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*2011 Ill. App. Unpub. LEXIS 1531, **

EXECUTIVE MAILING SERVICE, Petitioner on Review-Appellant, v. JOSHUA GARCIA, Respondent on Review-Appellee, and **WORKERS' COMPENSATION** COMMISSION.

NO. 1-10-1014WC

APPELLATE COURT OF ILLINOIS, FIRST DISTRICT, **WORKERS' COMPENSATION** COMMISSION DIVISION

2011 Ill. App. Unpub. LEXIS 1531

June 27, 2011, Filed

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PRIOR HISTORY: [*1]
Appeal from Circuit Court of Cook County. No. 09L50484. Honorable James C. Murray, Judge Presiding.

DISPOSITION: Affirmed.

CORE TERMS: utilization, claimant, discogram, medical expenses, recommended, manifest, review reports, evidence presented, appropriateness, work-related, guidelines, health care services, arbitrator, injections, medically, efficacy, therapy, patient, employer to pay, arbitrator's decision, conservative treatment, overwhelming evidence', non-certification, pathology, invasive, pain

JUDGES: PRESIDING JUSTICE McCULLOUGH delivered the judgment of the court. Justices Hoffman, Hudson, Holdridge, and Stewart concurred in the judgment.

OPINION BY: McCULLOUGH

OPINION

ORDER

Held: The **Workers' Compensation** Commission's award of medical expenses was not against the manifest weight of the evidence.

On January 30, 2008, claimant, Joshua Garcia, filed an application for adjustment of claim pursuant to the **Workers' Compensation** Act (Act) (820 ILCS 305/1 *et seq.* (West 2006)), seeking benefits from employer, Executive Mailing Service. The arbitrator found claimant sustained back injuries that arose out of and in the course of his employment on January 18, 2008, and awarded him 21-2/7 weeks' temporary total disability (TTD) benefits. The arbitrator also awarded claimant certain medical expenses in connection with his injury. However, he relied on **utilization review** reports submitted by employer to deny expenses for the cost of claimant's physical therapy rendered after February 25, 2008; transforaminal injections; IDET procedures; discogram; and facet injections.

On review, the **Workers' Compensation** Commission **[*2]** (Commission) modified the arbitrator's decision to require employer to pay for claimant's discogram and IDET procedures. It otherwise affirmed and adopted the arbitrator's decision. On judicial review, the circuit court of Cook County confirmed the Commission's decision. Employer appeals, arguing (1) the Commission's award of medical expenses for claimant's discogram and IDET procedures was against the manifest weight of the evidence. We affirm.

The parties are familiar with the evidence presented and we will discuss it only to the extent necessary to put their arguments in context. On appeal, employer argues the Commission's award of medical expenses for claimant's discogram and IDET procedures was against the manifest weight of the evidence. It points to the medical utilization reports it submitted, noting they recommended non-certification of those procedures.

Pursuant to the Act, a claimant is entitled to receive all reasonable and necessary medical expenses incurred to cure or relieve the effects of his or her accidental injury. 820 ILCS 305/8 (a) (West 2006). "The claimant bears the burden of proving, by a preponderance of the evidence, his entitlement to an award of medical expenses **[*3]** under section 8(a)." *Westin Hotel v. Industrial Comm'n*, 372 Ill. App. 3d 527, 546, 865 N.E.2d 342, 359, 310 Ill. Dec. 18 (2007). Whether medical charges are reasonable or causally connected to a claimant's work-related injury "are questions of fact to be resolved by the Commission, and its resolution of such matters will not be disturbed on review unless against the manifest weight of the evidence." *Westin Hotel*, 372 Ill. App. 3d at 546, 865 N.E.2d at 359.

Section 8.7 of the Act (820 ILCS 305/8.7 (West 2006)) permits the performance of a "**utilization review**" to determine the appropriateness of medical services provided to a claimant. That section states as follows:

> "**Utilization review** means the evaluation of proposed or provided health care services to determine the appropriateness of both the level of health care services medically necessary and the quality of health care services provided to a patient, including evaluation of their efficiency, efficacy, and appropriateness of treatment, hospitalization, or office visits based on medically accepted standards." 820 ILCS 305/8.7(a) (West 2006).

The Commission must consider a **utilization review** "along with all other evidence and in the same manner as all **[*4]** other evidence, in the determination of the reasonableness and necessity of the medical bills or treatment." 820 ILCS 305/8.7(i) (West 2006).

Here, the record shows, and employer does not dispute, that claimant sustained work-related lower back injuries on January 18, 2008. He underwent conservative treatment for his injuries with little success. After conservative treatment failed, Dr. Scott Glaser recommended the discogram and IDET procedures at issue. The **utilization review** reports submitted by employer recommended non-certification of those procedures. However, the Commission ordered employer to pay for them as reasonable and necessary medical expenses.

Employer relies on its utilization reports to challenging the Commission's decision. In finding claimant entitled to medical expenses for the discogram and IDET procedures, the Commission stated that **utilization review** reports were not intended to be dispositive "but rather as evidence to be assessed just like all other evidence." The plain language of section 8.7 of the Act supports the Commission's finding, stating **utilization review** evidence should be considered "with all other evidence and in the same manner as all other evidence." **[*5]** Employer's utilization reports were clearly not special evidence entitled to greater weight by the Commission than other evidence presented.

The utilization reports were also not immune from criticism. The Commission found fault with the reports as follows:

> "[T]he **utilization review** criteria regarding the recommended discogram and intradiscal electrothermic therapy (IDET) procedure may be a bit too strict. First, the **utilization review** appears to discount IDET completely as a certifiable treatment *** because of the lack of precise proof of its efficacy. Second, the basis for rejecting the discogram because of the lack of 'documentation of consistent and overwhelming evidence' of pathology appears to be particularly unduly rigid because the discogram is primarily a diagnostic tool and it would be difficult to establish 'consistent and overwhelming evidence' of pathology without one."

Although the **utilization review** report stated evidence based guidelines did not consistently and overwhelmingly support the discogram or IDET procedures, it acknowledged the use of both procedures to treat low back injuries and even the recommendation of the IDET procedure by certain guidelines. With respect **[*6]** to the IDET procedure, the utilization report noted 60,000 such procedures had been performed world wide up to June 2005, and early studies showed some advantages over more invasive treatment. Additionally, the report stated that the IDET procedure was "recommended by practice guidelines written by the American Society of Interventional Pain Physicians." The report further showed that, although studies recently "questioned" the use of discography, it had been used in the past as part of the preoperative evaluation for patients with low back pain.

In this instance, the discogram and IDET procedures were recommended by claimant's treating physician. They were performed on him as an alternative to more invasive treatment and after he had received unsuccessful conservative treatment. Employer's utilization report acknowledged the use of both procedures under similar circumstances. That there is not "overwhelming" support for the performance of those procedures is not the standard by which medical expenses are awarded under the Act. The evidence presented was sufficient for the Commission to find the discogram and IDET procedures were reasonable and necessary to treat claimant's work-related **[*7]** injury. Its decision to award claimant costs associated with those procedures was not against the manifest weight of the evidence.

For the reasons stated, we affirm the circuit court's judgment.

Affirmed.

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*9 IWCC 310; 2009 Ill. Wrk. Comp. LEXIS 323, **

JOSHUA GARCIA, PETITIONER, v. **EXECUTIVE MAILING** SERVICE, RESPONDENT.

NO: 08WC 4166

ILLINOIS WORKERS' COMPENSATION COMMISSION

STATE OF ILLINOIS, COUNTY OF COOK

9 IWCC 310; 2009 Ill. Wrk. Comp. LEXIS 323

April 2, 2009

CORE TERMS: arbitrator, injections, temporary total disability, utilization, discogram, physical therapy, transforaminal, lumbar, facet, permanent disability, temporary, written request, diskogram, causally, medial, block, total compensation, modifies, notice, amount of compensation, overwhelming evidence, average weekly wage, evidence submitted, insurance carrier, fee schedule, group health, amount paid, pain, electrothermic, intradiscal

JUDGES: David L. Gore; James F. DeMunno; Mario Basurto

OPINION: [*1]

DECISION AND OPINION ON REVIEW

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

The Arbitrator denied certain medical expenses based on utilization review reports submitted by Respondent. While such reports are relevant, utilization reviews are not intended necessarily to be dispositive, but rather as evidence to be assessed just like all other evidence. The Commission **[*2]** finds that the utilization review criteria regarding the recommended discogram and intradiscal electrothermic therapy (IDET) procedure may be a bit too strict. First, the utilization review appears to discount IDET completely as a certifiable treatment altogether, because of the lack of precise proof of its efficacy. Second, the basis for rejecting the discogram

because of the lack of "documentation of consistent and overwhelming evidence" of pathology appears to be particularly unduly rigid because the discogram is primarily a diagnostic tool and it would be difficult to establish "consistent and overwhelming evidence" of pathology without one. Accordingly, the Commission modifies the Decision of the Arbitrator to require Respondent to pay for the discogram and IDET procedures.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $ 226.67 per week for a period of 21 2/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation **[*3]** for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay medical expenses for the discogram and intradiscal electrothermic therapy under §8(a) of the Act.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $ 15,000.00. The probable cost of the record to be filed as return to Summons is the sum of $ 35.00, payable to the Illinois Workers' Compensation Commission in the form of cash, check or money order therefor **[*4]** and deposited with the Officer of the Secretary of the Commission.

DATED: APR 2 2009

ATTACHMENT:

ILLINOIS WORKERS' COMPENSATION COMMISSION 19(b) ARBITRATION DECISION

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on June 27, 2008. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:
C. Did an accident occur that arose out of and in the course of the petitioner's employment by the respondent?
F. Is the petitioner's present condition of ill-being causally related to the injury?
G. What were the petitioner's earnings?
J. Were the medical services that were provided to petitioner reasonable and necessary?
K. What amount of compensation is due for temporary total disability?

FINDINGS

. On January 18, 2008, the respondent was operating under and subject to the provisions of the Act.

. On this date, an employee-employer relationship existed between the petitioner **[*5]** and respondent.

. Timely notice of this accident was given to the respondent.

. The petitioner sustained an accident on January 18, 2008, arising out of and in the course of his employment with the respondent.

. The petitioner's average weekly wage is $ 340.00.

. At the time of injury, the petitioner was 26 years of age, *single* with no children under 18.

. Necessary medical services *have not* been provided by the respondent.

. To date, $ 0.00 has been paid by the respondent on account of this injury.

ORDER:

. The respondent shall pay the petitioner Temporary Total Disability benefits of $ 226.67/week for 21-2/7 weeks, from January 31, 2008, through June 27, 2008, which is the period of Temporary Total Disability for which compensation is payable.

. The cost of the physical therapy rendered the petitioner after February 25, 2008, the transforaminal injections, IDET procedures, diskogram and facet injections are denied. The reasonable cost of evaluations, examinations, the lumbar medial branch block on April 3, 2008, and other treatment by the Pain Net Group is awarded. The respondent shall pay the medical bills incurred after February 1, 2006, in accordance with **[*6]** the Act and the medical fee schedule. The respondent shall be given credit for any amount it paid toward the medical bills, including any amount paid within the provisions of Section 8(j) of the Act, and any adjustments, and shall hold the Petitioner harmless for all the medical bills paid by its group health insurance carrier.

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

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

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

Robert Williams

8/8/08

Date

FINDINGS OF FACTS:

The petitioner, **[*7]** a forklift operator, received care for low back pain at Concentra Centers on January 19, 2008. The diagnosis was a lumbar strain. X-rays on January 22, 2008, were negative. He started care with Dr. Herba of the Pain Net Medical Group on January 31, 2008,

for back pain with left radiculopathy. He reported that an MRI revealed two small disc herniations. At the request of the respondent, the petitioner was evaluated by Dr. Shermer, who opined that the MRI on February 5, 2008, revealed disc degenerated findings at L4/5 and L5/S1, small bulges at the L4-L5 and L5-S1 levels that were not consistent with herniations.

The petitioner received physical therapy, transforaminal injections, facet joint injections, a lumbar medial branch block and IDET procedures without any long-term benefits.

FINDING REGARDING WHETHER THE PETITIONER'S ACCIDENT AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH THE RESPONDENT:

Based upon the testimony and the evidence submitted, the petitioner proved that he sustained an accident on January 18, 2008, arising out of and in the course of his. employment with the respondent. The petitioner prepared an employee accident report the day of his injury and reported **[*8]** to Concentra's medical staff that his back locked when he stood up from bending and lifting a plastic bin.

FINDING REGARDING THE AMOUNT OF WAGES:

In the year preceding the injury, the petitioner earned $ 8.50 per hour. For a 40-hour workweek, his average weekly wage is $ 340.00.

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

Utilization reviews by CorVel failed to certify the physical therapy after February 25, 2008, the transforaminal injections, IDET procedures, diskogram and facet injections rendered by the Pain Net Medical Group. The cost of the physical therapy rendered the petitioner after February 25, 2008, the transforaminal injections, IDET procedures, diskogram and facet injections are denied. The reasonable cost of evaluations, examinations, the lumbar medial branch block on April 3, 2008, and other treatment by the Pain Net Group is awarded. The respondent shall pay the medical bills incurred after February 1, 2006, in accordance with the Act and the medical fee schedule. The respondent shall be given credit for any amount it paid toward the medical bills, including any amount paid within the provisions of **[*9]** Section 8(j) of the Act, and any adjustments, and shall hold the Petitioner harmless for all the medical bills paid by its group health insurance carrier.

FINDING REGARDING WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Based upon the testimony and the evidence submitted, the petitioner proved that his current condition of ill-being is causally related to the work injury.

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

The petitioner has been off of work pursuant to his doctor's recommendations from January 31, 2008, through. June 27, 2008. The respondent shall pay the petitioner temporary total disability benefits of $ 226.67/week for 21-2/7 weeks, from January 31, 2008, through June 27, 2008, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the petitioner.

Legal Topics:

For related research and practice materials, see the following legal topics:
Labor & Employment Law > Disability & Unemployment Insurance > Disability Benefits > General Overview

Workers' Compensation & SSDI > Compensability > Course of Employment > General Overview

Workers' Compensation & SSDI > Compensability > Injuries > Normal Exertion

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EMPLOYER	EXECUTIVE MAILING SERV INC	100 W RANDOLPH ST STE 8-200	
SETTING	CHICAGO	CHICAGO	IL 60601
ARBITRATOR	WILLIAMS, ROBERT	ACCIDENT DATE 01/18/08	
COMMISSIONER	GORE, DAVID	CASE FILED 01/30/08	
BODY PART	BACK N/A		

EMPLOYEE ATTORNEY	EMPLOYER ATTORNEY
MC HARGUE, JAMES P LAW OFFICE	HEYL ROYSTER VOELKER & ALLEN
100 W MONROE	120 W STATE STREET
SUITE 1112	PO BOX 1288
CHICAGO IL 60603	ROCKFORD IL 61105

STATUS REMANDED-ARB

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*11 IWCC 792; 2011 Ill. Wrk. Comp. LEXIS 818, **

NOEMI SOLIS, PETITIONER, v. HOSPITALITY STAFFING SOLUTIONS, RESPONDENT.

NO. 09WC 43221

ILLINOIS WORKERS' COMPENSATION COMMISSION

STATE OF ILLINOIS, COUNTY OF COOK

11 IWCC 792; 2011 Ill. Wrk. Comp. LEXIS 818

August 11, 2011

CORE TERMS: arbitrator, prescribed, therapy, return to work, opined, medical care, injection, guidelines, hotel, temporary, physical therapy, causally, light duty, evidence-based, preponderance, utilization, ill-being, symptoms, proven, temporary total disability, medical treatment, written request, recommended, baseline, lumbar, strain, pound, pain, permanent disability, notice

JUDGES: David L. Gore; James F. DeMunno; Mario Basurto

OPINION: [*1]

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 29, 2010 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for

further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for **[*2]** Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $ 10,100.00. The probable cost of the record to be filed as return to Summons is the sum of $ 35.00, payable to the Illinois Workers' Compensation Commission in the form of cash, check or money order therefor and deposited with the Office of the Secretary of the Commission.

ATTACHMENT:

ARBITRATION DECISION

19(b)

Noemi Solis
Employee/Petitioner

v.

Hospitality Staffing Solutions
Employer/Respondent

Case # **09WC43221**

Chicago, arbitrator Jutila

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter **[*3]** was heard by the Honorable **Gerald Jutila,** Arbitrator of the Commission, in the city of **Chicago,** on **October 15, 2010.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES
F. [X] Is Petitioner's current condition of ill-being causally related to the injury?
J. [X] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [X] Is Petitioner entitled to any prospective medical care?
L. [X] What temporary benefits are in dispute?
[X] TTD
M. [X] Should penalties or fees be imposed upon Respondent?

FINDINGS

On the date of accident, **August 13, 2009,** Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner's **[*4]** current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned $ **17,990.96;** the average weekly wage was $ **345.98.**

On the date of accident, Petitioner was **33** years of age, ***married*** with **2** dependent children.

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

Respondent shall be given a credit of **$ 6,655.50** for TTD previously paid.

ORDER

Medical benefits

Respondent shall pay outstanding reasonable and necessary medical services provided by Dr. Montella and Hanover Park Physical Therapy (see PX8) as provided in Sections8(a) of the Act but subject to the limitations of the Medical Fee Schedule, Section 8.2 of the Act.

Prospective medical benefits

Respondent shall pay reasonable and necessary prospective medical services as prescribed by Dr. Montella, limited to injections and physical therapy, as provided in Section 8(a) of the Act.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $ **309.33**/week for **54** weeks, commencing **October 1, [*5] 2009** through **March 29, 2010,** and from **April 1, 2010** through **October 15, 2010,** as provided in Section 8(b) of the Act.

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

December 29, 2010

Date

FINDING OF FACTS

Respondent HSS (Hospitality Staffing Solutions) is in the business of hiring, training, and placing able bodied housekeeping staff for approximately 25 different hotels. Petitioner is a Spanish speaking female employed as a hotel maid **[*6]** by the respondent HSS and was

assigned to work at the Hyatt Summerfield Suites in Schaumberg, Illinois.

The parties agree that petitioner was injured in an accident that arose out of and in the course of her employment by the respondent on August 13, 2009. Petitioner testified that on that date she had bent over to lift a bed mattress while in the process of changing bed linens. While doing so she turned to tuck a bed sheet under a mattress at which time she felt a pinch or spasm in her low back and a shock down her right leg. She was unable to straighten up or walk.

Petitioner was taken from the hotel to Northwest Community Hospital, (PX1). The history contained in the records is consistent with petitioner's testimony and complaints. X-rays were negative. Petitioner was diagnosed with a lumbar strain. She was prescribed medications, advised off from work, and directed to follow-up at a company preferred provider of medical care.

Petitioner was directed to a Concentra Medical Facility, (PX2). Physical therapy was prescribed. However, the insurance carrier preferred petitioner treat at another facility. Petitioner was seen at the Concentra facility on August 18, 20, and 25. The **[*7]** Concentra physicians permitted petitioner to return to work with a 10 pound **weight** restriction. Petitioner testified that she did in fact work light duty through September 2009. She was provided with a helper.

Respondent arranged for petitioner to receive therapy at the Centers for Physical Therapy, (PX3). Petitioner attended 15 sessions between August 31 and December 10, 2009 with little if any improvement in her symptoms.

Meanwhile petitioner consulted with Dr. Montella at Midwest Sports Medicine on October 1, 2009, (PX4). She testified that she was referred to this physician by the manager of the hotel where she worked. Dr. Montella's physical examination revealed a positive contralateral straight leg raise test (SLR) and no positive Waddell signs. He diagnosed a lumbar disc herniation, prescribed MRI and EMG studies, medications, a course of chiropractic care and physical therapy, and took petitioner off from work.

Respondent arranged for petitioner to be examined by Dr. Singh, a spine specialist at Midwest Orthopaedics, on December 9, 2009, (RX4). He found a positive SLR on the right at 30 degrees and negative Waddell findings. He opined that petitioner's examination was consistent **[*8]** with a L5-S1 radiculopathy and that her current complaints were reasonable in that they correlated with the objective (findings). He recommended proceeding with the MRI study. Dr. Singh felt that petitioner could work with less than 10 pounds lifting.

The MRI study was finally done on December 17, 2009. It revealed 3 to 4 and 4 to 5 mm subligamentous posterior disc herniations with extruded nuclei pulposi and small peripheral annular tears at those levels, indenting the thecal sac, without significant spinal stenosis or neuroforaminal narrowing. Dr. Montella continued petitioner's therapy prescriptions and her off work status, and renewed his recommendation for the EMG study.

Meanwhile Dr. Singh reviewed the MRI study and issued another report on February 1, 2010, (RX5). He opined that petitioner sustained a temporary aggravation of a pre-existing condition although his prognosis was guarded. He prescribed a work conditioning program after which he opined petitioner would be a maximum medical improvement with a return to work without restrictions.

The EMG study was finally done on February 19, 2010. The physician who read the study wrote that it revealed bilateral L4-5 lumbar radiculopathy **[*9]** affecting the common peroneal nerves, (PX4).

Petitioner attempted to return to work on March 30 and 31, 2010. She worked on two consecutive days but was not able to complete a full shift on either day. Apparently the work

involved handling heavy wet towels.

Petitioner underwent the work conditioning program at an ATI facility from April 12 through May 9, 2010, (PX6). The records reflect that she participated in the program as instructed and although some improvement was noted she continued to demonstrate lower extremity weakness with increased back pain with increased activity. She was discharged from work hardening to return to physical therapy on the advice of her physician, Dr. Montella. However, the ATI records reflect that the insurance denied payment for physical therapy services, (AX6).

Dr. Singh also reviewed the EMG study and issued a third report on May 21, 2010, (RX6). He opined that petitioner has received an excessive amount of medical treatment. He declared that petitioner's EMG is a "classic" example of a false positive and he did not believe the patient's current symptoms are causally related to her work injury. Dr. Ross opined the EMG study appears to be misleading, **[*10]** (PX7). Dr. Singh believed petitioner had returned to her baseline condition.

Petitioner has continued to follow with Dr. Montella on a monthly basis. He has noted little if any improvement in petitioner's symptoms, even with the therapy he ordered. Indeed, he noted an increase of symptoms following a course of work hardening. He has continued petitioner's off work status and prescribed epidural steroid injections, (PX4).

Petitioner was also evaluated by a neurosurgeon, Dr. Ross, who issued a report on May 14, 2010, (PX7). Dr. Ross opined that petitioner was most probably suffering from a lumbosacral strain and sacroiliitis. He concurred with the recommendation of Dr. Montella that she proceed with cortisone injections, both epidural and sacroiliac. He also felt it appropriate for petitioner to return to work on a light duty basis, limiting lifting to 20 pound **weights.**

Petitioner testified that she desires to proceed with the therapy and injections prescribed by Dr. Montella. She testified that the injuries are causing significant limitations on her activities of daily living. Nevertheless, she is willing to return to work in a light duty capacity as recommended by Dr. Ross if such **[*11]** work would be made available to her and the respondent honored the restrictions imposed on her by her physicians. However, respondent's witness testified that the hotel is unwilling to accept the petitioner back at work with restrictions on her physical activities.

ISSUES AND CONCLUSIONS

Is the petitioner's present condition of ill-being causally related to the injury?

The arbitrator concludes that petitioner has proven by a preponderance of the evidence that her present condition of ill-being relative to her low back is causally related to an injury she sustained at work on August 13, 2009. This conclusion is based upon a sequence of events analysis of all the evidence including petitioner's credible testimony, the medical records in evidence, and the opinions of Dr. Montella, Dr. Singh, and Dr. Ross.

Were the medical services that were provided to petitioner reasonable and necessary?

and

Should the respondent be required to authorize and provide for prospective medical care?

The arbitrator concludes that petitioner has proven by a preponderance of the evidence that her past medical care reflected in bills for services rendered (PX8) constitute necessary **[*12]** medical care reasonably required to cure or relieve her from the effects of her injuries and therefore those bills are the responsibility of the respondent, subject to the limitations in the

Medical Fee Schedule, (Section 8.2 of the Act).

The arbitrator also concludes that petitioner has proven by a preponderance of the evidence that additional prospective conservative treatment and injection therapy prescribed by Dr. Montella and recommended by Dr. Ross also constitutes necessary medical care reasonably required to cure or relieve her from the effects of her injury. Therefore, the prescribed injection therapy is the responsibility of the respondent.

In reaching these conclusions the arbitrator has considered the contrary opinion of Dr. Singh and finds it to be unpersuasive. Dr. Singh opined that petitioner has returned to her baseline. In fact, the petitioner's baseline up until her injury on August 13, 2009 was that she was able to work full duty without restrictions and without pain. The arbitrator is not suggesting that petitioner should not return to work until she is free from all pain and discomfort. However, the evidence is that petitioner has not responded to conservative **[*13]** treatments as quickly as she or any of the physicians involved would desire and she remains under significant restrictions. There is significant objective evidence in the record demonstrating petitioner sustained an injury to her low back. There is nothing in the record from which the arbitrator could conclude that petitioner is malingering. Indeed, all of the physicians who examined her were unable to find any Waddell signs.

Respondent has also proved the arbitrator with **utilization reviews** by two California physicians and the evidence deposition of one of those physicians (RX2 & 3). The arbitrator has also considered this additional evidence in reaching his conclusions. Respondent argues that the opinions of the utilization reviewers originate from "evidence-based" guidelines and therefore should be entitled to greater **weight.** The arbitrator is not persuaded by the **utilization reviews** and the testimony of Dr. Schaffzin. Dr. Schaffzin would have the arbitrator favor the evidence-based guidelines and ignore the substantial evidence presented by petitioner in this case.

Recent enactments by the California legislature established a presumption of correctness of therapies in California **[*14]** workers' compensation claims based upon evidence-based medical treatment guidelines, (PX9). Illinois law does not recognize any such presumption in favor of evidence-based medical treatment guidelines. Specifically, Section 8.7 (i) of the Act provides that a **utilization review** will be considered by the Commission, along with all other evidence and in the same manner as all other evidence, in the determination of the reasonableness and necessity of medical bills and treatment. The California reviewers rely on guidelines or standards which represent a "one size fits all" template on whether or not certain treatments should be approved. The guidelines do not appear to recognize that strains or sprains can be of different degrees of complexity, that different jobs have different physical demand levels, and that some individuals heal at different rates than others.

What temporary benefits are in dispute?

The arbitrator concludes that petitioner has proven by a preponderance of the evidence that she has been temporarily totally disabled for a period of 54 weeks from October 1, 2009 through March 29, 2010 and from April 1, 2010 through October 15, 2010. This conclusion is based upon **[*15]** work restrictions imposed by petitioner's treating physician, Dr. Montella, and supported by petitioner's testimony regarding the "light duty" work that she attempted to return in late March 2010, and the testimony of respondent's witness that the hotel will not allow petitioner to return to work in a restricted capacity.

Should penalties or fees be imposed upon respondent?

The arbitrator concludes that the imposition of penalties or fees on respondent is not appropriate at this time.

Legal Topics:

For related research and practice materials, see the following legal topics:
Workers' Compensation & SSDI > Administrative Proceedings > Claims > Time Limitations > Notice Periods

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

Workers' Compensation & SSDI > Compensability > Injuries > General Overview

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