initially sought treatment on October 5, 2010. The records and testimony of Petitioner's podiatrist, Dr. Olszewski, show that the ulcer was fully

healed by the end of 2010. Therefore, we find that Petitioner failed to prove her current condition of ill-being is causally related to the accident of September 21, 2010.

Petitioner was discharged from the Advocate Lutheran General Wound Care Center on December 21, 2010. In a letter to Petitioner's family physician, Dr. Brander, the Wound Care Center concluded that all treatment goals had been met and that closure of Petitioner's venous ulcer had been achieved. When Petitioner returned to Dr. Olszewski for her regular appointment on December 28, 2010, Dr. Olszewski did not mention any ulcers. Dr. Olszewski testified that if there was still an active problem on that day she believed she would have mentioned it. (PX1, p. 80-81) On January 6, 2011, Dr. Brander confirmed that the right ankle ulcer was healed. Petitioner continued to see Dr. Brander and Dr. Olszewski on a monthly based from January 2011 through the beginning of November 2011 and the records do not indicate any active right ankle ulcers; both Dr. Brander and Dr. Olszewski find that the former ulcer is healed.

Dr. Olszewski testified on direct examination that the work-related injury on December 21, 2010 made Petitioner more susceptible to future problems and therefore the original injury "greatly contributed" to the problem for which Petitioner began treating for in November of 2011. (*Id. at* 41) However, on cross-examination, Dr. Olszewski was confronted with multiple medical records regarding prior ulcers and openings in the skin in the same area before the September 21, 2010 accident. Dr. Olszewski admitted that prior to rendering her opinion on causal connection she was not aware that Petitioner had earlier episodes of ulcers on the same ankle. Dr. Olszewski did not review any of Petitioner's prior medical records before rendering her causal opinion, nor did she review any treatment records from Dr. Brander or the Wound Care Center other than the December 21, 2010 discharge note. In light of the credible medical records, Dr. Olszewski's causal opinion is not persuasive. We do not find that Petitioner's right ankle ulcer occurring in November of 2011 is related to her employment by Respondent.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $220.00 per week for a period of 7 and 1/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $220.00 per week for a period of 20.875 weeks, as provided in §8(b)2 of the Act, for the reason that the injuries sustained caused 12.5% loss of use of the right foot.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay bills pursuant to §8(a) and §8.2 of the Act for medical treatment related to the accidental injury of September 21, 2010 but shall not be liable for any medical expenses incurred by the Petitioner after December 21, 2010 including but not limited to any costs for office visits, testing, treatments, medications or medical equipment or supplies. Specifically, the medical bills submitted at hearing show charges of $4,886.00 from Advocate Lutheran General for treatment from October 25, 2010 through December 21, 2010 and Respondent shall pay these bills 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.

17IWCC0455

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for the amount of $1,778.01 for payment of a Medicare lien for Petitioner.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $6,600.00. 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: JUL 18 2017
KWL/plv
o-6/29/17
46

Kevin W. Lamborn

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0455

LIVINGSTONE, SHERRY
Employee/Petitioner

Case# **12WC033303**

THE TJX COMPANIES
Employer/Respondent

On 9/8/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.47% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0000 PAPPAS & BELL LLC
JAMES PAPPAS ESQ
234 WAUKEGAN RD
GLENVIEW, IL 60025

1120 BRADY CONNOLLY & MASUDA PC
MEGHAN P MURRAY ESQ
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

17IWCC0455

17IWCC0455

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

SHERRY LIVINGSTON
Employee/Petitioner

v.

THE TJX COMPANIES
Employer/Respondent

Case # **12** WC **33303**

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 **June 23, 2016**. After reviewing all of the 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 and average weekly wage?
H. ☐ What 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 Respondent due any credit for Medicare payments made for Petitioner?

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FINDINGS

On the date of accident, **September 21, 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 as explained infra.

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

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

In the year preceding the injury, Petitioner earned **$11,036.97**; the average weekly wage was **$220.74**.

On the date of accident, Petitioner was **73** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of **$0.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** 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 to Petitioner the sum of **$35,296.15** for medical services provided by Dr. Mary Olszewski, Orsini Medical Clinic, Advocate Lutheran General, Byram Healthcare, Inc., Dr. Samer Najjar and pay unpaid prescriptions in the amount of **$1,130.32,** as provided in Section 8(a) and 8.2 of the Act. Respondent shall be given a credit for any payments it has made on these bills.

Temporary Total Disability
Respondent shall pay petitioner $220.00 per week for a period of 7 6/7th weeks, as provided in Section 8(b) of the Act.

Permanent Partial Disability
Respondent shall pay to Petitioner $220.00 for 33.4 weeks as the injury sustained caused 20% loss of use of the right foot as provided by Section 8(b)2 of the Act.

Respondent's Credit
Respondent shall be given a credit in the amount of $1778.01 for payment of a Medicare lien for Petitioner.

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.

The disputed issues in this matter are: 1) accident; 2) casual connection; 3) earnings; 4) average weekly wage; 5) medical bills; 6) temporary total disability; 8) Respondent's credit; and 9) the nature and extent of Petitioner's injuries. *See,* AX1.

FINDINGS OF FACTS

Petitioner's testimony

Ms. Sherry Livingston, ("Petitioner"), a 79 year old woman, was employed by the TJX Companies, Inc. ("Respondent"), as an associate cashier for four (4) years prior to the date of the claimed accident. She testified that part of her job duties included moving, lifting and carrying heavy objects and doing whatever the manager told her to do. She also testified that she had no prior problem with the particular part of her right foot that she claimed was injured on the date of accident.

On September 21, 2010, she was working as a cashier and instructed to affect the sale of a large mirror. She attempted to move the 5 ½' x 5' foot mirror closer to the register by "rocking" it and in the course of that action, the mirror struck her right ankle. She stated that she felt immediate pain in her right ankle, lifted her cuff and saw redness in the area where the mirror struck her. She stated that the accident was witnessed by another associate cashier named Maryanne.

She testified that she continued to work until her break, then went to the employee lunchroom to the medicine cabinet. She obtained gauze pads and tape which she used to bandage that area of her right ankle. Petitioner further stated that after her work shift she went home, removed the bandage on her right ankle and noticed blood on the bandage.

Petitioner testified that she is and was, at the time of the accident, a type 2 diabetic. She has approximately thirty (30) years of wound care experience, having been a caregiver for her mother through doctor's instructions and having taken care of pressure wounds on her legs. She testified that over the next few days after the accident she tried to control the wound herself but the wound got out of control. It expanded and the skin changed colors, which meant a possible infection. She testified that in her experience, it is more difficult to close an open wound if you have type 2 diabetes. She reported the accident to Assistant Manager, Armi Eberhart and made an appointment for October 5, 2010, to see Dr. Mary Olszewski.

On October 5, 2010, she was seen by Dr. Olszewski regarding the wound on her right ankle and gave a history of how the accident occurred. On October 19, 2010, she was seen by Dr. Brander who referred her to the Lutheran General Wound Center. She then returned to Dr. Olszewski, who took her off work from October 29, 2010 until January 1, 2011, while her wound was cared for. Petitioner was afraid of losing her job because the respondent hired seasonal employees therefore, she asked Dr. Brander for an early release to return to work. Petitioner stated that at the time she was discharged from care, on or about January 10, 2011, the wound had improved but had not completely healed. She

testified that throughout the next months of 2011, she continued to care for the wound herself by applying saline, Santyl, Mepilex and bandages. In October of 2011, the wound had scabbed over. In late 2011 and 2012, she was sent back to the Luther General Wound Center for care.

Petitioner testified that she had great pain in her right ankle and that her doctors prescribed the pain medications that she had marked in yellow in Petitioner's Exhibit 5, in the amount of $1,130.32. She eventually underwent three (3) surgeries to apply Apligraft graphs to the wound on her right ankle, twice by Dr. Olszewski and once by Lutheran General Wound Care Center. Closure of the wound was finally achieved in February of 2013.

Petitioner testified that prior to the date of the subject accident; she had never injured her right ankle in that spot. Also, Petitioner testified that the bills for medical treatments, doctors' bills and equipment company bills that are included in Petitioner's Group Exhibit #4, in the total of $35,874.16, were incurred in treatment of her right ankle injury and were not paid. She continues to experience shooting pains in her right ankle once in a while and that she has to put cream on it constantly, to keep the graph on her ankle from drying.

During cross-examination, Petitioner testified that on three (3) separate occasions, in 2013 and 2014, she was accused by the respondent of giving checks back to customers that were meant to be payment for goods; and as a result, she was terminated from her employment. On re-direct examination she stated that she did give two checks back to customers by mistake. She realized that she had made the mistake on the second occasion; and reported it to the loss prevention department. She stated that did not believe that it happened a third time and asked to see the surveillance video, but that request was denied.

Respondent's witness

Ms. Armi Eberhart testified that she is an assistant manager employed by Respondent. She further testified that Petitioner had never reported ulcer issues before the date of the accident on September 21, 2010. Ms. Eberhart corroborated the Petitioner's testimony that she reported the accident to her a few days after the accident.

She further testified that she had known the petitioner for approximately three (3) years and knows that she is diabetic. She has observed bandages on Petitioner's foot prior to the date of accident and that the petitioner wore ace bandages around her foot for protection. Ms. Eberhart never states which foot she saw the bandages and is not specific as to when she saw the bandages. Ms. Everhart corroborated Petitioner's testimony that the mirror was large and heavy. However, she also testified that the clerks are not required to move heavy objects as the respondent has workers who move furniture.

Sherry Livingston
12 WC 33303

Deposition of Dr. Olszewski dated April 8, 2016

Dr. Olszewski testified that she is the petitioner's treating physician. She is a licensed doctor of podiatric medicine, who is certified by the American Board of Podiatric Surgery and the American Board of Podiatric Orthopedics; with over 25 years of experience in the field. She testified that patients who are diabetic and have open wounds, are more prone to infection and have a slower healing time.

She personally examined the petitioner on February 6, 2010 and May 4, 2010 and at those times, Petitioner's right ankle did not have any ulcers or open areas on the skin. She also examined the petitioner on October 5, 2010 and took a history from her. On that date, she noted an ulceration on Petitioner's right ankle. Based on the history of the accident, it was her opinion that Petitioner's injury to her right ankle was caused by the mirror hitting that spot. She also said that her examination revealed some scarification from a previous ulceration which, in her opinion, was not related to this accident. It was her opinion that the petitioner had a traumatic injury that she sustained at work. The doctor prescribed medication, compression and requested that Petitioner return in a few weeks. She also clarified the clerical error where she references the ulcer being on the left ankle.

Dr. Olszewski further testified that when she examined the petitioner on October 19, 2010, the ulceration had grown in size and that Petitioner had been referred to the Lutheran General Wound Care Center for treatment. Dr. Olszewski also examined Petitioner on December 28, 2010, March 22, 2011 and May 31, 2011. She stated that on May 31, 2011, her records showed that she noted scarification on the medial aspect of the right lower extremity, although the ulceration was closed. She further testified that in wound care, a closed ulcer could be an ulceration that has a scab over it which appears to be closed, but the ulceration could be open underneath. Dr. Olszewski corroborated Petitioner's testimony that the petitioner was well versed in taking care of ulcerations.

Dr. Olszewski testified that she examined the petitioner on October 4, 2011 and noted scarification at the site of the injury. She stated that Petitioner had had a prior injury with scar tissue at that spot, and therefore the tissue is less pliable. She stated that when there is a scar, there is less blood supply to the area, which makes the area prone to re-injury. Dr. Olszewski opined that Petitioner had a previous injury which left residual scarring, contributing to this problem.

Dr. Olszewski testified that on November 3, 2011, after the scab peeled off, the ulceration on the right ankle was evident. She further testified that on November 15, 2011, she re-examined the ulceration and opined that it was located in the same area as the ulceration that was the result of the injury Petitioner sustained on September 21, 2010.

The doctor then stated as is typical with diabetics, ulcerations usually occur at the end of toes; and they {diabetics} typically do not get ulcers on the inside or outside of the ankle, unless there is some traumatic event. Dr. Olszewski testified that since the petitioner's wound continued to grow, an Apligraft surgical procedure was medically necessary to help the ulceration heal.

Dr. Olszewski testified that she continued to treat the petitioner for the ulceration on her right ankle through August of 2012. She opined that the ulcer and pain that Petitioner was experiencing at that time, was initially caused by the traumatic injury Petitioner sustained at work, in 2010. She stated that the prior injury that Petitioner sustained on that ankle, made her more susceptible to future problems and that it was her opinion that that the traumatic injury on September 21, 2010, greatly contributed to the problems Petitioner was experiencing in August 7, 2012.

Dr. Olszewski further testified that the ulcer, which occurred on Petitioner's inside right ankle, had healed at one time but had opened again. Dr. Olszewski testified that due to a change in her record keeping to electronic medical records, any recurring notes that Petitioner's condition was present for 6-8 weeks with sudden onset, were not accurate statements.

Dr. Olszewski testified that she believed the ulcer had become a chronic problem by September of 2012 and that the traumatic injury of September 21, 2010 started the whole process. She further testified that an Apligraft procedure was performed in October 2012, involving the surgical application of the Apligraft combination Xeno/Allograft. She testified that a third application of the Apligraft was prescribed and that the surgery was performed on November 2, 2012. Dr. Olszewski testified that thereafter, on January 2, 2013, her notes did not suggest that the ulcer reappeared therefore although it took the ulcer a long time, it finally did heal.

Dr. Olszewski testified that to a reasonable of medical certainty, she believed that Petitioner's treatments for her ulcerated ankle, including surgeries and debridements, were caused by the injury that Petitioner sustained when the corner of the mirror jabbed into the medial aspect of her ankle. Dr. Olszewski further testified that the treatments that she afforded to Petitioner relating to the right lower extremity and the bills she charged were reasonable in her community; and that the treatments were necessary in the healing of the wound for the right lower extremity.

On cross-examination Dr. Olszewski testified that venostasis was not significant to the cause of Petitioner's injury but that venostasis could be part of the complication as to the retardation of the healing. She testified that a prior pin-hole sized opening would not be significant to this injury. On re-direct, Dr. Olszewski also opined that Petitioner's diabetes did not cause the medial ankle ulcer however, did contribute to retardation of healing. PX1.

Deposition of Dr. Simon Lee dated June 7, 2016

Dr. Lee testified that he is an orthopedic surgeon, board certified since 2005. He was asked by the respondent, to conduct an independent medical evaluation ("IME") of the petitioner and he examined her on April 17, 2013. According to his review of her records, Petitioner did not mention an ulcer of her right ankle until October 19, 2010. Dr. Lee testified he took a history from Petitioner and then reviewed her medical records. His diagnosis of Petitioner was right bilateral lower extremity

peripheral vascular disease, neuropathy venous stasis, calcification with medial malleor bilaterally, healed and resolved; which was not caused by the September 21, 2010 incident.

He testified that the wound care center discharge note of December 21, 2010, stated that the wound should be closed in a week and Dr. Olszewski's notes from May 31, 2011 indicated that the wound was closed; and there was no mention of the open ulceration until November 2011. He testified that he needed to see his IME report and addendum to refresh his memory regarding his findings. He testified that he believed Petitioner had significant history regarding her lower extremities, including chronic and recurring ulcerations; and that her records seem to indicate to him that Petitioner experiences openings from everyday minimal or minor traumas. He testified that people with diabetes and other problems should wear special shoes and stockings. Dr. Lee testified that Petitioner had reached maximum medical improvement ("MMI") for the alleged September 21, 2010 ulcer sometime between December 21, 2010 and May 31, 2011, based on Dr. Olszewski's notes of that date, when Petitioner was discharged from the wound care center. He opined that there is no permanent disability that he could note.

On cross-examination Dr. Lee stated that all of the records that he reviewed in preparation of his opinions were provided to him by the respondent's attorney. He further admitted that he did not know that Petitioner had been examined by Dr. Olszewski on October 5, 2010 and that all of his opinions were made without the benefit of the information contained in Dr. Olszewski's initial consultation, which occurred within two (2) weeks of the accident.

Dr. Lee stated that all of his opinions were based upon his impression that there was no complaint about Petitioner having suffered an injury to her right lower extremity before October 19, 2010. He stated that he drafted his opinions on April 17, 2013, approximately thirty (30) months after the accident and that he had never examined the petitioner when she had an active problem with her right lower extremity. Dr. Lee agreed that Petitioner had an accident on September 21, 2010. Dr. Lee also stated that he agreed that Petitioner sustained an injury to her right lower extremity as a result of the accident that she had on September 21, 2010 and that Petitioner "appears to have consistency of the mechanism as she describes here".

During Dr. Lee's testimony, the record reflects that Dr. Lee passed a written note to Respondent's attorney. Dr. Lee was asked to read what the note stated. At that point Respondent's attorney stated that the note was "just for us" and that Dr. Lee was her agent. The note, when read, contained statements from Dr. Lee to the Respondent's attorney regarding the notes of Dr. Olszewski's October 5, 2010 records of the petitioner.

Dr. Lee stated that he never treated the petitioner and he acknowledged that Dr. Olszewski was Petitioner's treating physician. He testified that he did not necessarily agree with the statement that a treating physician is in a better position to make opinions as to the patient's condition rather than

someone who reviews records thirty (30) months after the accident. Dr. Lee testified that when he scribbled the note regarding Petitioner's October 5, 2010 visit and handed it to Respondent's attorney during his cross examination, that he was not trying to help Respondent's counsel. At no time during the testimony of Dr. Lee was his independent medical report ever attempted to be introduced into evidence. RX10.

CONCLUSIONS OF LAW

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

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 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 facts and circumstances that might not justify an award. *Neal vs. Industrial Commission*, 141 Ill.App3d 289, 490 N.E.2d 124 (1986). Uncorroborated testimony will support an award for benefits only if consideration of all facts and circumstanced 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 (9180), *Caterpillar v Industrial Commission*, 73 Ill.2d 311,383 N.E. 2d 220

(9178). 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 finds that the petitioner's current conditions of ill-being is casually related to her work injury of September 21, 2010 and in so finding, relies upon the records and testimony of Dr. Olszewski the medical records of Dr. Brander; and the information contained in the Employer's First Report of Injury.
The Arbitrator notes that the petitioner worked for the respondent for four (4) years, with no apparent health complaints being made regarding her right lower extremity or ankle. Petitioner had a previous medical condition of type 2 diabetes and venous vascular disease. The Arbitrator acknowledges that generally, an employer takes its employees as it finds them and a pre-existing condition does not bar compensation of an injury if the employment was a causative factor.

After sustaining a work accident on September 21, 2010, the petitioner was not able to continue working from November 2, 2010 through December 26, 2010. The history of the accident and mechanism of injury is confirmed by testimonies of Drs. Olszewski and Lee, the medical records from Dr. Olszewski and the information contained in Employer's First Report of Injury.

Dr. Lee's opinions are not persuasive as he did not take into account any of the information or history contained in the October 5, 2010 initial visit notes of Dr. Olszewski; and based all of his opinions on the presumption that Petitioner never complained of the injury until October 19, 2010. The Arbitrator notes that Respondent's counsel referred to Dr. Lee as an agent for Respondent.

The Respondent's evidence of how the Petitioner was discharged from employment in 2014 as a reason to suspect her credibility is unconvincing. Petitioner, an elderly woman of 79 years testified that she made a mistake when returning a check to a customer and then, self-reported another instance of mistake to Respondent.

The Arbitrator relies upon the more persuasive findings and opinions of Dr. Olszewski, whose opinions were consistent with her initial medical records and the subsequent treatment, opinions and examinations that she provided. The Arbitrator finds that the petitioner has proven, by preponderance of the evidence, that her current condition of ill-being, is causally related the work accident of September 21, 2010.

G. What were Petitioner's earnings and average weekly wage?
The Arbitrator finds that the petitioner's average weekly wage was the minimum allowed for her date of accident or $220.00.

J. Were the medical services provided to petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

The Arbitrator finds that the petitioner's medical treatment, including the three (3) Apligraft surgeries were reasonable and necessary in the treatment of the injury she sustained on September 21, 2010. The Arbitrator finds the respondent is liable for any outstanding medical bills and medicinal prescriptions for treatment rendered to petitioner after September 21, 2010. In doing so, the Arbitrator relies on Dr. Olszewski's testimony, the treating medical records from Dr. Olszewski and Lutheran General Wound Care Center and Petitioner's testimony; which demonstrate that Petitioner's current condition of ill-being is causally connected to her work injury of September 21, 2010. Further, the Arbitrator relies on the admitted exhibits #2, Group #4 and Group #5 in determining that Respondent has not paid the charges for all reasonable and necessary medical services. Respondent is entitled to a credit of $1,778.01 for money paid to Medicare. Respondent shall pay Petitioner the sum of $34,096.15 for outstanding medical bills and $1,130.32 for outstanding medical prescription bills.

K. What temporary benefits are in dispute?

The Arbitrator finds the petitioner was disabled from November 2, 2010 to December 26, 2010, after which date she returned to work. The Arbitrator relies upon the disability reports of Dr. Brander in awarding said temporary total disability. Respondent did not produce proof of payment of these benefits. Respondent shall pay Petitioner TTD for a period of 7 6/7th weeks, at the rate of $220.00 per week a total of $1,676.13. Respondent shall receive a credit for any TTD previously paid.

L. What is the nature and extent of Petitioner's injuries?

Respondent shall pay to Petitioner 33.4 weeks of permanent partial disability as the injury has caused 20% loss of use of the right foot, i.e. $7,348.00.

N. Is Respondent due any credit?

The Respondent is seeking a credit of $3,846.26 it claiming it paid in medical benefits pursuant to Section 8(j) of the Act however, the petitioner is disputed this claim and the respondent did not lay a foundation to have any supporting document admitted into evidence therefore, this credit is not allowed.

O. Is the Respondent due any credit for the Medicare payments paid for Petitioner?

Respondent's Exhibit 3 shows that a payment in the amount of $1,778.01 was issued to Commercial Repayment Center for claimant Sherry Livingston in the subject matter. The respondent shall be given a credit for this amount.

Sherry Livingston
12 WC 33303

17IWCC0455

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
12WC33303
SIGNATURE PAGE

Signature of Arbitrator

September 8, 2016
Date of Decision

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 up	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

GARY WALLISER,

Petitioner,

vs.

NO: 12 WC 2451

17IWCC0603

WASTE MANAGEMENT EAST,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of nature and extent, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below but attaches the Decision for the Findings of Fact, which is made a part hereof with the modifications noted.

Petitioner was a garbage truck driver who sustained left shoulder and low back injuries on December 20, 2011, while putting a sleeper sofa into the back of the truck. He had left shoulder surgery on March 2, 2012, but was eventually released at maximum medical improvement with no restrictions to the shoulder. On September 14, 2012, Petitioner underwent lumbar surgery, including L3-L5 fusion, with Dr. Kennedy. He was eventually released on February 27, 2013 with permanent restrictions of 20-pounds lifting, only occasional bending/ twisting/stooping, and only being able to sit/stand for one hour at a time. Petitioner has continued, however, for pain management with Dr. Gunapooti, including injections and medication.

There is no dispute about Petitioner's restrictions and he is clearly not "medically" permanently and totally disabled. Petitioner argues that he is an "odd-lot" permanent total based on his showing: 1) a diligent but unsuccessful job search and 2) that he is not regularly employable in a well-known branch of the labor market due to his age, skills, training, and work history. Respondent argues that Kelly Burger, the vocational counselor at GENEX, opined that Petitioner is capable of finding an entry level, minimum wage job.

Petitioner testified that he previously worked at a gas station, Dairy Queen, and a nightclub for a while but most of his jobs since high school have been driving semi-trailer trucks. After his release by Dr. Kennedy, he started his vocational rehabilitation with GENEX in May 2013. He worked with a few different counselors over the years but primarily with Ms. Burger up through the date of the hearing.

Petitioner has no high school diploma and his transcripts indicate that he failed out of school in

the 10th grade. Even with the assistance of Ms. Burger and taking GED classes, he has failed multiple attempts at passing the test. Ms. Burger testified that:

- Petitioner complied with her recommendations and goals at each vocational meeting.
- He has made a valid and notable effort to try and pass the GED test.
- He has made valid efforts to date to find a position in the workforce.
- She has no criticism of his effort.
- Petitioner has not secured a position in the workforce to date.
- Petitioner provided copies of his job search logs and she followed up on some of the businesses he listed to confirm that he did, in fact, apply for those positions.
- Petitioner's job search logs reflect a valid and full effort.

Despite his lack of success thus far, Ms. Burger still believed that he could find an entry level, minimum wage position making between $8 and $12 per hour. On cross-examination, Ms. Burger admitted that, in general, six months to a year and a half is adequate to find out what the labor market will sustain for an individual. The Commission notes that Petitioner has been receiving vocational counseling with GENEX for over three years, since May 2013. Ms. Burger testified that 80 to 90% of employers require a high school diploma or GED and that this would be a "big barrier" to Petitioner finding a job. She admitted that it is not surprising that he is having a difficult time passing the GED considering his educational background and transcripts. She testified that Petitioner had been going to GED classes but was told to stop attending the class because he had used up his allowed amount of time. Now, he only has access to online training and practice tests. She agreed that Petitioner's effort was commendable. Petitioner almost passed the GED test at one point but then the test was made harder with a new format and he has never passed.

Despite Petitioner's lack of a GED, she encouraged him to apply to those jobs anyway and indicate that he is "trying" to obtain his GED so employers would see that he is at least trying to work on it. She admitted that she did not currently know of a job that was available for Petitioner but stated, "it is not impossible in my eyes" and that just because she hasn't found him a job so far doesn't mean that there isn't one out there. Ms. Burger estimated that Petitioner's job search included close to 1,000 companies but she wouldn't be surprised if it was 2,000. She agreed that this is a "pretty good sample" and, out of those, he's not employable.

We find that Petitioner is a compliant and motivated client who gave full, valid effort for more than three years with the assistance of multiple vocational counselors at GENEX; yet, still, has been unsuccessful in finding a job. Ms. Burger, despite all the evidence to the contrary, basically opines that it is possible (Px25 at 32) that Petitioner could find a job due to his "potential" (Id. at 33). We find that this opinion is completely speculative and contradicted by the actual evidence. Petitioner is required to show a "diligent but unsuccessful job search," which he has done. He is not required to engage in a universally exhaustive job search that excludes every possible employer that might, possibly, offer employment to him at some undetermined point in the future.

Respondent argues that Petitioner failed to meet his burden of proof because he did not have his own vocational counselor testify that he was unemployable. However, the parties agreed that GENEX would provide the vocational rehabilitation services and we find that Ms. Burger's testimony made it unnecessary for Petitioner to need another opinion. There is no evidence that Petitioner was uncooperative or unmotivated. Ms. Burger testified that Petitioner gave full, valid effort for over three years. We find that Ms. Burger's opinion is based more on hope and a desire to not give up on Petitioner than a rational analysis of the situation.

In addition to Ms. Burger's completely speculative opinion, the Arbitrator's primary basis for denying the odd-lot permanent total award seems to be her "suspicion" that Petitioner did not really

apply for more than 2,000 jobs because some of them are duplicated, since he applied online and also in person at some of them. Although Petitioner's job search logs are not very detailed, they do list the date, name, position, and how they were contacted. We note that this was not a self-directed job search, which could require a more careful review of those logs. Instead, Petitioner worked closely with Ms. Burger who commended him on a valid job search and she, in fact, had contacted some of the employers to confirm that Petitioner actually applied for the positions he listed. In addition, Petitioner's multiple contacts with the same employers via different methods could be viewed as diligence in trying to "get in the door." Although not specifically about this issue, Ms. Burger testified that they were trying different avenues to get around the fact that Petitioner did not have a GED and he was having great difficulty passing the exam. Regardless, whether it was 2,000 job search contacts or 1,000, and whether some of them were contacted in more than one way, the point is that Ms. Burger testified that it was a valid job search and Petitioner was unable to secure employment within his restrictions.

Based on all of the above, we find that Petitioner has proven that he is entitled to a permanent total disability award under the "odd-lot" theory by showing a diligent and unsuccessful job search for three years, even with the assistance of a vocational counselor. The parties stipulated that Petitioner's average weekly wage was $933.33 in the year preceding his injury. This results in a permanent total disability benefit of $622.22 per week, as provided in §8(f) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay the petitioner the sum of $622.22 per week for life, commencing December 21, 2016, as provided in §8(f) of the Act, because the injury caused the permanent and total disability of the Petitioner.

IT IS FURTHER ORDERED BY THE COMMISSION that commencing on the second July 15th after the entry of this award, the Petitioner may become eligible for cost-of-living adjustments, paid by the Rate Adjustment Fund, as provided in §8(g) 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: SEP 29 2017

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

SE/
O: 8/30/17
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WALLISER, GARY
Employee/Petitioner

Case# **12WC002451**

WASTE MANAGEMENT EAST
Employer/Respondent

17IWCC0603

On 4/5/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.91% shall accrue from the date listed above to the day before the 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
TODD J SCHROADER
3673 HWY 111 PO BOX 488
GRANITE CITY, IL 62040

1109 GAROFALO SCHREIBER HART ETAL
CRAIG M SCARPELLI
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

17IWCC0603

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Gary Walliser
Employee/Petitioner

v.

Waste Management East
Employer/Respondent

Case # 12 WC 2451

Consolidated cases: N/A

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Collinsville**, on **December 21, 2016**. By stipulation, the parties agree:

On the date of accident, **December 20, 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's earnings were $48,533.16 and the average weekly wage was **$933.33**.

At the time of injury, Petitioner was **47** years of age, ***married,*** with **0** dependent children.

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

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

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, commencing December 21, 2016, of $408.89/week until Petitioner reaches age 67 or five years from the date of the final award, whichever is later, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.

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.

Melinda M. Gore-Gillian

Signature of Arbitrator

4/3/17
Date

17IWCC0603

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Gary Walliser
Employee/Petitioner

Case # 12 WC 2451

v.

Consolidated cases: N/A

Waste Management East
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he is currently age 52. He testified that back in December of 2011, he had an accident while putting a sofa sleeper into a trash truck and that he injured his left shoulder and low back. He testified that he underwent surgery in March of 2012 with Dr. Dusek, and that after that he had additional surgery on his low back with Dr. Kennedy. He testified that he continues to undergo treatment with his pain management physician.

Petitioner testified that he was given permanent restrictions by Dr. Kennedy. He testified that he then began performing a job search. He testified that he did not complete high school and that as part of his vocational rehabilitation, he attempted to pass the GED but was not successful. He testified that he took the GED several times but did not receive a passing grade at any point. He testified that he received tutoring and did his best to try to pass, but that the format for the GED had changed and was now more difficult to pass.

Petitioner testified that his work history includes having worked at a gas station, at Dairy Queen and at a nightclub as well as driving trucks. He testified that he was a driver of a trash truck at the time of the accident and that he had been able to perform those duties up until the accident occurred. He testified that since the accident, he has not been able to work and has not had a job. He testified that in addition to receiving help in taking the GED, his vocational counselor also assisted in trying to find a job for him. He testified that he worked with multiple vocational counselors, the most recent of which was Kelly Burger. He testified that he continues to work with her, but has not been successful in finding a job with her. He testified that he has given his best effort.

Petitioner testified that he has applied for more than 2,000 jobs and continues to perform his job search to date, but that he has not been successful. He testified that in his job searches, it has been a problem that he does not have a GED. He testified that some of the employers have stated that he needed a high school diploma.

Petitioner testified that his current restrictions do not allow for him to drive a truck. He testified that he was not able to return to work with Respondent. He testified that he attempted to return, but they sent him a termination letter in 2014. He testified that after receiving the letter, he started his job search and has been searching for almost three years both with and without the help of vocational counselors. He testified that during his job search, he has tried to apply for a lot of different types of work including customer service, dispatching and security jobs.

On cross examination, Petitioner testified that he was released from care by Dr. Kennedy in January of 2014 and that as to the left shoulder, he was released by Dr. Dusek in August of 2012. He testified that Dr. Dusek released him for the left shoulder with no restrictions, and that his permanent restrictions only applied to his lower back.

The medical records of Concentra Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. Petitioner was seen on December 23, 2011, at which time it was noted that on December 20, 2011, he had to lift a heavy sleeper-sofa into his refuse truck and that as he did so, he felt a pain in his left shoulder and lower back. It was noted that the pain had persisted and even worsened, and that the shoulder hurt when lifting or raising the arm. It was noted that his back was worsened by bending over or lifting, and that there was no radiation of pain into the extremities. It was noted that x-rays of the lumbar spine noted no fracture and that degenerative changes were present; x-rays of the left shoulder were interpreted as negative. The assessment was that of (1) left shoulder strain, moderate; (2) lumbar strain, moderate. Petitioner was given medications and instructed to begin physical therapy. Petitioner was also placed under work restrictions. (PX1).

The records of Concentra Medical Center reflect that Petitioner was seen on December 28, 2011 for a recheck, at which time it was noted that he felt the pattern of his symptoms was about the same as the last visit for the left shoulder and lower back. The assessment was noted to be that of (1) left shoulder strain, moderate; (2) lumbosacral strain, moderate. At the time of the January 4, 2012 visit, Petitioner noted that his pain was still about the same. The assessment was noted to be that of (1) left shoulder strain, moderate; (2) lumbosacral strain, moderate. At the time of the January 11, 2012 visit, it was noted that Petitioner felt the pattern of symptoms was stable and it was noted that he had been working within the duty restrictions. The assessment was noted to be that of (1) shoulder strain, left; (2) lumbar strain. At the time of the January 27, 2912 visit with Dr. Khariton, it was noted that Dr. Dusek had recommended shoulder surgery and that Petitioner was being seen for his low back complaints. The assessment was noted to be that of (1) low back pain, left lower extremity pain and paresthesia per patient's complaints; (2) history of work-related injury on December 20, 2011, with no significant improvement of symptoms. Petitioner was referred for an MRI of the lumbar spine to rule out discogenic cause of his pain versus nerve root compression. (PX1).

The records of Concentra Medical Center reflect that Petitioner was seen on February 8, 2012, at which time it was noted that he noted no significant change in regard to his low back pain and left lower extremity pain. The impression was noted to be that of (1) low back pain, left lower extremity and paresthesia per patient's complaints; (2) degenerative disease of lumbar spine with neuroforaminal narrowing particularly at L5-S1 level. At the time of the February 22, 2012 visit, it was noted that Petitioner reported no significant changes in regard to his low back pain and left lower extremity pain. The impression was noted to be that of (1) low back pain, left lower extremity and paresthesia; (2) degenerative disease of lumbar spine as per MRI of lumbar spine from February 1, 2012. At the time of the March 28, 2012 visit, it was noted that Petitioner noted that he had had an epidural steroid injection about one week ago and that he stated it did not change his symptoms in regard to low back pain. The impression was noted to be that of (1) low back pain, left lower extremity and paresthesia per patient's complaints; (2) history of work-related injury on December 20, 2011 with no significant improvement with conservative treatment. Petitioner was referred to an orthopedic spine specialist at that time. (PX1).

The medical records of Dr. Dennis Dusek were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. Petitioner was seen on January 19, 2012, at which time it was noted that he stated that his left shoulder had been asymptomatic until December 20th, at which time he was in the process of picking up a couch and love seat and felt something happen to his left shoulder. It was noted that Dr. Dusek was concerned that Petitioner may have a rotator cuff tear and was recommended to undergo an MRI. A letter directed to "To Whom It May Concern" dated January 27, 2012 was included within the records, which noted that Petitioner's MRI showed a full thickness tear of the anterior supraspinatus

tendon and that there was no sign of a SLAP tear. It was noted that Petitioner was recommended to undergo arthroscopic rotator cuff repair. (PX2).

The records of Dr. Dusek reflect that Petitioner was seen by Dr. Kumar on February 28, 2012, at which time it was noted that he was being seen regarding his lower back and left-sided lower extremity radicular symptoms at the request of Dr. Khariton for an epidural injection. The assessment was noted to be that of (1) most likely left-sided L5 radiculitis; (2) lumbar strain; (3) multilevel lumbar degenerative disease, worse at L5-S1 with discogenic bulge and severe left foraminal stenosis. At the time of the March 12, 2012 visit with Dr. Dusek, it was noted that Petitioner had undergone left shoulder arthroscopic double row rotator cuff repair with subacromial decompression and shaving of the biceps tendon 10 days ago. At the time of the April 13, 2012 visit, it was noted that Petitioner was coming along nicely in physical therapy and that he stated that he was 50-60% less painful than before surgery already. At the time of the May 11, 2012 visit, it was noted that Petitioner seemed to be improving very nicely and no longer woke up from sleep at night and had quite a bit less pain during the day. (PX2).

The records of Dr. Dusek reflect that Petitioner was seen on June 7, 2012, at which time it was noted that he was beginning to feel very good pain relief and his physical therapy report was very encouraging with essentially full active motion and minimal pain. At the time of the July 5, 2012 visit, it was noted that Petitioner was showing full overhead motion to the shoulder and noted minimal pain. The assessment was noted to be that of partial rotator cuff tear. At the time of the August 2, 2012 visit, it was noted that Petitioner had done extraordinarily well and showed excellent progress in physical therapy to the point where he had essentially full strength and essentially full motion. It was noted that Petitioner had no complaints referable to the shoulder, but was still under the care of Dr. Kennedy for his back. It was noted that Petitioner would reach maximum medical improvement as of August 6, 2012 and he was released to full duty with respect to his shoulder on that date. (PX2).

The medical records of Dr. David Kennedy were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. Petitioner was seen on May 1, 2012, at which time it was noted that on December 20, 2011 he was picking up a couch and attempting to place it into a truck when he had pain in the lower lumbar area and left shoulder. The diagnostic impression was noted to be that of sciatica secondary to a disc herniation as noted on the MRI, and that the abnormality correlated with Petitioner's pain complaints. At the time of the June 19, 2012 visit, it was noted that Petitioner had not had any improvement with treatment thus far including injections. After a lumbar myelogram was performed on June 25, 2012, it was noted that there was a disc herniation at L4-5 and that there was also stenosis noted at L3-4. Petitioner was recommended to undergo lumbar decompression and fusion. (PX3).

The records of Dr. Kennedy reflect that Petitioner was seen on September 14, 2012 for an elective decompression and fusion in conjunction with Dr. Robson. The impression was noted to be that of spinal stenosis L3-4 with severe foraminal encroachment and disc space collapse at L4-5, and it was noted that Petitioner was admitted for elective lumbar decompression and fusion at L3-4 and L4-5. The Operative Report dated September 14, 2012 noted pre- and post-operative diagnoses of (1) herniated nucleus pulposus at L4-5; (2) spinal stenosis at L3-4, and the procedure performed included (1) L3-4 laminectomy; (2) L4-5 laminectomy and facetectomy with disk removal; (3) pedicle screw fixation and fusion, L3 to L5; (4) posterolateral fusion, L3 to L5. (PX3).

The records of Dr. Kennedy reflect that Petitioner was seen on October 22, 2012, at which time it was noted that he reported constant low back pain radiating down his left leg that was keeping him awake during the night. It was noted that Petitioner was to continue wearing the bone growth stimulator and was strongly advised to quit smoking as much as possible. At the time of the December 4, 2012 visit, it was noted that Petitioner continued to have lower lumbar pain with radiating pain into the left leg and left flank. At the time of the January 18, 2013 visit, it was noted that Petitioner had been going to physical therapy three times per week which aggravated his pain even more. At the time of the February 27, 2013

visit, it was noted that Petitioner was still having pain. It was noted that the recent myelogram showed that Petitioner was solidly fused, and that the FCE reflected the fact that he was not able to work in his normal job capacity. Petitioner was recommended to not lift more than 20 pounds nor do more than occasional bending, twisting or stooping and should not sit or stand for more than an hour at a time without an opportunity to change positions. Petitioner was instructed to return as needed and was recommended to undergo an evaluation by a pain management specialist for further treatment, if necessary. Petitioner was thereafter seen on January 30, 2014, at which time it was noted that he had undergone a series of injections by Dr. Gunapooti which did not help. (PX3).

The medical records of Injury Specialists were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. Petitioner was seen on May 23, 2012, at which time it was noted that he was referred by Dr. Kennedy with a history of low back pain down the left lower extremity. The impression was noted to be that of (1) lumbar radiculopathy; (2) lumbar spondylosis without myelopathy; (3) back pain; (4) sacroiliitis. Petitioner was recommended to change medications and undergo a selective nerve root block/"transformational" facet injection left L5-S1. The first injection was performed on May 23, 2012, the second was performed on May 31, 2012 and the third was performed on June 7, 2012. (PX4).

The medical records of Dr. Mahendra Gunapooti were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. Petitioner was seen on May 24, 2013 for an initial medical exam. It was noted that Petitioner was seen for evaluation of chronic low back pain with radiation to the hips to leg to calf, as well as intermittent numbness and tingling. It was noted that Petitioner appeared to have chronic left lumbar radiculitis and history of spinal surgery with fusion and possible post-laminectomy syndrome. At the time of the August 30, 2013 visit, Petitioner was seen for a medication refill. At the time of the September 12, 2013 visit, Petitioner underwent a lumbar transforaminal epidural. At the time of the September 26, 2013 visit, Petitioner underwent a lumbar transforaminal epidural. At the time of the October 17, 2013 visit, Petitioner underwent a lumbar transforaminal epidural. (PX5).

The records of Dr. Gunapooti reflect that Petitioner was seen on November 15, 2013, at which time it was noted that he was seen for a medication refill. Petitioner was advised to follow-up with a spine surgeon, and it was noted that he appeared to have chronic lumbar radiculitis, lumbar degenerative disc disease and spondylosis and a history of lumbar spine surgery, possible post-laminectomy syndrome. Petitioner was advised about a multimodal approach to controlling his pain with a combination of lumbar spinal blocks, oral medications and as needed basis of physical therapy. (PX5).

The records of Dr. Gunapooti reflect that Petitioner was seen on December 13, 2013 at which time it was noted that he was not able to see Dr. Santiago and was requesting to see another spine surgeon. Petitioner was given a referral to Dr. Bailey. At the time of the January 10, 2014 visit, it was noted that Petitioner had an appointment with Dr. Kennedy in a few weeks. At the time of the February 6, 2014 visit, Petitioner underwent a lumbar transforaminal epidural and was advised to undergo an MRI of the lumbar spine. At the time of the March 6, 2014 visit, Petitioner was given a medication refill and underwent a lumbar transforaminal epidural. (PX5).

The records of Dr. Gunapooti reflect that Petitioner was seen on October 10, 2014, at which time it was noted that he was being seen for a medication refill. At the time of the November 21, 2014 visit, Petitioner was seen for a medication refill. At the time of the December 11, 2014 visit, Petitioner underwent a lumbar transforaminal epidural. At the time of the January 15, 2015 visit, Petitioner underwent a lumbar transforaminal epidural. At the time of the February 19, 2015 visit, Petitioner underwent a lumbar transforaminal epidural. (PX5).

The records of Dr. Gunapooti reflect that Petitioner was seen on March 30, 2015, at which time it was noted that he was still dealing with workers' compensation. At the time of the April 24, 2015 visit, Petitioner was seen for a medication refill. At the time of the May 22, 2015 visit, Petitioner was seen for

a medication refill. At the time of the June 19, 2015 visit, Petitioner was seen for a medication refill. At the time of the July 17, 2015 visit, Petitioner was seen for a medication refill. At the time of the August 14, 2015 visit, Petitioner was seen for a medication refill. At the time of the September 11, 2015 visit, Petitioner was seen for a medication refill. At the time of the October 9, 2015 visit, Petitioner was seen for a medication refill. At the time of the November 6, 2015 visit, Petitioner was seen for a medication refill. At the time of the December 11, 2015 visit, Petitioner was seen for a medication refill. (PX5).

The records of Dr. Gunapooti reflect that Petitioner was seen on January 22, 2016 for a medication refill. At the time of the February 19, 2016 visit, Petitioner was seen for a medication refill. At the time of the April 1, 2016 visit, Petitioner was seen for a medication refill. At the time of the April 29, 2016 visit, Petitioner was seen for a medication refill. It was noted that Petitioner reported seeing his primary care physician, Dr. Mahey, as well as a nephrologist, Dr. Singh, and reported there was improvement in his kidney function. At the time of the May 27, 2016 visit, Petitioner was seen for a medication refill. At the time of the June 24, 2016 visit, Petitioner was seen for a medication refill. At the time of the August 5, 2016 visit, Petitioner was seen for a medication refill. At the time of the September 2, 2016 visit, Petitioner was seen for a medication refill. At the time of the September 30, 2016 visit, Petitioner was seen for a medication refill. (PX5).

The records of Dr. Gunapooti reflect that Petitioner was seen on November 4, 2016 for a medication refill. At the time of the December 2, 2016 visit, Petitioner was seen for a medication refill. It was noted that Petitioner complained of chronic moderate low back pain with radiation to the hips, to the legs and to the feet, increasing with activity, standing, walking and weather changes, as well as intermittent associated numbness and tingling and with activity. (PX5).

Various x-rays reports of the lumbar spine were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. Petitioner underwent x-rays of the lumbar spine on December 23, 2011 which were interpreted as revealing spondylosis, and he also underwent x-rays of the left shoulder on the same date which were interpreted as revealing no acute osseous abnormality. Petitioner underwent x-rays of the lumbar spine on June 25, 2012, which were interpreted as revealing degenerative changes most severe L4 through S1. Petitioner also underwent x-rays of the lumbar spine on October 22, 2012, which were interpreted as revealing (1) internal disc derangement; (2) postoperative instrumentation and fusion L3-L5. Petitioner underwent additional x-rays of the lumbar spine on November 29, 2012, which were interpreted as revealing post laminectomy changes with transpedicular screws seen extending from L3-L5 with narrowing of the disc spaces between L4-L5 and L5-S1. The x-rays of the lumbar spine performed on January 31, 2013 were interpreted as revealing post-surgical changes. (PX6).

Various x-rays reports of the left shoulder were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. Petitioner underwent x-rays of the left shoulder and axillary lateral views of both shoulders on January 19, 2012, which were interpreted as revealing no evidence of osseous pathology in the left shoulder and two anchors from what appeared to be a superior labral repair of the right shoulder. On March 12, 2012, x-rays of the left shoulder were performed and were interpreted as revealing anchors in excellent position on the greater tuberosity, a type I acromion after the subacromial decompression and no fracture, dislocation or other bony abnormality. (PX7).

Various CT reports of the lumbar spine were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. Petitioner underwent a CT myelogram of the lumbar spine on June 25, 202, which was interpreted as revealing (1) spinal canal stenosis L3-L4 and L4-L5; (2) left subarticular disc protrusion which contains a few locules of air L4-L5, resulting in narrowing of the left lateral recess; (3) bilateral foraminal narrowing, severe at L4-L5 on the right and L5-S1 on the left; (4) scoliosis. Petitioner also underwent a CT myelogram of the lumbar spine on January 31, 2013, which was interpreted as revealing (1) prominent degenerative disc disease as described L3 through S1; (2) post-surgical changes consistent with posterior instrumentation L3 to L5; solid fusion not yet present posteriorly; (3) foraminal

narrowing as described due to marginal vertebral body osteophyte overgrowth most prominent at L5-S1 especially on the left but also noted at L4-L5; (4) incidental atherosclerosis of the aorta and its branches. (PX8).

Various lumbar myelogram reports were entered into evidence at the time of arbitration as Petitioner's Exhibit 9. Petitioner underwent lumbar myelography on June 25, 2012, which was interpreted as revealing (1) spinal canal stenosis L3-L4 and L4-L5; stenosis appears more prominent at L3-L4; (2) degenerative disc space narrowing most severe at L4 through S1; (3) scoliosis. Petitioner also underwent lumbar myelography on January 31, 2013, which was interpreted as revealing (1) marked disc space narrowing with end plate sclerosis and osteophytes note at L3 through S1; (2) bilateral posterior pedicle screws L3 through L5 connected by bilateral vertical rods; (3) no canal stenosis observed at this time. (PX9).

The Interpretive Report for an MRI of the left shoulder dated January 25, 2012 was entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The study was interpreted as revealing (1) full-thickness anterior insertional tear of the supraspinatus, measuring 19 mm AP diameter with retraction of the torn free end by approximately 12 mm; there is tendinopathy and delamination to the intact posterior supraspinatus rim, extending into the upper infraspinatus; (2) AC joint arthropathy and 7 mm undersurface spurring resulting in supraspinatus outlet stenosis and supraspinatus myotendinous junction impingement. (PX10).

The Interpretive Report for an MRI of the left sacroiliac joint dated February 1, 2012 was entered into evidence at the time of arbitration as Petitioner's Exhibit 11. The study was interpreted as revealing sacroiliac joints negative for asymmetry or widening; no sacral fracture or pelvic hematoma seen. (PX11).

The Interpretive Report for an MRI of the lumbar spine dated February 1, 2012 was entered into evidence at the time of arbitration as Petitioner's Exhibit 12. The study was interpreted as revealing (1) moderate to severe degenerative changes of the mid and lower lumbar spine as discussed; (2) focal moderate to severe left neuroforaminal stenosis at the L5-S1 level secondary to combination of moderate left sided lateralizing disc bulge and facet hypertrophy; (3) moderate central canal stenosis at the L3-5 levels; (4) no fracture seen. (PX12).

The Interpretive Report for an MRI of the left shoulder dated February 11, 2014 was entered into evidence at the time of arbitration as Petitioner's Exhibit 13. The study was interpreted as revealing (1) there has been interval fusion from the L3 to L5 levels via posterior approach; (2) mild left convex scoliosis; (3) 8 mm retrolisthesis of L5 on S1; (4) 2 mm retrolisthesis of T12 on L1; (5) degenerative disc disease and spondylosis of the lumbar spine as noted; (6) at T120L1 on sagittal imaging, there is a minimal posterior disc bulge; (7) at L1-2 there is a posterior disc bulge; (8) at L2-3 facet hypertrophy and left neural foraminal disc bulge result in mild left neuro foraminal stenosis; (9) at L3-4 and at L4-5 facet hypertrophy and a disc bulge result in bilateral neural foraminal stenosis as noted; (10) at L5-S1 facet hypertrophy, a disc bulge and endplate spurring result in bilateral neural foraminal stenosis as noted. (PX13).

Various injection reports were entered into evidence at the time of arbitration as Petitioner's Exhibit 14. Petitioner underwent a selective left L5 transforaminal epidural injection under fluoroscopy on February 28, 2012 and transforaminal epidural injections on May 31, 2012 and June 7, 2012. (PX14).

The Operative Report dated March 2, 2012 was entered into evidence at the time of arbitration as Petitioner's Exhibit 15. Petitioner underwent a left shoulder arthroscopic rotator cuff repair using double-row technique with subacromial decompression and shaving of biceps tendon on March 2, 2012 by Dr. Dusek. The pre-operative diagnosis was noted to be that of left shoulder rotator cuff tear and the post-

operative diagnoses were noted to be that of left shoulder rotator cuff tear plus partial biceps fraying. (PX15).

The Operative Report dated September 14, 2012 was entered into evidence at the time of arbitration as Petitioner's Exhibit 16. Petitioner underwent L3-4 laminectomy, L4-5 laminectomy and facetectomy with disk removal, pedicle screw fixation and fusion, L3-L5 and posterolateral fusion, L3-L5 on September 14, 2012. The pre-operative and post-operative diagnoses were noted to be that of (1) herniated nucleus pulposus at L4-5; (2) spinal stenosis at L3-4. (PX16).

The Functional Capacity Evaluation dated February 12, 2013 was entered into evidence at the time of arbitration as Petitioner's Exhibit 17. It was noted that the DOT placed Petitioner's occupation as a Garbage Collector in the very heavy strength category, and that he did not meet these strength requirements and may not return to work as a Garbage Collector. It was noted that Petitioner was capable of a position in the Medium strength category, and that his maximum lifting capacity was 40 pounds and that his maximum carrying capacity was 25 pounds. It was noted that in order for Petitioner to successfully return to work in the medium strength category, the following job factor restrictions must be met: no standing for more than 12 minutes continuously; no sitting for more than 23 minutes continuously; no walking for more than 0.2 miles continuously; no balancing activities that require crouching. (PX17).

Various physical therapy records from Fitness Designs were entered into evidence at the time of arbitration as Petitioner's Exhibit 18.

The transcript of the deposition of Dr. David Kennedy was entered into evidence at the time of arbitration as Petitioner's Exhibit 19. Dr. Kennedy testified that he is a physician specializing in neurosurgery and that he took a history from Petitioner at the time of the May 1, 2012 visit. He testified that the history provided by Petitioner matched up with the history he reviewed in the Concentra Medical Center records. He testified that the MRI dated March 1, 2012 demonstrated a disc herniation with significant foraminal encroachment at L5-S1 on the left side, as well as at least moderate stenosis noted at L3-4 and L4-5. He testified that he thought that Petitioner had sciatica secondary to the disc herniation noted on the MRI, for which he recommended additional conservative measures including pain management. He testified that he believed that Petitioner's symptoms were the result of the work injury of December 20, 2011. (PX19).

Dr. Kennedy testified that when he next saw him on June 19, 2012, Petitioner had had some injections and had not had any improvement so he was set up for a lumbar myelogram. He testified that the lumbar myelogram noted a disc herniation at L4-5 on the left that corresponded to the MRI level, and there was also stenosis at L3-4 from a combination of disc bulging and some facet degenerative changes. He testified that he then recommended surgery to include nerve root decompression and fusion at L3-4 and L4-5. He testified that surgery was performed on September 14, 2012 with Dr. Robson. (PX19).

Dr. Kennedy testified that what was visualized in the surgery was related back to the accident that Petitioner told him of in his initial visit, and that all of the medical bills were related to the procedure and the care and treatment of Petitioner. He testified that the medical bills were related to the accident that took place on December 20, 2011, and that all of the time off work was also related to the accident as well. (PX19).

On cross examination, Dr. Kennedy testified that the accident history that he obtained he obtained directly from Petitioner when he was first seen on May 1, 2012. He agreed that Petitioner provided a similar history to Concentra Medical Center. (PX19).

Petitioner's GED Information was entered into evidence at the time of arbitration as Petitioner's Exhibit 20. Petitioner took the test on December 4, 2013, July 28, 2014 and September 23, 2014 but did not qualify for an Illinois High School Equivalency Certificate. (PX20).

The Job Searches performed by Petitioner were entered into evidence at the time of arbitration as Petitioner's Exhibit 21. The records reflect that Petitioner applied for a number of positions during the timeframe of March 2, 2013 through June 20, 2016. (PX21).

Additional Job Searches performed by Petitioner were entered into evidence at the time of arbitration as Petitioner's Exhibit 22. The records reflect that Petitioner applied for a number of positions during the timeframe of June 29, 2016 through December 12, 2016. (PX22).

Various reports from Genex were entered into evidence at the time of arbitration as Petitioner's Exhibit 23. A Labor Market Survey was performed on July 5, 2013 by Brenda Latham. The records reflect that Petitioner's work history was summarized in the following DOT titles: Garbage Collector; Garbage Collector Driver; Truck Driver, Heavy; and Salvage Worker, non-ferrous metal. Appropriate vocational alternatives identified for Petitioner were noted to include Assembler; Telephone Solicitor (any industry); Dispatcher, Motor Vehicle; Security Guard, Unarmed; Escort Vehicle Driver; Customer Service Clerk and Cashier-Checker. It was noted that of the 10 employers listed in the Labor Market Survey 6-10 provided salary information with advertised job openings or it was requested through telephone contact. Salary information obtained included: Telemarketing – Inside Sales ($11.00-$11.50 per hour); Call Center, Customer Service Positions ($10.00 per hour); Inside Sales, Automotive Repair Tools ($14.50 per hour plus commissions); Unarmed Security Guards ($7.75-$11.00 per hour). It was noted that it was anticipated that Petitioner would be able to secure employment within the $7.75 (Missouri Minimum Wage) per hour starting salary range to a high starting salary range of $16.37 per hour, and that salary information provided by employers identified current advertised job openings in the $7.75-$14.50 starting salary range. (PX23).

A Rehabilitation Plan signed on July 15, 2015 with an Addendum dated June 5, 2015 was included within the records. The Job goals were noted to include Dispatcher; Cashier; Delivery Driver; Telephone Solicitor; Inspector; Security Guard; Customer Service Representative and other jobs within his restrictions not listed. (PX23).

Additional reports from Genex were entered into evidence at the time of arbitration as Petitioner's Exhibit 24.

The transcript of the deposition of Kelly Burger was entered into evidence at the time of arbitration as Petitioner's Exhibit 25. Ms. Burger testified that she is a vocational case manager for Genex Services and is a certified rehabilitation counselor. She testified that she was retained by agreement of both of the parties to perform vocational services for Petitioner. (PX25).

Ms. Burger testified that she met with Petitioner personally to establish a vocational rehabilitation plan, and that a plan was formalized which was agreed to by both parties. She testified that after establishing the agreed plan, she then began providing vocational assistance to Petitioner. She testified that Petitioner complied with her recommendations and goals at each vocational meeting, and that he made a valid effort to try and pass the equivalency exam for a high school diploma. She testified that he had made valid efforts to find a position in the workforce and did not have any criticism of his effort. (PX25).

Ms. Burger testified that she believed that Petitioner was employable, but that he had some barriers like passing the GED and a time gap in employment. She testified that she felt that he remained a good candidate for vocational rehabilitation. She testified that realistically she believed that Petitioner

would likely need to have an entry level position because of his restrictions and not being able to do what his past work history was as a truck driver, and that he would likely earn $8-12 per hour depending on the job. She testified that her only concern was that if he did not pass the GED, it would continue to make it hard for him. (PX25).

Ms. Burger testified that she felt that Petitioner's job search logs reflected a valid and full effort by Petitioner to apply for and follow up on the positions that he listed within the logs. She testified that she did not have any cause to disagree with the opinions and results of the July 5, 2013 labor market survey prepared by Brenda Latham. (PX25).

On cross examination when asked what would be the time period that she would say was adequate to figure out what the labor market would sustain for an individual, Ms. Burger responded that in general it would be six months to a year and a half depending on the person's background and skills but also the economy. She agreed that if someone was off work too long, it made it harder to place them. She agreed that Petitioner had a significant barrier concerning his education. She agreed that she reviewed his high school transcript and that she found it to be disturbing. She agreed that given the GED and Petitioner's grades, it was not surprising that he was having a tough time passing the GED. (PX25).

On cross examination, Ms. Burger agreed that there were a lot of employers that required a GED or high school equivalent. She testified that she believed that 80-90% of employers required a high school diploma or GED. She agreed that the changes that occurred with the GED test did not help Petitioner, that he was close to passing with the old test and that once they shifted to the new test it became a lot harder for him to even get close to passing. She agreed that none of Petitioner's job searching on his own lead to a job nor did their combined efforts lead to a job. (PX25).

On cross examination, Ms. Burger agreed that the earlier labor market survey did not incorporate the idea that Petitioner could not pass the GED. She agreed that the labor market survey was not up-to-date. She testified that she believed that there were various jobs available in the $8-12 per hour range including a delivery driver, sales, telemarketer and dispatcher. She testified that she thought the biggest barriers that she usually saw were a lack of computer skills and criminal backgrounds. She agreed that Petitioner did not have a criminal background. She testified that Petitioner did fairly well on the computer and that he was capable of doing basic computer work. She agreed that when Petitioner started he was terrible, and that now he was functional with a computer. (PX25).

On redirect examination, Ms. Burger testified that in her experience, a change in the administration could also cause a change in the job market. She testified that she hoped that there was potential for that to improve Petitioner's potential of finding a job over the next year. She agreed that it was fair to say that Petitioner's most likely prospect of finding a job would be something that would earn him the minimum wage in either Illinois or Missouri. (PX25).

The Madison Public School Transcript was entered into evidence at the time of arbitration as Petitioner's Exhibit 26.

The October 10, 2012 Section 12 Report of Dr. Brett Taylor was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The report noted that Dr. Taylor opined that Petitioner had severe end-stage lumbar degenerative disc disease combined with congenital stenosis, and that it most notably affected his L3-4, 4-5 and L5-S1 levels. It was noted that Petitioner's work exposure of December 20, 2011 was not the prevailing factor causing his spinal condition, that Petitioner's need for lumbar surgery was based on preexisting degenerative disc disease and that the work event at most aggravated the preexisting lumbar degenerative disc disease. It was noted that Petitioner's need to maintain out of work was due to his post-surgical state and that his fusion L3-5 had not yet healed. It was noted that Petitioner's persistent use of nicotine greatly increased his risk of a complication in the form of

a nonunion, and that the use of a bone stimulator and strict cessation of nicotine might provide a solid fusion. It was noted that Petitioner carried a guarded prognosis for return to a high level of function, if there was a successful osseous union. (RX1).

The December 2, 2014 Report and Rating of Dr. Robert Bernardi was entered into evidence at the time of arbitration as Respondent's Exhibit 2. It was noted that Petitioner reported that since the surgery, he was pretty much the same. It was noted that Petitioner was assigned permanent restrictions and discharged by Dr. Kennedy, and that since then he had been seeing Dr. Gunapooti, a pain management physician, who had been prescribing medications and also performed additional injections. It was noted that Dr. Bernardi did not note any Waddell's signs on physical examination, and that there was nothing to suggest that Petitioner did not give a full effort during his February 12, 2013 FCE. (RX2).

The Dr. Bernardi report reflects that he opined that Petitioner had untreated foraminal stenosis in his low back that was responsible for his ongoing complaints. It was noted that Dr. Bernardi opined that it was extraordinarily unlikely that additional non-operative intervention had anything to offer Petitioner and that to try and address his problem; he most likely needed additional surgery and that to address his symptoms he would need a left L5 foraminotomy and his L3-5 fusion would need to be extended to L5-S1. It was noted that Petitioner had already undergone an L3-L5 fusion which increased his risk of developing a pseudoarthrosis at L5-S1 following a revision procedure, and that Petitioner continued to smoke which represented a significant risk factor for the development of a failed/delayed fusion. (RX2).

The Dr. Bernardi report reflects that if Petitioner was interested in additional treatment, he could not currently determine the degree of impairment he had sustained as a result of his work accident. It was noted that if Petitioner did not wish to pursue additional treatment, Dr. Bernardi opined that Petitioner had a 17% whole person impairment related to his December 20, 2011 work injury. (RX2).

The July 5, 2013 Labor Market Survey from Brenda Latham was entered into evidence at the time of arbitration as Respondent's Exhibit 3. The Rehabilitation Plan dated July 15, 2015 was entered into evidence at the time of arbitration as Respondent's Exhibit 4. The September 21, 2016 Vocational Report of K. Burger was entered into evidence at the time of arbitration as Respondent's Exhibit 5. The November 22, 2016 Vocational Report of K. Burger was entered into evidence at the time of arbitration as Respondent's Exhibit 6.

CONCLUSIONS OF LAW

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injury, the Arbitrator notes that "To receive an award under section 8(d)(1), an injured worker must prove (1) that he or she is partially incapacitated from pursuing his or her usual and customary line of employment and (2) that he or she has suffered an impairment in the wages he or she earns or is able to earn." *Cassens Transport Co. v. Industrial Comm'n*, 218 Ill.2d 519, 844 N.E.2d 414 (Ill. 2006). The Arbitrator finds that both of these elements have been met by the evidence in this case.

In her deposition, Ms. Burger testified that realistically she believed that Petitioner would likely need to have an entry level position because of his restrictions and not being able to do what his past work history was as a truck driver, and that he would likely earn $8-12 per hour depending on the job. (PX25). She testified that she did not have any cause to disagree with the opinions and results of the July 5, 2013 labor market survey prepared by Brenda Latham. (PX25). While the Arbitrator concedes that Ms. Burger testified that she felt that Petitioner's job search logs reflected a valid and full effort to apply for and follow up on the positions that he listed within the logs, the Arbitrator also notes that there were multiple entries throughout the logs demonstrating that Petitioner made arguably duplicative entries reflecting not

only an attempt to visit a prospective employer in person, but also the completion of the online application. (PX21; PX22). As such, the Arbitrator is suspicious of Petitioner's assertion that he applied for more than 2,000 jobs.

That said, placing significant reliance upon Ms. Burger's opinions that Petitioner is employable and would likely earn $8-12 per hour depending on the job, the Arbitrator finds that Petitioner is entitled to 2/3rds of $613.33 ($933.33 - $320.00), or $408.89/week, until Petitioner reaches age 67 or five years from the date of the final award, whichever is later, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.