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*11 IWCC 920; 2011 Ill. Wrk. Comp. LEXIS 925, **

ELVIS RIDGEWAY, PETITIONER, v. TLC, INC., RESPONDENT.

No. 02WC 65692, 02WC 55534

ILLINOIS WORKERS' COMPENSATION COMMISSION

STATE OF ILLINOIS, COUNTY OF PEORIA

11 IWCC 920; 2011 Ill. Wrk. Comp. LEXIS 925

September 15, 2011

CORE TERMS: ankle, pain, doctor, fusion, discomfort, surgery, brace, recommended, fracture, mechanic, knee, walking, lumbar, foot, gait, disability, full-time, lateral, leg, wage differential, left foot, underwent, orthotic, symptoms, mild, scan, prescribed, foraminal, opined, truck

JUDGES: Molly C. Mason; Yolaine Dauphin

OPINION: [*1]

DECISION AND OPINION ON REVIEW PURSUANT TO SECTIONS 8(a) AND 19(h)

This matter comes before the Commission on Petitioner's timely Petition for Review under §§ 8 (a) and 19(h). The Commission, having jurisdiction over the persons and subject matter, and after considering the evidence and issues of § 8(a) and § 19(h), grants Petitioner's Petition for Review under §§ 8(a) and 19(h), finding that Petitioner's ongoing medical treatment is causally related to the January 8, 2002 work accident, thereby entitling Petitioner to an award of reasonable and necessary medical costs pertaining to that treatment, and further finding that Petitioner proved a material increase in his disability since the date of arbitration, thereby entitling Petitioner to an additional award of 35% man as a whole pursuant to § 8(d)2.

FINDINGS OF FACT

1. Petitioner testified that on January 8, 2002, he was employed as a head mechanic for Respondent. On that day, he went out to work on a truck, knocked over a jug containing a slippery substance, stepped in the substance, fell, and twisted his left ankle. Petitioner was taken to BroMenn emergency room by ambulance. At the emergency room, Petitioner complained **[*2]** of left ankle pain

and an inability to bear weight on his left ankle. He reported hearing a pop and a crack in his left ankle when he fell and twisted it. Left ankle x-rays showed a fracture of the lateral malleolus with dislocation at the ankle joint. (PX 6). The emergency room doctor diagnosed a left lateral fibular fracture with probable disruption of the medial deltoid ligament and with some medial displacement of the tip of the fibular joint region. The doctor prescribed Vicodin, an Ace wrap, and a splint with crutches. Petitioner was to follow-up with Dr. Nord. (PX 5).

2. Petitioner underwent treatment with Dr. Nord from January 2002 through December 2009. On January 9, 2002, Dr. Nord performed surgery, consisting of an open reduction and internal fixation of the left ankle fracture. A cast was applied. (PX 7). Petitioner returned to sedentary work for Respondent five weeks later. Petitioner underwent a second operation on March 18, 2003, for a left heel distal fibular fracture, and removal of a plate from the left heel/ankle. (PX 8) (PX 1, pp 4-9). Thereafter, Petitioner returned to full duty on May 5, 2003.

3. Between March 20, 2003 and October of 2003, Dr. Nord noted ongoing **[*3]** symptoms, pain, and continuing improvement.

4. In October of 2003, Dr. Nord ordered a whole body scan to evaluate Petitioner's complaints of left foot pain. The scan showed: 1. moderately intense uptake in the left ankle and sequela of prior trauma and bony injury to the left ankle; 2. mild increased uptake in the left ankle which might be related to degenerative change or secondary to trauma; and 3. mild to moderate increased uptake in the region of the right first metatarsophalangeal joint, possibly stress-related or secondary to degenerative change. (PX 10).

5. Dr. Nord referred Petitioner to Dr. Meyn, an orthopedic surgeon at Midwest Orthopaedic Center, for a second opinion and consultation regarding an orthotic. That visit took place on October 16, 2003. An x-ray of Petitioner's left ankle showed evidence of a small bone fragment at the tip of the medial malleolus. Dr. Meyn described Petitioner's fracture as quite severe, noting that a piece of bone appeared to have been fractured from the posterior malleolus on the tibia of the left ankle thereby making Petitioner's injury the equivalent of a tri-malleolar fracture of the left ankle. The doctor recommended a Spenco arch cushion, **[*4]** and a speed brace. (PX 11).

6. Petitioner received additional care from Dr. Nord between December of 2003 and September of 2004, with the doctor noting improvement and returning Petitioner to full duty work on December 11, 2003. At the December 11, 2003, and December 18, 2003 visits, Petitioner indicated his brace was stabilizing his left ankle, he was walking better, and he was able to work up to fourteen hours a day without pain or discomfort. Based upon his March 16, 2004, September 13, 2004, and November 22, 2004 examinations, wherein Petitioner repeatedly voiced increased discomfort in his left ankle when he was not using his orthotic, Dr. Nord requested another left ankle MRI. That MRI, taken on September 20, 2004, revealed: 1. a shallow osteochondral defect of the medial talar dome associated with a small subchondral cyst, but no joint effusion or loose body; 2. a well-defined area of altered signal intensity within the lateral aspect of the distal tibia consistent with an area of bone marrow infarction; 3. peroneus brevis tendinopathy without a discrete tear; and 4. mild posterior tibial tendinopathy without evidence of a tear. Based upon these findings, Dr. Nord recommended **[*5]** additional care, treatment, and monitoring. At a November 22, 2004 office visit, Petitioner complained of mild left ankle discomfort when using his orthotic and increased pain without it. Dr. Nord recommended that Petitioner avoid activities that aggravated his discomfort, and only use his ankle orthotic when ambulating. (PX 7, 23) (PX 1, pp. 9-12).

7. Petitioner again saw Dr. Nord on December 20, 2004. Petitioner reported since his surgery he had been experiencing a chronic aching in his left ankle area. On occasion, while standing or walking, his left ankle would give out. Forceful use, movement, lifting, cool damp weather, exercise, standing, climbing ladders, and walking increased his left ankle pain. Petitioner indicated he was not interested in a left ankle fusion. On February 5, 2010, Dr. Nord noted Petitioner had sustained an acute left ankle fracture as a result of a work accident in January of 2002. The accident necessitated open surgery from which Petitioner had recovered fairly well. According to Dr. Nord, however, Petitioner's continued use of a brace, traumatic arthritis to the left ankle, and ongoing symptomatology indicated some left ankle instability. Dr. Nord noted **[*6]** that Petitioner might need fusion surgery in the future, but surgery could be postponed if Petitioner used a brace and avoided falling. (PX 3).

8. Arbitrator Falcioni approved a Settlement Contract Lump Sum Petition and Order on February 18, 2005, with Respondent agreeing to pay Petitioner 40% loss of use of the left foot. Pursuant to the settlement contract, the parties agreed to keep § 8 (a) and § 19(h) rights open under the Act.

9. At the § 8(a)/19(h) hearing held on June 21, 2010, Petitioner testified that after settling his workers' compensation claim, he continued to work, full duty, wearing his AFO brace. Petitioner explained he has chronic problems with his left ankle, as well as lower back problems. He has trouble with his gait, walking, bending, and sitting for long periods of time. Lastly, he experiences numbness in his foot and has swelling and pain in his left knee which he attributes to wearing the brace. (T. 17-19).

10. Dr. Nord monitored Petitioner's progress from May through November of 2005, noting increasing discomfort in Petitioner's left ankle. The doctor ordered a more rigid AFO brace to reduce Petitioner's ankle instability. On March 9, 2006, Dr. Nord noted **[*7]** improvement in Petitioner's left ankle discomfort with the new left ankle brace. However, Petitioner had some paresthesias in the left lower extremity, and mild swelling in the left ankle. Petitioner's gait was normal. The doctor ordered an EMG, and recommended an epidural steroid injection. (PX 13).

11. Respondent sent Petitioner for a § 12 examination with Dr. Weinger on February 9, 2006. Dr. Weinger noted complaints of moderately severe low back symptoms radiating into both legs. A lumbar spine x-ray revealed evidence of a Grade 1 to Grade II spondylolisthesis of L5 to S1 with marked narrowing of the disc space, and bilateral pars defects involving L5. Dr. Weinger also noted some shortening of Petitioner's right leg and his use of the AFO brace on the left foot. The doctor recommended a half-inch sole for Petitioner's right foot.

12. Dr. Nord sent Petitioner to Dr. Pegg for an EMG which was performed on March 14, 2006. (T. 19). Petitioner complained of low back pain radiating down the anterior aspect of his left thigh and lower leg, and occasional numbness on the top of his left foot. Dr. Pegg felt Petitioner's complaints suggested a possible left S1 radiculopathy. While the **[*8]** changes in Petitioner's distal muscles could be related to a mild peripheral polyneuropathy, Dr. Pegg did not believe that explained the irritability of Petitioner's left S1 paraspinals. (PX 16).

13. Due to Petitioner's low back symptoms, Dr. Nord ordered a lumbar spine MRI which was performed on April 13, 2006. The radiologist's impression was L5 spondylolysis with Grade II L5-S1 spondylolisthesis and moderate to severe bilateral foraminal stenosis, with no focal disc herniation. (PX 14). Thereafter, Petitioner received low back epidural injections and physical therapy per Dr. Nord.

14. At the request of Dr. Nord, Petitioner presented to Dr. Nardone on July 5, 2006. Petitioner complained of low back pain, as well as left leg pain and numbness. Dr. Nardone felt Petitioner had symptomatic L5-S1 spondylolisthesis and foraminal stenosis, and recommended a pedicle screw fixation at L5-S1 with foraminal decompression, possible transforaminal lumbar interbody fusion, posterior lumbar interbody fusion, and posterior lumbar interbody fusion with allograft bone and bone morphogenetic protein. (PX 15).

15. Petitioner underwent a § 12 medical examination with Dr. Chabot on August 16, 2006. **[*9]** Dr. Chabot opined Petitioner had evidence of osteoarthritic changes involving the left ankle which, to some degree, predated his injury. The doctor noted it would be important to obtain the initial x-rays, as well as the ones following the ankle repair, to confirm his suspicions. Dr. Chabot did not understand why Petitioner wore a brace, as Petitioner exhibited no instability involving the left ankle. With the high-laced boots that Petitioner wore, there was no need to wear an AFO brace. If the brace was meant to treat Petitioner's osteoarthritis, Petitioner might benefit from a different type of brace. Dr. Chabot felt Petitioner had reached maximum medical improvement regarding his left ankle, and that Petitioner's underlying left ankle osteoarthritis would continue to be a problem. Dr. Chabot recommended against surgical intervention to the left ankle, felt steroid injections to reduce Petitioner's occasional ankle complaints might be appropriate, and opined that Petitioner could return to regular work duties. Dr. Chabot further opined that Petitioner's back complaints were unrelated to his left ankle injury as they represented developing symptoms associated with chronic degenerative **[*10]** changes involving the L5-S1 level and developmental deformities involving the L5 pars resulting in spondylolisthesis. Further, Petitioner's symptoms were not work-related as they did not develop until 2005; rather, they represent a progression of the disease process resulting in loss of disc space height and neural foraminal narrowing. (RX 1).

16. Petitioner presented to Dr. Nord on March 6, 2007, with continuing complaints of low back discomfort associated with his left ankle pain. The doctor ordered an EMG/NCV to assess nerve root compression and lumbar radiculopathy; discussed left ankle fusion surgery with Petitioner; prescribed use of anti-inflammatory medication, and an ankle support; and recommended weight loss. (PX 23). If the findings of the EMG/NCV were positive, Dr. Nord planned to refer Petitioner to Dr. Nardone for possible back surgery.

17. Petitioner underwent repeat EMG/NCV testing with Dr. Pegg on March 13, 2007, reporting that he still had the same back pain as when he had undergone the first EMG/NCV test in 2006. Dr. Pegg noted some recent extension of symptoms on the right side of Petitioner's lower back, and left leg discomfort that seemed to go down the outer **[*11]** and frontal aspect of the thigh, into the lower leg. Other than evidence of very mild irritability involving some of the L5-S1 muscles in the left lower extremity, and yet milder changes on the right side, there were no additional findings since the March 14, 2006 study. (PX 17).

18. On March 22, 2007, April 9, 2007, and May 10, 2007, Dr. Nord noted Petitioner's continuing complaints of low back pain, associated leg pain, and left ankle discomfort. Optional left ankle fusion surgery was discussed.

19. Dr. Nord performed an ankle arthrodesis on June 18, 2007, fusing the distal tibia with the talus, in an effort to eliminate both Petitioner's ankle motion and pain. On August 2, 2007, Petitioner was given a short leg cast. Petitioner underwent a CT scan of his left ankle on August 26, 2007. Dr. Nord prescribed a traveler boot on September 17, 2007, to reduce stress across the ankle joint, and allow further healing of the arthrodesis. He prescribed an AFO brace on November

15, 2007, along with another course of physical therapy. (PX 1. p. 16-19).

20. On October 18, 2007, Petitioner presented to Dr. Nord complaining of increased pain and swelling in his ankle. The doctor recommended **[*12]** that Petitioner reduce any activities that caused ankle swelling or pain, and use his walking boot to lessen ankle joint stress. On April 1, 2008, Dr. Nord noted Petitioner complained of discomfort of the proximal lateral aspect of the foot, aggravated by walking. Dr. Nord felt Petitioner was experiencing stress in some of the proximal foot bone articulations, thereby causing discomfort. The doctor noted Petitioner had decreasing discomfort at the fusion site with the use of his AFO. He recommended home exercises, and the avoidance of aggravating activities. Dr. Nord also referred Petitioner to Dr. Cortese, a podiatrist, due to the uncertain etiology of Petitioner's left foot discomfort. (PX 9)

21. A CT scan of Petitioner's left ankle, ordered by Dr. Nord and taken on August 28, 2008, showed an intramedullary rod causing arthrodesis between the tibiotalar and talocalcaneal joints, along with an old partially united fracture of the lower fibula. (PX 18).

22. Dr. Nord sent Petitioner to Dr. Cortese for evaluation and treatment of his left ankle on September 15, 2008. Petitioner complained of daily pain on the lateral side of his left ankle, in the area of the fibula, when walking. **[*13]** Petitioner described the pain as "shooting", and reported that it started on the bottom of the fibula and radiated behind it. The pain was relieved by sitting down. Dr. Cortese assessed pseudoarthrosis of the fibula of the left foot, and possible sural nerve neuritis due to fibrosis from scar tissue. Dr. Cortese casted Petitioner for a new AFO brace and gave Petitioner an injection into the ankle area. (PX 19).

23. Petitioner underwent a § 12 medical examination with Dr. Schmidt on December 8, 2008. Dr. Schmidt felt Petitioner suffered from posttraumatic ankle arthritis related to his ankle fracture. According to Dr. Schmidt, Petitioner had undergone a successful ankle arthrodesis but developed subtalar joint pain. The doctor explained that with an intramedullary device, one often has to undergo a formal fusion of the subtalar joint as well, or the joint may become painful. Based upon his review of Petitioner's CT scan, it was evident to Dr. Schmidt that Petitioner's subtalar joint was the source of Petitioner's pain, as it had not fused. He recommended surgery to remove the rod followed by a formal subtalar fusion. Excision of the sural nerve at the time of the surgery was another **[*14]** option; however, Dr. Schmidt did not think the sural nerve was the primary source of Petitioner's pain. The doctor felt that a successful fusion surgery would provide Petitioner the opportunity to return to his previous, or other, gainful employment. (PX 4).

24. Petitioner underwent a functional capacity evaluation on December 30, 2008. John Becker, MS Exercise Physiologist, performed this evaluation. Petitioner's target job was a truck diesel mechanic in the automotive services industry with a net time worked of 540 minutes. Becker reported that Petitioner, giving forth full effort, met 11 of 19 critical job demands. The limiting factors included standing on ladders, squatting, and carrying heavy loads. (PX 22).

25. On January 20, 2009, Petitioner returned to Dr. Nord for a follow-up examination because of residual discomfort in his left foot and ankle area following his June 2007 surgery. Examination showed minimal discomfort in the left ankle, particularly just distal to the lateral fibular malleolar area. The doctor recommended that Petitioner be rehabilitated into a job with sedentary work restrictions where he would not have to stand for more than two hours out of an eight **[*15]** hour day. It was the doctor's opinion that Petitioner should not be doing any squatting,

crouching, climbing, or anything that put excessive stress across the ankle and foot joint. Because Petitioner complained of discomfort with walking, he was also limited to walking no more than two hours per day. (PX 1, pp. 23-26).

26. Respondent provided vocational case management services to Petitioner between April 9, 2009 and October 1, 2009. Case manager Mary Andrews documented her work with Petitioner by preparing a vocational assessment after each meeting with Petitioner. Overall, Petitioner was noted to have limited computer skills, but was agreeable to taking a computer class to improve his skills. Ms. Andrews implemented job placement services which included ongoing job search support while obtaining career information from a local community college. Petitioner began working, part-time, at Joe's Towing and Recovery on August 10, 2009. Petitioner was hired as a mechanic/tow operator and was to be paid $ 15.00 per hour and work five to six hours per night, Monday through Friday. Petitioner expressed hope that the job would become full-time with an increase in wages. In the meantime, Ms. **[*16]** Andrews requested that Petitioner continue his job search efforts, but on a part-time basis. The goal was to find full-time employment. Thereafter, Petitioner and Ms. Andrews met regularly to discuss Petitioner's job at Joe's Towing and Recovery as well as his job search efforts. Petitioner's employer accommodated his restrictions so that he could occasionally sit down and stretch his ankle. At his own expense, Petitioner subsequently enrolled in a keyboarding class. He also applied for numerous jobs and submitted job logs as required. However, Petitioner began reporting increased symptoms in his left ankle due to his increased work activities at the towing company. As of September 11, 2009, Petitioner advised he was unsure he could physically handle an 8-hour work day. He had received no calls or e-mails regarding any jobs he had applied for. Andrews told Petitioner to look for part-time work to supplement his work at Joe's Towing. Vocational services were terminated as of October 1, 2009, after Petitioner did not show up for his appointment on September 28, 2009, and did not return Ms. Andrews' telephone calls of September 28, 2009 and October 1, 2009. (PX 24)

27. Petitioner returned **[*17]** to Dr. Nord on September 17, 2009 with complaints of low back pain radiating down his left leg and some residual low grade left ankle discomfort. The doctor recommended Petitioner work solely in a sit-down position, and participate in a weight loss program. The doctor also prescribed home exercises, Tylenol, and MRI scans of the lumbar spine and left knee.

28. An MRI of Petitioner's left knee performed on September 21, 2009 showed: 1. myxoid degeneration of the lateral meniscus without magnetic resonance evidence for a lateral meniscus tear; 2. low grade fibular collateral ligament sprain; 3. marked chondromalacia of the patellofemoral joint without focal chondral defect or loose body; 4. intermediate grade chronic ACL partial tear; and 5. low grade degenerative change of the medial compartment. (PX 20). An MRI of the lumbar spine taken on the same date showed: 1. progression of degenerative changes; 2. L5 spondylosis with Grade II anterolisthesis; 3. retrolisthesis at L4-L5; 4. multilevel spinal and neural foraminal stenosis; and 5. abdominal aortic aneurysm, unchanged since the last scan. (PX 21).

29. Petitioner followed up with Dr. Nord on October 6, 2009. Based upon the MRI, **[*18]** Dr. Nord diagnosed left lumbar radiculitis secondary to spondylolisthesis and severe bilateral foraminal stenosis. Dr. Nord referred Petitioner to Dr. Nardone for a surgical evaluation. Dr. Nord remarked that if Dr. Nardone did not recommend surgical treatment on Petitioner's spine, Petitioner could consider left knee arthroscopic debridement. On the last follow-up visit on December 1, 2009, Dr. Nord made similar findings and recommendations.

30. Dr. Nord was deposed on February 5, 2010. An orthopedic surgeon with 34

years of experience, he first saw Petitioner at the referral of the emergency room physician. (PX 1, p. 4-6). Dr. Nord opined that the finding on the September 20, 2004 MRI was consistent with traumatic osteoarthritis which developed in Petitioner's ankle subsequent to his work-related injury. (PX 1, pp. 9-12).

> Based upon Petitioner's April 13, 2006 MRI and April 14, 2006 EMG, Dr. Nord opined that Petitioner's leg and foot complaints were coming from his spine. The doctor noted that Petitioner had a history of low back pain with left sciatica after wearing his left ankle orthotic, as indicated in the medical notes beginning on March 9, 2004. Dr. Nord prescribed the **[*19]** left ankle orthotic to eliminate the mobility in the ankle and the orthotic, in turn, caused Petitioner to alter his gait. (PX 1, pp. 13-15).
>
> It was Dr. Nord's opinion that as a result of the January 8, 2002 accident, Petitioner sustained a fracture dislocation of his left ankle, and developed traumatic osteoarthritis. Dr. Nord indicated that while Petitioner's left foot was not immobilized, his ankle was immobilized, resulting in no movement in the ankle joint. Dr. Nord testified that the treatment, surgeries, and subsequent permanent restrictions were causally related to that work accident. The doctor further testified that Petitioner might need some occasional anti-inflammatory medications. (PX 1, p. 27-29).
>
> Dr. Nord opined that Petitioner's left ankle injury and fusion contributed to or aggravated Petitioner's low back condition because they resulted in an abnormal gait that eventually caused back pain to develop. Dr. Nord noted Petitioner never gave a history of having injured the knee; rather, his knee pain developed following the ankle arthrodesis. Dr. Nord felt the left knee pain was causally related to Petitioner's ankle injury because the changes shown on the MRI were degenerative **[*20]** in nature and could have been caused by Petitioner's abnormal gait. (PX 1, p. 30-31).
>
> On cross-examination, Dr. Nord acknowledged that the accident did not cause Petitioner's back changes. The doctor agreed that being overweight, as Petitioner was, could contribute to the development of degenerative back and knee changes. However, Dr. Nord testified further that Petitioner's ankle fusion led to the development of an abnormal gait which aggravated pre-existing arthritis in Petitioner's knee and back. (PX 1, p. 31-36).
>
> Dr. Nord testified that Petitioner first complained of low back pain on November 8, 2005, prior to the fusion surgery. After the accident, Petitioner never had a normal gait. Even though the fracture healed, Petitioner developed traumatic osteoarthritis, and complained of back and knee pain which related back to his ankle and antalgic gait. Dr. Nord attributed Petitioner's knee and back pain to his abnormal gait. (PX 1, p. 36-39).

31. Dennis Gustafson prepared a Vocational Assessment Report on March 29, 2010, indicating that Petitioner required a full-time seated or sedentary job. In his opinion, those restrictions ruled out either truck driving or full-time

mechanic **[*21]** work. Petitioner could not operate a tractor-trailer because of problems climbing in and out of the vehicle, and because he could not use his left foot to operate a clutch, due to the ankle fusion. He also noted that Petitioner's ability to perform work as a mechanic is restricted to 3 hours a day, 5 days a week, since the position involves constant standing. Gustafson believed Petitioner could secure full-time employment paying between $ 8.00 and $ 10.00 per hour, with the starting pay most likely falling between $ 8.50 and $ 9.50. Petitioner would be financially better off by combining his current job (mechanic's work of 15 hours per week at $ 15.00 per hour) and a part-time sit-down position paying in the vicinity of $ 9.00 per hour. Thus, Gustafson felt Petitioner might be able to work the equivalent of full-time and earn an average hourly wage in the vicinity of $ 11.25. (PX 2).

32. Petitioner testified that he experiences pain in his left ankle every day, and his left ankle and knee become swollen, depending upon his level of activity. He usually takes a hot shower, and elevates his leg. Petitioner stated that he has reduced his work schedule as a part-time mechanic at Joe's **[*22]** Towing and Recovery so as to lessen the pain in his left knee and back. (T. 29-31).

CONCLUSIONS OF LAW

Petitioner requests that the Commission award him causally related medical expenses he has incurred since February 18, 2005. He also asks that the Commission find he has shown a material increase in his disability warranting a wage differential award pursuant to § 8(d)1.

Petitioner's outstanding medical bills (PX 27, 28, and 29) total $ 5,507.66, before the application of the Medical Fee Schedule. The Commission awards Petitioner those medical expenses pursuant to § 8(a), finding Dr. Nord's opinions as to their causal connection and necessity more credible and convincing than those of Dr. Chabot, upon whom Respondent relies. Dr. Nord's care and treatment of Petitioner spanned a nine-year period while Dr. Chabot based his opinion on a one-time medical examination of Petitioner. In light of Dr. Nord's long standing care of Petitioner, we give greater weight to his opinions. The Commission, having reviewed the medical bills, finds they represent charges for reasonable, necessary, and related treatment, and award medical expenses in the amount of $ 5,507.66. This award is not **[*23]** subject to the fee schedule based on the Appellate Court's recent holding in **Tower Automotive** v. IWCC, 407 Ill.App.3d 427, 943 N.E.2d 153, 2011 Ill.App.LEXIS 45 (1st Dist. 2011). In **Tower Automotive**, the Court held that the amendatory change to § 8(a) giving rise to the fee schedule (i.e., P.A. 94-0277) applies to claims for accidents occurring on or after February 1, 2006. Petitioner's accident occurred before February 1, 2006.

With regard to his wage differential claim, Petitioner maintains that his disability has increased since his settlement as evidenced by his increased ankle arthritis requiring fusion surgery, his development of scar tissue in the area of the fusion leading to sural nerve pain, and his development of subtalar pain requiring possible future surgery. As a result of this additional treatment, Petitioner's employability has been adversely affected as he can no longer work full-time work as a mechanic, truck driver, or roofer, and is, therefore, prevented from returning to his usual and customary line of employment.

Respondent maintains Petitioner is barred from seeking a wage loss differential pursuant **[*24]** to § 8(d)1 having both elected a specific remedy and waived recovery under all other provisions of the Act at the time he settled his claim in 2005. Having settled his claim for 40% loss of use of the left foot pursuant to § 8(e)11, Respondent contends Petitioner is now barred from attempting to "convert" his election into a wage loss. The settlement contract specifically states that the parties agreed to keep § 8(a) medical rights and § 19(h) rights open, while all other provisions of the Act were waived by Petitioner. Additionally, Respondent

maintains that any award for a wage differential would be based upon speculation since Petitioner failed to submit into evidence the exact dollar amount Petitioner was earning while working for Respondent as of June 21, 2010, which is needed to compare to the dollar amount of his current earnings.

We begin by noting that Petitioner has proven a material increase in his disability as required by § 19(h). In so finding we rely upon the credible testimony of Dr. Nord. We also find that when Petitioner settled his case in 2005 he did not elect a particular remedy, barring recovery under other provisions of the Act. However, Petitioner has failed **[*25]** to prove his entitlement to a wage differential award.

To sustain a claim for a wage differential award, Petitioner must show the average amount he would be able to earn in the full performance of his duties as a head mechanic. Petitioner has failed to provide this evidence. In the case of Flynn v. Solid Platform, Inc., 02 WC 32673; 07 IWCC 0465 (April 19, 2007), the Commission rejected the claimant's claim for wage differential benefits because the claim was based on speculation. The Commission awarded benefits based upon the loss of use of the person as a whole instead. We find Flynn persuasive.

While we do not find Petitioner entitled to a wage differential award pursuant to § 8(d)1, Petitioner is entitled to an award pursuant to § 8(d)2. Due to his left foot impairment, Petitioner continues to work subject to permanent sedentary restrictions. Petitioner is unable to return to work as a full-time truck mechanic or truck driver because he cannot stand or walk for longer than two hours, is unable to open a truck hood with a foot pedal, and cannot stand on truck frames. Petitioner has undergone multiple surgeries, including an ankle fusion which **[*26]** left him with substantial physical limitations, which, in turn, have impacted his ability to work. While Petitioner has returned to work, he has done so at a job with less pay and fewer hours, and for a different employer. In other cases, the Commission has found it appropriate under § 8 (d)2 to award for a specific loss. See Sheets v. Wick Building, 02 WC 22041, 8 IWCC 0808 (31 year-old construction worker with several surgeries to the right ankle, including ankle fusion, returned to work full time at a lesser rate of pay), and O'Leary v. City of Chicago, 98 WC 08840, 7 IWCC 043 (female ironworker, loss of career case losing the ability to return to perform construction work, no loss of earning capacity). As such, the Commission finds Petitioner has incurred a material increase in his disability to the extent of 35% loss of use of a man as whole pursuant to § 8(d)2.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition for Review under Sections 8(a) and 19(h) is granted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the additional sum of $ 492.87 per week for a period of 175 weeks, **[*27]** as provided in § 8(d)2 of the Act, for the reason that Petitioner sustained a material increase in his disability to the extent of 35%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $ 5,507.66 for medical expenses under § 8(a) of the Act. Further, the Commission finds that Respondent shall hold Petitioner safe and harmless for all claims by Respondent's group carrier for reimbursement.

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 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.

CONCURBY: NANCY LINDSAY

DISSENTBY: NANCY LINDSAY

DISSENT: Concurrence and Dissent

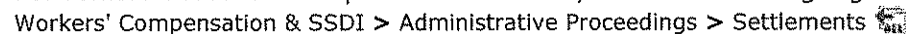
While I concur in the Majority's decision to award Petitioner **[*28]** medical expenses of $ 5,507.66, I respectfully disagree with its finding that Petitioner did not waive recovery under Section 8(d)1 when he settled his claim in 2005 and I disagree with its finding that Petitioner sustained a material increase in his disability to the extent of 35% man as a whole under Section 19(h) of the Act.

Not only did Petitioner fail to prove entitlement to a wage loss differential, but Petitioner also waived his right to such a recovery. Under the terms of the settlement contract approved on February 18, 2005, Respondent agreed to keep only Section 8(a) medical rights and Section 19 (h) rights open pursuant to the Workers' Compensation Act. All other provisions of the Act were expressly waived by Petitioner. Under the clear and express terms of the settlement contract Petitioner elected to receive a permanency award pursuant to Section 8(e)11 and waived all other provisions of the Act, including Section 8(d)1. Having elected one remedy and clearly waiving other rights, Petitioner is barred from pursuing a wage loss differential at this time.

Finally, while I agree with the Majority that Petitioner did prove a material increase in his disability pursuant to Section **[*29]** 19(h), I disagree with its decision to award Petitioner 35% man as a whole.

Legal Topics:

For related research and practice materials, see the following legal topics: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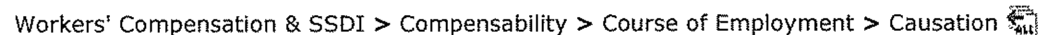
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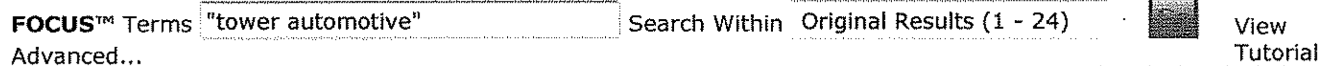
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*2011 Ill. Wrk. Comp. LEXIS 204, **

CAROLYN OCCHUIZZO, PETITIONER, v. JOLIET PUBLIC SCHOOL DISTRICT 86, RESPONDENT.

Nos. 02WC 5367

ILLINOIS WORKERS' COMPENSATION COMMISSION

STATE OF ILLINOIS, COUNTY OF WILL

2011 Ill. Wrk. Comp. LEXIS 204; 11IWCC 0190

February 24, 2011

CORE TERMS: surgery, fusion, pain, lumbar, symptoms, spinal, degenerative, spine, instrumentation, stenosis, temporary total disability, physical therapy, causally, accelerated, underwent, patient, opined, medical treatment, degeneration, cane, leg, pre-operative, work-related, therapist, undergone, actually paid, provider, surgical intervention, causal relationship, acceleration

JUDGES: Kevin W. Lamborn; James F. DeMunno

OPINION: [*1]

DECISION AND OPINION PURSUANT TO SECTION 8(A)

This claim comes before the Commission on Petitioner's Petition for Review under Section 8(a), filed on August 31, 2009. No question has been raised concerning the timeliness of the Petition. Commissioner DeMunno conducted a hearing on March 15, 2010. Counsel for both parties appeared at this hearing and a record was made.

In her Petition for Review under Section 8(a), Petitioner claims that her lumbar spine condition of ill-being which required surgery on October 8, 2008 was accelerated by the lumbar fusion surgery she underwent in 2002, which itself was necessitated by the work-related injuries sustained on January 31, 2001. Based on that claim, Petitioner requests that Respondent be ordered to pay all the medical charges incurred as a result of the second surgery and related treatment, pursuant to Section 8(a), temporary total disability benefits in the amount of $ 502.23 per week for 13.28 weeks (October 8, 2008 through January 6, 2009), pursuant to Section 8(b), and penalties and attorneys' fee, pursuant to Sections 19(k), 19(1), and 16.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. On January 31, 2001, Petitioner **[*2]** was injured when a student in her classroom pushed a desk which struck Petitioner in the legs. She filed an Application for Adjustment of Claim pertaining to this injury on January 31, 2002. The procedural history of this case is as follows:

a) An arbitration hearing was held on January 22, 2004 in front of Arbitrator Hennessey. The Arbitrator issued a Decision on May 22, 2004 finding that Petitioner sustained accidental injuries arising out of and in the course of her employment, that Petitioner condition of ill-being was causally related to that accident, and that Petitioner was entitled to medical benefits in the amount of $ 118,057.22, temporary total disability benefits in the amount of $ 502.23 per week for 10-4/7 weeks, and partial permanent disability benefits in the amount of $ 452.45 per week for 325 weeks because the work related injuries resulted in a 65% loss of the person as a whole. The Arbitrator also awarded penalties and attorneys' fees due to Respondent's delay and denial of Petitioner's temporary total disability benefits. (PX C, exh. 1).

b) Both parties filed Petitions for Review and a hearing was held. The Commission issued a Decision on July 1, 2005 in which **[*3]** it corrected the Arbitrator's award of temporary total disability from 10-4/7 weeks to 14-2/7 weeks and vacated the penalties and attorneys' fees, but otherwise affirmed and adopted the Arbitrator's Decision. (PX C, exh. 2).

c) Both parties appealed to the Circuit Court which affirmed the Commission Decision on January 30, 2006. (PX C, exh. 3).

d) Once again, both parties filed appeals and, on December 28, 2006, the Appellate Court of the Third District issued a Rule 23 Order affirming the circuit court's ruling but remanding the case back to the Commission for further proceedings pertaining to Respondent's entitlement to Section 8(j)(l) credit. (PX C, exh. 4).

e) Neither party appealed the Appellate Court's ruling. On September 7, 2007, the Commission issued a Decision and Opinion on Remand pursuant to the Court's remand order. (PX C, exh. 5).

2. As a result of the injuries Petitioner sustained on January 31, 2001, Petitioner underwent a posterior spinal fusion with instrumentation from L3 through L5 on June 10, 2002 with Dr. Mirkovic. The operative report indicates that prior to the surgery, Petitioner was apprised of the benefits and risks, including the possibilities that **[*4]** the surgery would not improve her symptoms, that the instrumentation might fail, or that she may require further surgery. (PX 2, Circ. Ct. transcript).

3. On September 17, 2002, Dr. Mirkovic found that Petitioner's incision was well healed. He recommended that she return to work and also gave her a referral for physical therapy. (RX 2, p. 2).

4. On June 24, 2003, Petitioner returned to Dr. Mirkovic for her one year postsurgical evaluation. She reported a complete resolution of her pre-operative symptoms. Dr. Mirkovic instructed her to return in one year or earlier if there were any changes in her condition. (PX 11 at 22; RX 2, p. 2).

Petitioner returned to Dr. Mirkovic on June 8, 2004. Dr. Mirkovic took X-rays which showed that

that the instrumentation placed in Petitioner's back in 2002 was still in good alignment. Petitioner reported low back pain which increased with lifting but was significantly than before her surgery. She also reported some difficulty climbing stairs and some discomfort in the right hip over the last few months. Petitioner admitted that she had not been following her home exercise plan and Dr. Mirkovic advised her to resume those exercises. Petitioner was advised **[*5]** to follow up in three years or earlier if there were any changes in her condition. (PX 11 at 25-26; RX 2, p. 2). Petitioner did not see Dr. Mirkovic June 2007. (PX 11 at 27-28).

5. On August 7, 2008, Petitioner returned to Dr. Mirkovic's office. (PX 11 at 8). Petitioner completed a back pain history form at this visit which indicated her present pain started in the summer of 2003. On the questions regarding her first attack of pain, Petitioner indicated that her pain came on gradually and did not result from a work or non-work related accident, a motor vehicle accident, or a pregnancy. Where the form asked if work accelerated her pain, Petitioner wrote "N/A." (RX 1).

6. Petitioner began physical therapy at Newsome Rehabilitation Clinic on August 11, 2008. On a patient information sheet completed for Newsome Clinic on August 8, 2008, Petitioner indicated that her present condition related to an injury incurred on January 31, 2001 when a student pushed a desk into her. She stated that she'd undergone surgery for that injury in June 2002. Petitioner also indicated that she was not employed and that her primary insurer was Pyramid Life. (PX 10). The initial evaluation, done on August **[*6]** 11, 2008, noted that Petitioner had begun using a single point cane over the prior year and was unable to walk more than 15 minutes without it. (PX 10).

7. On August 14, 2008, Petitioner underwent a lumbar spine MRI which showed severe central canal stenosis at the L1-2 and L2-3 levels on the basis of retrolisthesis at each level, superimposed on moderate-to-marked degenerative changes and postoperative changes of the posterior spinal fusion and laminectomies from L3 through L5 with no evidence of central canal stenosis or neural foraminal narrowing. (PX 3).

8. On August 28, 2008, Petitioner reported that she was able to take out the garbage with the use of an assistive device. The therapist noted Petitioner tolerated therapy well and overall her strength was improving. (PX 10).

9. On September 11, 2008, Petitioner reported to her physical therapist that her pain increased when ascending or descending stairs while carrying groceries or laundry and that she still used a cane when ambulating in crowded areas or for long distances. Petitioner also reported that she no longer awoke from pain and that she had increased her activities since starting therapy. The therapist noted that Petitioner's **[*7]** lower extremity strength, range of motion, and core stabilization had all improved since the initial evaluation. (PX 10).

10. Petitioner underwent a lumbar spine CT scan on September 24, 2008 which showed degenerative changes at L1-2 and L2-3 with degenerative retrolisthesis contributing to severe central spinal canal stenosis at L2-3 and moderate to severe central stenosis at L1-2. The radiologist also noted a solid bony fusion through the L3-L5 segments. (PX 3).

11. Petitioner was discharged from physical therapy on September 18, 2008 because of her pending surgery. The therapist noted that Petitioner had met all the goals set in the initial evaluation. (PX 10).

12. Petitioner underwent a pre-operative examination on October 7, 2008 at Northwestern Memorial Hospital. It was noted that Petitioner had undergone a prior spinal surgery in 2002 but developed back pain which had gotten progressively worse over the last year. The pain had radiated into Petitioner's left leg causing her to use a cane while walking but after two months of physical therapy, her leg pain resolved and she no longer needed a cane. (PX 1).

13. Petitioner was admitted to the hospital on October 8, 2008 and underwent **[*8]** surgery

with Dr. Mirkovic. The operative report indicates that Petitioner had previously undergone an L3 to L5 fusion which had initially been successful, but then she began to experience an onset of back and bilateral lower extremity symptoms. Petitioner was informed of alternative treatments and the risks, benefits, and prognosis of the surgery, including the possibility that the surgery might not improve her symptoms and that further surgery might be needed. During the surgery, the instrumentation from 2002 was removed from L3 and L4, but the screws were left in place at L5. Exposure of the area indicated that the prior fusion from L3 to L5 was solid. Dr. Mirkovic then performed hemilaminectomies at L1, L2, and L3, posterolateral fusions at L1-2 and L2-3 with instrumentation, an iliac crest bone graft and an allograft, after which bilateral rods and drains were put into place. (PX 3).

14. Petitioner returned to physical therapy at Newsome Rehabilitation Clinic on January 29, 2009. A progress report issued on March 26, 2009 after Petitioner had completed 15 sessions. Petitioner had on-going complaints regarding her endurance levels but he therapist noted that Petitioner tolerated **[*9]** running several errands at once without a rest break, was able to ascend and descend several flights of stairs while carrying objects such as groceries or laundry, was able to complete her activities of daily living without assistance, and could ambulate without a single point cane for several hours at a time. It was determined that Petitioner had met all of the goals set and that prognosis was good with a home exercise plan. (PX 10).

15. On May 10, 2009, Dr. Mirkovic issued a letter to Petitioner's attorney indicating that Petitioner presented to him on August 7, 2008 with "increased degenerative changes proximal to her fusion." A subsequent MR1 showed spinal stenosis at L1-2 and L2-3. Dr. Mirkovic opined that the degenerative changes above the fusion and the ensuing spinal stenosis were related to the degenerative process which was "causally accelerated by the presence of the previous fusion at L3 to L5." He further opined that the need for the second surgery he performed on Petitioner was "causally related to the original injury which led to the need for the first surgical intervention." (PX 11, Dep. Exh. 4).

16. Dr. Mirkovic gave a deposition on December 10, 2009. He testified **[*10]** that he had performed a lumbar laminectomy and fusion with instrumentation on Petitioner in June 2002. He said that Petitioner did well following that surgery and that he had imposed a 20 pound weight restriction on her. (PX 11 at 7-8).

Dr. Mirkovic treated Petitioner again on August 7, 2008 and diagnosed her with lumbar instability, degenerative changes, and low back pain. After a course of physical therapy failed to improve her condition, Dr. Mirkovic recommended an extension of the prior fusion with instrumentation and laminectomy. (PX 11 at 8). The second surgery involved a removal of the hardware that had been installed earlier and a fusion at L1-2 and L3 with placement of new instrumentation, notably screws and rods. (PX 11 at 9). Dr. Mirkovic believed the surgery was successful. He could not remember what specific restrictions he imposed but said the usual recommendation was no lifting over 20 to 30 pounds. He also advised Petitioner to take care of her back, do her exercises, and avoid sudden motions with her back. (PX 11 at 9).

Dr. Mirkovic's last visit with Petitioner was on October 20, 2009. Petitioner had no leg pain but was experiencing occasional weakness that was greater **[*11]** on her left side and intermittent low back pain, which was to be expected. Dr. Mirkovic noted that Petitioner had a history of a left ankle fracture. (PX 11 at 10).

17. Dr. Mirkovic testified that the first surgical intervention had been causally related to Petitioner's original injury and that "the second intervention was needed in order to address the degenerative changes which occurred above the previous fusion. Those degenerative changes were accelerated by the presence of the previous fusion at L3 to L5." (PX 11 at 13). He further opined that Petitioner may need future medical treatment, including the removal of the instrumentation he had placed in her spine. (PX 11 at 13).

18. On cross-examination, Dr. Mirkovic testified that when he saw Petitioner on June 24, 2003,

he noted that she was doing exceptionally well a year after her spine surgery and that her pre-operative symptoms had resolved. (PX 11 at 22).

Dr. Mirkovic next saw Petitioner on June 8, 2004. He took X-rays which showed that that the instrumentation from the fusion was still in good alignment. Petitioner reported some low back and right hip symptoms, but admitted she had not been performing her home exercise plan. **[*12]** Dr. Mirkovic instructed Petitioner to resume her exercises. He asked her to return for a follow-up in three years but told her to call in the interim if she experienced any increased symptomology. (PX 11 at 25-27). Dr. Mirkovic testified that Petitioner did not return for the 2007 visit. He could not recall speaking with Petitioner during that time. (PX 11 at 27-28).

Dr. Mirkovic testified that Petitioner's weight of 230 pounds could increase the stress on her spine. (PX 11 at 29). He agreed that the August 14, 2008 lumbar spine MRI indicated Petitioner had lumbosacral spondylosis which he explained was another name for degeneration of the spine. Dr. Mirkovic said that spondylosis could be caused by trauma, but he did not think that was the cause in this case. (PX 11 at 30-31). Dr. Mirkovic also agreed that the MRI did not show any spinal stenosis in the area where had performed the fusion in 2002. (PX 11 at 32).

Dr. Mirkovic testified that he did not specifically recall telling Petitioner in 2002 that there was a chance she would need a revision surgery but said he told all his patients that "the degenerative process continues and they may require some kind of treatment in the future." **[*13]** (PX 11 at 34). He reiterated his earlier testimony that the 2002 fusion surgery accelerated the onset of the stenosis in the discs above the fusion. He said that it was a "well-known fact" that such an acceleration could occur and he was aware of it when he performed the first surgery in 2002. (PX 11 at 34). Dr. Mirkovic believed that if Petitioner developed additional stenosis following the October 2008 surgery, more likely than not it would develop above or below the spinal fusion. (PX 11 at 38-39).

Dr. Mirkovic's last visit with Petitioner was on October 20, 2009. At that visit, Petitioner reported intermittent low back symptoms, which Dr Mirkovic said were to be expected, leg cramps exacerbated by sitting for long periods of time, and weakness on her left side greater than the right, which he attributed to Petitioner's history of left ankle fracture. (PX 11 at 39-40). Dr. Mirkovic testified that Petitioner had not been compliant with her exercise program and only left her home twice a week. He opined that patients who were depressed took longer to recover from surgery because they were less motivated, which affected compliance with the exercise plans. (PX 11 at 40-42).

Dr. Mirkovic **[*14]** testified that on September 16, 2008, he had apprised Petitioner that with a lumbar fusion all the way through L1, there was a possibility of breakdown in the L1-T12 disc level, which could eventually require surgery. (PX 11 at 42-43).

19. On December 30, 2009, Dr. Kevin Walsh issued a record review of Petitioner's case at the request of Respondent. The review indicates Dr. Walsh reviewed medical records from Dr. Mirkovic, records from Newsome Rehabilitation Clinic, and the October 2008 pre-operative report from Northwestern Memorial Hospital. Dr. Walsh concluded that the surgery performed by Dr. Mirkovic on October 8, 2008 was a reasonable approach for Petitioner's spine condition but that it was not caused by the work accident of January 2001 nor was it the result of the fusion surgery performed in June 2002. He opined that the 2002 fusion surgery could not be responsible for the back pains Petitioner began to experience in 2003 because such an affect would not occur that quickly. He stated that "more likely than not, all of the findings seen on the MRI scan and the CT scan in 2008 were the result of degenerative changes, not caused, aggravated or accelerated by a previous lumbar **[*15]** fusion in 2002." Dr. Walsh noted that Petitioner had elected to go through with surgery in 2008 even though she had experienced improvement in physical therapy. He also noted that depression and anxiety can interfere with recovery from surgery and opined that if Petitioner had performed the appropriate strengthening exercises and kept her weight under control, her need for surgical intervention would have been less likely. (RX 2).

ANALYSIS

The Commission notes that almost none of Dr. Mirkovic's treating records were entered into evidence despite extensive references to those records throughout Dr. Mirkovic's deposition (PX 11) and Dr. Walsh's record review. (RX 2). Most notably absent is the treating note from September 16, 2008 in which Dr. Mirkovic apparently informed Petitioner that her extensive lumbar fusion could cause stresses and a possible breakdown at the T12 disc area, requiring yet another surgery. (PX 11 at 42-43). Also of note is that the treating records entered into evidence in the prior hearings in this case do not indicate that Dr. Mirkovic ever explicitly informed Petitioner, or Respondent, of the "well known fact" that a spinal fusion in one area is likely **[*16]** to accelerate the disc degeneration in the areas above and below the fusion site, as he testified. (PX 11 at 34, 38-39).

The absence of such explicit warnings, however, is not enough to defeat Petitioner's claim that her second surgery was causally related to the work accident of January 31, 2001. The operative report from June 10, 2002, indicates that Petitioner was informed that the surgery might not fully or permanently resolve her symptoms and that more surgery night be needed in the future. (PX 2, Circ. Ct. transcript). Based on the entire record in this case, it is reasonable to believe that Respondent was in possession of the 2002 operative report long before Petitioner's second surgery in October 2008. Also of significance is that Dr. Mirkovic warned Petitioner on September 16, 2008, that an extension of her lumbar fusion could cause a breakdown at the L1-T12 disc area. (PX 11 at 42-43). The Commission notes that this warning was extended almost a year before Petitioner filed her 8(a) petition and long before Dr. Mirkovic was asked to provide a causation opinion in regard to the second surgery. (PX C; PX 11, dep. exh. 4).

Furthermore, the only medical evidence Respondent offered--Dr. **[*17]** Walsh's December 30, 2009 record review--in no way rebuts or discredits Dr. Mirkovic's opinion that a spinal fusion at one disc level increases and/or accelerates the degeneration at the disc levels above and below the fusion site. (PX 11 at 13, 34, 38-39). Dr. Walsh's only disagreement with Dr. Mirkovic's opinion was that such an effect was *unlikely* to occur so quickly: "The medical record clearly indicates the patient had progressive symptoms in her back beginning in 2003. It is not likely that the symptoms in 2003 are causally related to the surgery in 2002. That surgery would not have caused an acceleration or exacerbation of the degenerative changes in such a brief period of time." (RX 2). A medical opinion that an acceleration was "unlikely" to occur so quickly as a result of the 2002 fusion is far from persuasive, particularly when that opinion is expressed by a doctor who never saw or treated Petitioner. Also, after Dr. Walsh issued the above opinion, he stated that Petitioner's failure to perform her exercise program and to control her weight after the 2002 surgery made her need for surgery more likely. (RX 2). If that is true, then it is reasonable to infer that those **[*18]** same factors would impact the fusion-induced degeneration, causing it to occur more quickly in Petitioner than in a thinner and more compliant patient.

Respondent's argument against a causation finding also relies on Petitioner's four year gap in treatment with Dr. Mirkovic, as well as her indication on August 7, 2008 that her current back symptoms began in 2003 and were not work-related. (PX 11 at 27-28; RX 1). The Commission does not find these facts to be persuasive. Petitioner's lack of medical treatment between June 2004 and August 2008 in no way proves that her second surgery was related to something other than the accident of 2001 and the subsequent surgery in 2002. It only proves that she chose not to seek medical treatment with Dr. Mirkovic during that period. Nor is it significant that in August 2008 Petitioner failed to connect her symptoms to a work accident. It is not clear that Petitioner was ever told directly that her 2002 fusion could cause or accelerate further degeneration in her lumbar spine. There is also no evidence that Petitioner sustained an intervening accident at work just prior to the onset of her 2003 symptoms. Furthermore, Petitioner reported low back **[*19]** and right hip pain to Dr. Mirkovic in June 2004 and there is no indication he associated those symptoms to either the January 2001 work accident or the

2002 fusion surgery. Given all of that, the Commission finds it understandable that Petitioner would not readily connect her symptomology in 2008 with the work accident of 2001.

Based on the medical records in evidence and Dr. Mirkovic's deposition, the Commission finds that Petitioner's 2008 spinal surgery was causally related to her work accident of January 31, 2001 because the 2002 L3 to L5 spinal fusion, necessitated by that work accident, accelerated the degenerative changes at the L1-2 and L2-3 disc levels. The CMS summary contained in PX 12 indicates that the costs relating to the 2008 spinal surgery total $ 226,940.40, of which Medicare paid $ 38,511.62. Respondent argues that should the Commission find a causal relationship between Petitioner's second surgery and the January 2001 work accident, it should only require Respondent to pay the amount Medicare paid since that payment can be presumed to be a measure of reasonableness. Paying more than that, Respondent states, "would create a windfall for the Petitioner." (Resp. brief, **[*20]** p. 8).

The Commission notes that a very recent decision by the Appellate Court supports Respondent's conclusion that it should only be held liable for the amount paid by Medicare for Petitioner's treatment. **Tower Automotive** v. IWCC, 2011 Ill. App. LEXIS 45 (1st Dist., January 31, 2011). In Tower, the Court held that Section 8(a) of the Act requires that the employer provide and pay for all the medical services necessary to treat the effects of the accidental injury and that "by paying, or reimbursing an injured employee, for the amount actually paid to the medical service providers, the plain language of [Section 8(a)] is satisfied." Id. at 21-22. The Court went on to deny the applicability of the collateral source rule, under which the tortfeaser is prevented from receiving a windfall by having to pay the full amount billed by a medical provider rather than the reduced amount actually paid by a source independent of, and collateral to, the tortfeaser, to workers' compensation cases. The Court found that the Workers' Compensation Act was intended to establish a "system of liability without fault" and, therefore, "there is no wrongdoer or tortfeasor **[*21]** in a claim brought pursuant to the Act." Id. at *25. The Court also noted that limiting an employer's obligation to the amount actually paid to the employees' medical providers served the purpose of relieving the injured party and his family of the costs of medical care, as intended by the Act. Id. The Commission notes that the Court limited this decision to workers' compensation cases arising from accidents that occurred prior to the implementation of the fee schedule. Id. at 25-26. Because the case at hand involves an accident that occurred on January 31, 2001, the Commission finds that Respondent is only required to pay the $ 38,511.62 paid by Medicare to Petitioner's medical providers.

Petitioner is also requesting temporary total disability benefits, for the period of October 8, 2008 through January 6, 2009, as well as penalties and fees. (PX A; PX C). On the issue of temporary total disability, the Commission notes that Petitioner failed to provide any evidence at all regarding being taken off work on October 8, 2008 or being released back to work on January 6, 2009. In fact, the medical records indicate that Petitioner was not even employed on October 8, 2008. On **[*22]** August 7, 2008, Petitioner indicated that she was not working on the questionnaire she completed for Dr. Mirkovic. (RX 1). Petitioner also indicated that she was not employed on the patient information sheet she completed at Newsome Rehabilitation Clinic on August 8, 2008. (PX 10). Although it is reasonable to infer Petitioner was not able to work on October 8, 2008, the day of her second spinal surgery, or for the weeks following that surgery, a reasonable inference is an insufficient basis upon which to award the 93 days of temporary total disability benefits Petitioner is requesting. (Pet. brief, p. 6).

The Commission also finds that Petitioner has failed to prove that penalties and fees are warranted in this case. In her brief, Petitioner argues that penalties and fees should be imposed on Respondent because Petitioner never received "a written notification of denial or reasons for a denial of TTD or of the medical bills submitted." (Pet. brief, p. 9). While that may be true, the Commission notes that Petitioner did not even notify Respondent that she was undergoing medical treatment for her back until March 6, 2009 (PX C, exh. 7), approximately five months after Petitioner had **[*23]** already undergone the second surgery and months of physical therapy. Also, there are no medical records in evidence indicating a causal relationship between the medical treatment and the January 2001 work accident until Dr. Mirkovic's letter of May 9,

2009. (PX 11, Dep. Exh. 4). Instead, there is Petitioner's denial on August 7, 2008 that her condition is work-related (RX 1) and a four year gap in treatment. Respondent should have issued a formal denial of benefits at some point after it became aware of Petitioner's claim and certainly soon after the 8(a) Petition had been filed on August 31, 2009. However, there is no doubt that Respondent's decision to not pay benefits rested on a real controversy as to the causal relationship between Petitioner's lumbar spine condition and the work accident of January 31, 2001.

Based on the binding effect of the unappealed Appellate Court Order of December 28, 2006, and the evidence presented at the March 15, 2010 hearing, the Commission finds that Petitioner's need for a second lumbar spine surgery on October 8, 2008 was causally related to the work accident on January 31, 2001. The Commission further finds that Petitioner failed to prove she **[*24]** was temporarily and totally disabled as a result of the work-related lumbar back condition for the period of October 8, 2008 through January 6, 2009 or that Respondent's failure to pay the medical expenses for the October 8, 2008 surgery and related medical treatment was unreasonable and vexatious.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition under Section 8(a) is hereby granted in part and that Respondent shall pay to Petitioner the sum of $ 38,511.62 in reasonable and necessary medical expenses pursuant to Section 8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's request for temporary total disability benefits for the period of October 8, 2008 through January 6, 2009 is denied.

IT IS FURTHER ORDERED that Petitioner's Petition for fees and penalties under Sections 16, 19 (k) and 19(l) is denied.

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

CONCURBY: MOLLY C. MASON

CONCUR: SPECIAL CONCURRENCE

I acknowledge the application of **Tower Automotive** v. IWCC, 2011 Ill.App. LEXIS 45, **[*25]** to this case but write separately because I disagree with that case's holding that the collateral source rule does not apply to claims for work accidents occurring prior to February 1, 2006. I adhere to the logic of Justice Stewart's dissenting opinion.

In the instant case, Respondent refused to pay for the surgery Dr. Mirkovic performed on October 8, 2008, even though its examiner, Dr. Walsh, conceded that this surgery was a "reasonable approach" for Petitioner's stenosis and spinal instability. RX 2. Petitioner was thus left with no choice but to submit her bills to Medicare. Respondent should not be allowed to reap the benefits of the discount provided by this federal agency.

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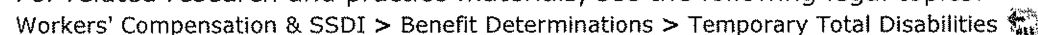
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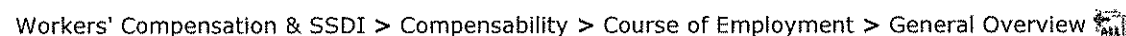
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*11 IWCC 1041; 2011 Ill. Wrk. Comp. LEXIS 1061, **

DONNA J. THORPE, PETITIONER, v. PALOS COMMUNITY HOSPITAL, RESPONDENT,

NO: 08WC 24529

ILLINOIS WORKERS' COMPENSATION COMMISSION

STATE OF ILLINOIS, COUNTY OF COOK

11 IWCC 1041; 2011 Ill. Wrk. Comp. LEXIS 1061

October 25, 2011

CORE TERMS: wrist, thermometer, probe, right hand, surgery, medical treatment, temperature, temporary total disability, twisting, symptoms, causally, patient, ear, carpal tunnel syndrome, physical therapy, ulnar, nerve, pain, box, arbitration, recommended, suggestive, ill-being, cartridge, credible, clinical, neuritis, median, accidental injury, current condition

JUDGES: Mario Basurto; David L. Gore

OPINION: [*1]

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 25, 2011 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $ 25,600.00. 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 **[*2]** of the Secretary of the Commission.

ATTACHMENT

ILLINOIS WORKERS' COMPENSATION COMMISSION 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 **Brian Cronin,** Arbitrator of the Commission, in the city of **Chicago,** on **11/16/10.** 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

C. Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
F. Is Petitioner's current condition of ill-being causally related to the injury?
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?

TTD

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

FINDINGS

On **August 21, 2007,** Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship **[*3]** ***did*** exist between Petitioner and Respondent.

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

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

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

In the year preceding the injury, Petitioner earned $ **24,776.96;** the average weekly wage was $ **476.48.**

On the date of accident. Petitioner was **46** years of age, ***married*** with **2** dependent children.

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

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

Respondent shall be given a credit of $ **11,299.27** for TTD, $ **0.00** for TPD, $ **0.00** for maintenance, and $ **0.00** for other benefits, for a total credit of $ **11,299.27.**

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $ **317.65/week** for **56** weeks, commencing **August 22, 2007 through September 16, 2008,** as provided in Section 8(b) of **[*4]** the Act, and Respondent shall be given a credit of $ **11,299.27** for temporary total disability benefits that have been paid.

Respondent shall pay, to the Petitioner, an amount equal to a total of the outstanding bills of Dr. Jerry Chow/Dr. Chow Hand Therapy Division for the reasonable and necessary medical services provided, subject to Sections 8(a) and 8.2 of the Act. Respondent shall also pay, to the Petitioner, $ **10,250.57,** for the medical bills that Petitioner's husband's group carrier paid, per a **negotiated rate.**

Respondent shall pay Petitioner permanent partial disability benefits of $ **285.89/week** for **30.75 weeks,** because the injuries sustained caused the **15%** loss of use of the right hand, as provided in Section 8(e) of the Act.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed **[*5]** 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

February 24, 2011

Date

The Arbitrator makes the following findings of fact:

On August 21, 2007, Respondent, Palos Community Hospital, employed the Petitioner as a Certified Nursing Assistant ("CNA"). Her duties as a CNA involved providing care to various patients, which included taking and registering vital signs, including internal body temperatures. The Petitioner testified that she is right-hand dominant and was able to do all activities of her employment, without difficulty, up to that date.

The Petitioner testified that on August 21, 2007, she was working in Unit 3A for the Respondent and was in the process of preparing to take the temperature of a patient. Petitioner testified that she attempted to affix an ear temperature probe cover onto a tympanic ear "temperature probe" thermometer. To do this, she inserted the probe thermometer with her right hand into a "box cartridge" containing plastic ear probe covers. The Petitioner testified that she had to use a twisting motion in order **[*6]** to detach the probe cover from the "box cartridge" onto the thermometer probe. Her first attempt failed to cause the probe cover to become attached to the thermometer probe. The Petitioner testified that she again pushed the temperature probe into the box cartridge, and this time used more force in attempting twist the probe cover onto the thermometer. The Petitioner testified that she then felt a "pop" and intense pain in her right wrist. Petitioner testified that she immediately informed her "charge nurse", Jill Curtin, that she had suffered an injury to her right wrist when the temperature probe became stuck in the box of probe covers, and completed an "Employee Incident Report." (PX1)

The Petitioner testified that after reporting this injury to her supervisor, she was referred, by the Respondent, to Dr. Marco Cordero at the Palos Community Hospital emergency room. According to the medical records, the Petitioner gave a history of being injured while "using a twisting motion to loosen a temperature probe". In his chart notes, Dr. Cordero diagnosed the Petitioner with a right wrist sprain and hematoma, noting discoloration and swelling in the Petitioner's right wrist. (PX2)

The **[*7]** Petitioner testified that she was then referred to South Side Orthopedics, and the medical records reflect that on August 22, 2007, she saw Dr. David Butler. The records reflect that at the time of the initial visit, Petitioner gave a written history of becoming injured while "putting probe onto temp covers - twisted to get out & felt wrist snap."(PX3) Dr. Butler diagnosed a possible tendon tear in the volar aspect of the Petitioner's right wrist. The Petitioner testified that she was then taken off work, and a "cock-up" wrist brace was prescribed. The Petitioner testified that physical therapy was prescribed, and the medical records reflect that this was preformed at Occu-Sport Physical Therapy. (PX3)

The Petitioner testified that after minimal improvement, Dr. Butler then referred her to Dr. Jerry Chow, an orthopedic hand surgeon, for a second opinion. The medical records and the testimony of Dr. Chow reflect that the Petitioner was first seen on January 17, 2008, at which time Dr. Chow ordered an MRI. The February 2, 2008 MRI showed inflammation of the ulnar nerve, which was suggestive of ulnar neuritis, and an increased signal within the medial nerve of the right wrist. Dr. Chow **[*8]** then ordered an EMG/NCV, which was administered on February 11, 2008. This test showed mild right sensory median mononeuropathy at the right wrist, which was suggestive of carpal tunnel syndrome. Dr. Chow then rendered a diagnosis of right median neuritis. (PX4 and PX6) The Petitioner testified, and the medical records reflect, that Dr. Chow ordered physical therapy. Petitioner underwent the physical therapy at Dr. Chow's office from February 15, 2008 to March 27, 2008. During that period of time, Petitioner also received multiple cortisone injections. After conservative treatment failed to alleviate the Petitioners numbness in her right fifth finger and pain/tingling on the ulnar right wrist, Dr. Chow then recommended surgery. (PX4 and PX6)

With respect to medical causation, Dr: Chow testified that the Petitioner had a definite work injury on August 21, 2007. This was well documented by the Petitioner and by her initial treating physicians. Moreover, Petitioner's symptoms were all localized to that particular area and confirmed by clinical findings. Dr. Chow further testified that a single-event, twisting motion could cause carpal tunnel syndrome. He did not believe that her condition **[*9]** was associated with any underlying health condition. (PX6)

After Dr. Chow recommended the surgery, Respondent asked the Petitioner to be examined by Respondent's evaluating physician, Dr. Jay Pomerance. The examination took place on April 22, 2008. The Petitioner testified that, at the time of the examination, Dr. Pomerance did not attempt to ascertain the exact mechanism of her injury.

Dr. Pomerance testified that he took a history that the patient was removing a plastic ear covering from the device, which was used to take a person's temperature from the ear canal. Dr. Pomerance testified that the nerve conduction study, previously conducted on February 11, 2008, did show some findings consistent with carpal tunnel syndrome. He opined, however, that the work injury of August 21, 2007 did not cause the Petitioner's condition and that surgery was not necessary. Dr. Pomerance further testified that the Petitioner only may have sustained a contusion to her right wrist and that this event could not have caused the Petitioner's hand/wrist condition as the force needed to remove a plastic ear covering from the thermometer was negligible. Dr. Pomerance testified that he believed that the **[*10]** Petitioner's condition was due to other factors such as her gender or menopause or hypothyroidism. (RX3) Based on Dr. Pomerance's opinions, Respondent suspended the Petitioner's temporary total disability and medical benefits.

The Petitioner testified that on June 6, 2008, she then saw Dr. James Schlenker, for a second

opinion. Dr. Schlenker took x-rays of the right hand, recommended cortisone injections and a repeat MRI. (PX5).

The Petitioner testified that since Dr. Chow had already administered injections, she decided to continue to treat with Dr. Chow. She elected to undergo the surgery.

On July 9, 2008, Dr. Chow performed, on the Petitioner, a right open carpel tunnel release and a release of the right Guyon Canal. (PX4) Subsequent to her surgery, she completed a course of physical therapy with Dr. Chow's office.

Petitioner believed that the surgery was successful in relieving the symptoms of numbness and pain in her right wrist.

Dr. Chow testified that the surgery was successful and he eventually released the Petitioner from treatment and allowed her to return to work without restrictions on October 3, 2008. (PX6)

The Petitioner testified that she was terminated by the Respondent **[*11]** and was hired on September 17, 2008 by a company known as the Brighten Gardens (n/k/a Emeritus) of Wheaton. Her title is Life Enrichment Manager.

The Petitioner testified that when she first started working at Brighton Gardens, she was not able to lift a resident with her right hand because she doe not have the strength in the hand that she did pre-accident. She further testified that this loss of strength continues today. She takes Tylenol maybe twice a week for the pain.

On cross-examination, Petitioner admitted that in her current job she does lift patients, but that when she does so, she feels pain in her right wrist.

Petitioner testified that after her evaluation with Dr. Pomerance, Dr. Chow's medical bills were not paid. With regard to Dr. Schlenker's bills and the Palos Community Hospital surgery bills, Petitioner submitted the bills to her husband's group health insurance. (PX7)

The Respondent called, as their witness, Mr. Ken Lash. Mr. Lash testified that he is the manager of the clinical engineering department of Palos Community Hospital, and that he has held that position since the year 1995. Mr. Lash testified that two types of thermometers were used for 99% of the patients **[*12]** in the unit. These thermometers were then identified by Mr. Lash as Respondent's Exhibits # 1 & # 2. Mr. Lash testified that he was not present in Unit 3A at the time of the Petitioner's injury, and did not have personal knowledge as to which thermometer was being used. Mr. Lash further testified that he had no independent recollection of this incident nor did he have documentation concerning any internal investigation into this matter.

The Petitioner was asked several times during cross-examination, and re-redirect examination, if she using either of thermometers, that were identified in Respondent's Exhibits # 1 & # 2, when she was injured on August 21, 2007. The Petitioner testified that she was not using the thermometers identified and produced at arbitration; and that the tympanic thermometer, which she was using on the date of her injury, was a different "Welch/Allen" model which required her use a twisting motion in order to detach the probe cover from the "box cartridge" onto the thermometer probe. The Petitioner testified that this forceful twisting motion of her right hand caused her injury.

The Arbitrator makes the following conclusions of law:

C. In support of Arbitrator's [*13] decision relating to whether an accident occurred that arose out of and in the course of the Petitioner's employment by the Respondent, the Arbitrator concludes as follows:

The Arbitrator concludes that after reviewing all the testimony at arbitration and the medical records admitted into evidence, the Petitioner did suffer an accident on August 21, 2007 to her right hand/wrist that arose out of and in the course of her employment by the Respondent. The medical records of Palos Community Hospital and South Side Orthopedics document a history that the Petitioner sustained an injury to her right wrist as a result of work-related incident. The records indicate discoloration and swelling over the volar aspect of Petitioner's right wrist. (PX2, PX3)

The Arbitrator also concludes and that the testimony of the Petitioner, with respect to the detailed description of the thermometer she was using, the twisting mechanism of her injury and the force exerted with her right hand/wrist was credible. The Petitioner denied using the thermometers, produced by the Respondent at arbitration and identified and admitted into evidence. (RX1, RX2)

The Arbitrator points out that Ken Lash did not have any **[*14]** personal knowledge of the exact thermometer that the Petitioner was using in Unit 3A on August 21, 2007. He had no memory or records that related to an investigation that was carried out as a result of Petitioner's wrist injury.

The Arbitrator notes that the Employee Incident Report indicates that the clinical engineering department had, in fact, evaluated the thermometer and found no issue with it. (PX1)

Notwithstanding the foregoing, the Arbitrator concludes that Petitioner did sustain an accidental injury when she attempted to affix the probe cover into the thermometer.

F. In support of Arbitrator's decision relating to causal relationship between the Petitioner's current condition and the accident of August 21, 2007, the Arbitrator concludes as follows:

The Arbitrator concludes that the Petitioner's present condition of ill-being with respect to her right hand/wrist is causally related to the work accident she sustained on August 21, 2007. In support of this decision, the Arbitrator cites to the credible testimony of the Petitioner, the medical records admitted into evidence and the testimony and opinions of Dr. Jerry Chow, Petitioner's treating physician.

The Petitioner testified **[*15]** that prior to August 21, 2007, she had never suffered injuries to her right hand/wrist. She further testified that he had never received any medical treatment for her right hand/wrist prior to that date. Moreover, up to August 21, 2007, she was able to perform the entire job duties required of a CNA without difficulty. It was not until after the August 21, 2007 work accident that the Petitioner sought extensive medical treatment for her right hand/wrist injury. The Arbitrator concludes that the testimony of the Petitioner, with respect to the work activities, the severity of the work injury and the symptoms and treatment that followed the injury, was consistent and credible.

The Arbitrator concludes that as a result of the injury sustained by the Petitioner on August 21, 2007, the Petitioner ultimately came under the care of Dr. Jerry Chow, an orthopedic hand surgeon. The medical records and the testimony of Dr. Chow reflect that Dr. Chow ordered an MRI, which was taken on February 2, 2008. The MRI showed inflammation of the ulnar nerve, which is suggestive of ulnar neuritis and increased signal within the medial nerve of the right wrist. Dr. Chow then ordered an EMG/NCV, which was **[*16]** administered on February 11, 2008, and showed mild, right sensory median mononeuropathy at the right wrist. Such a finding was suggestive of carpal tunnel syndrome.

Dr. Chow then rendered a diagnosis of right median neuritis, which he felt was confirmed by the MRI and EMG/NCV. Dr. Chow then recommended surgery. (PX4 and PX6)

The Arbitrator finds the opinions of Dr. Jerry Chow more persuasive than those of Dr. Jay

Pomerance. Dr. Chow opined that the Petitioner's condition of ill-being, with respect to her right hand/wrist, was causally related to the work accident she sustained on August 21, 2007. Dr. Chow noted that the Petitioner had a definite work injury on August 21, 2007, which was well documented by the Petitioner and by her initial treating physicians, and that the Petitioner's symptoms were all localized to that area and confirmed by clinical findings. Dr. Chow further testified that a single-event, twisting motion could cause carpal tunnel syndrome.

The Arbitrator also concludes that, with the exception of Dr. Schlenker, the Petitioner received medical treatment from physicians selected or referred by the Respondent. It was not until Dr. Chow's recommendation of surgery that **[*17]** Respondent requested an examination by Dr. Pomerance.

J. In support of the Arbitrator's decision relating to medical benefits, the Arbitrator concludes as follows:

The Arbitrator concludes that all of the medical treatment received by the Petitioner was causally related to the work injury she sustained on August 21, 2007. As a result of this injury, Dr. Jerry Chow treated the Petitioner from January 17, 2008 to October 2, 2008. The Petitioner received this medical care and treatment for the purpose of attempting to provide relief from symptoms caused by her work injury. As a result of the medical treatment provided by Dr. Chow from April 22, 2008 through October 2, 2008, medical bills were incurred in the amount of $ 18,554.39. (PX4) The Petitioner testified that none of these bills have been paid by the Respondent, and they remain outstanding.

Accordingly, the Arbitrator concludes that that the medical bills and services from Dr. Jerry Chow and the Dr. Chow Hand Therapy Division constitute reasonable and necessary medical treatment pursuant to Section 8(a) of the Act. (PX4) The Petitioner is entitled to an amount equal a total of the medical bills in Petitioner's Exhibit # 4, **[*18]** subject to Section 8(a) and Section 8.2 of the Act.

The charges for the second opinion appointment with Dr. Schlenker on June 5, 2008 (PX5), the charges for the surgery at Palos Community Hospital on July 7, 2008 and the charges from Palos Anesthesia Associates and Associated Cardiovascular were incurred and paid, at the **negotiated rate,** by the Petitioner's husband's group medical insurance (BC/BS of Illinois) in the amount of $ 10,250.57. No objections were made with regard to the amounts paid.

The Arbitrator finds that the Petitioner has sustained her burden of proof that these medical charges constitute reasonable, necessary and causally related to the accident of August 21, 2007 and notes that the treatment dates on the account statement correspond to the medical records for treatment provided by Dr. Schlenker. Moreover, the hospital and related surgical charges correspond to the surgery that Dr. Chow performed. Accordingly, the Arbitrator concludes that these amounts, paid at the **negotiated rate** and submitted at arbitration as Petitioner's Exhibit # 7, constitute reasonable and necessary medical treatment pursuant to Section 8(a) of the Act.

The Petitioner is entitled to payment **[*19]** of the medical charges set forth in Petitioner's Exhibit # 7, without any 8(j) credit, in the amount of $ 10,250.57.

K. In support of the Arbitrator's decision relating to temporary total disability benefits, the Arbitrator concludes as follows:

The Arbitrator concludes that the Petitioner is entitled to temporary total disability benefits for the time period commencing August 22, 2007 thru September 16, 2008 for a total of 56 weeks. This conclusion is supported by the medical evidence presented in this case, as well as by the credible and unrebutted testimony of the Petitioner. The Petitioner testified that she remained off work pursuant to Dr. Jerry Chow's instructions, until her new employer hired her on September 17, 2008.

Therefore, the Arbitrator awards temporary total disability benefits for 56 weeks. The Arbitrator finds that Respondent is entitled to a credit of $ 11,299.27 for TTD benefits that they previously paid.

L. In support of the Arbitrator's decision relating to the nature and extent of the Petitioner's injury, the Arbitrator concludes as follows:

The Arbitrator concludes that prior to the date of August 21, 2007, the Petitioner had not suffered injuries **[*20]** to her right hand/wrist, nor did she receive any medical treatment for her right hand/wrist prior to that date. The Arbitrator notes that, up to August 21, 2007, she was able to perform the entire job duties required of a CNA without difficulty, and that this testimony stands unrebutted. It was not until after the August 21, 2007 work accident that the Petitioner sought extensive medical treatment for her right hand/wrist injury.

As result of her work-related injury of August 21, 2007, the Petitioner underwent surgery for a right carpal tunnel release on July 9, 2008. Petitioner is right-hand dominant. The Petitioner testified that the surgery was successful in relieving the symptoms of numbness and severe pain in her right wrist. She now takes Tylenol about twice a week.

In a letter dated April 7, 2009, Dr. Chow wrote that the carpal tunnel surgery was successful in that it relieved her symptoms. He also wrote that Petitioner was asymptomatic on October 2, 2008 and that she has no work restrictions. (PX4)

Although Petitioner testified that full strength has not returned to that hand, she continues to lift patients for her new employer.

Based on the above, the Arbitrator concludes **[*21]** that as a result of her accidental injury of August 21, 2007, Petitioner has sustained a loss of use of her right hand to the extent of 15% thereof, pursuant to Section 8(e) of the Act.

CONCURBY: MICHAEL P. LATZ

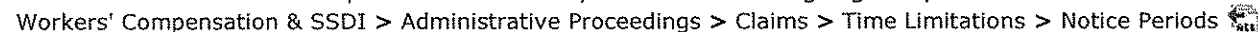
CONCUR: SPECIAL CONCURRING OPINION

This case was scheduled for Oral Arguments on October 13, 2011 before a three-member panel of the Commission including members James F. DeMunno, Mario Basurto and David L. Gore, at which time Oral Arguments were either heard, waived or denied. Subsequent to Oral Arguments and prior to the departure of James F. DeMunno on October 17, 2011, a majority of the panel members had reached agreement as to the results set forth in this decision and opinion, as evidenced by the internal Decision worksheet initialed by the entire three member panel, but no formal written decision was signed and issued prior to Commissioner DeMunno's departure.

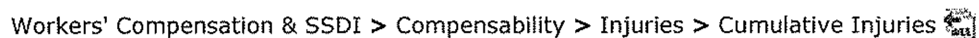
Although I was not a member of the panel in question at the time Oral Arguments were heard, waived or denied, and I did not participate in the agreement reached by the majority in this case, I have reviewed the Decision worksheet showing how Commissioner DeMunno voted in this case, as well as the provisions of the Supreme Court **[*22]** in Zeigler v. Industrial Commission, 51 Ill.2d 137, 281 N.E.2d 342 (1972), which authorizes signature of a Decision by a member of the Commission who did not participate in the Decision. Accordingly, I am signing this Decision in order that it may issue.

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 > General Overview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*2011 Ill. Wrk. Comp. LEXIS 771, **

STANISLAWA MIYNARCZTK, PETITIONER, v. SOPHIE OBROCHTA, RESPONDENT.

NO. 08WC 01595

ILLINOIS WORKERS' COMPENSATION COMMISSION

STATE OF ILLINOIS, COUNTY OF WILL

2011 Ill. Wrk. Comp. LEXIS 771; 11IWCC0747

July 29, 2011

CORE TERMS: cleaning, driveway, exposed, evening, snow, van, compensable, ice, accidental injury, failed to prove, cancellation, traveling, landlord, cleaned, church, drove, crew, incidental, performing, connected, lunch break, left hand, own car, interpreter, displaced, carrying, shoulder, fracture, started, distal

JUDGES: Daniel R. Donohoo; Thomas J. Tyrrell; Kevin W. Lamborn

OPINION: [*1]

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, temporary disability, permanent disability and penalties and fees and being advised of the facts and law, reverses the Decision of the Arbitrator.

Respondent appeals the January 26, 2010 decision of Arbitrator Hennessey finding that Petitioner sustained an accidental injury arising out of and in the course of her employment on December 5, 2007 and that Petitioner's current condition of ill-being is causally related to that work accident. As a result, Petitioner was temporarily totally disabled from December 6, 2007 through December 17, 2008 for 54 weeks under § 8(b) of the Illinois Workers' Compensation Act, incurred medical expenses in the amount of $ 34,818.91 and is permanently partially disabled to the extent of 65% loss of use of her left hand/wrist under § 8(e) of the Act.

After considering the entire record, and for the reasons set forth below, the Commission reverses the Decision of the Arbitrator and finds that Petitioner failed to prove she sustained

accidental injuries [*2] arising out of and in the course of her employment on December 5, 2007. The Commission vacates the Arbitrator's award of benefits and medical expenses for the reasons set forth below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner, a 60 year old janitorial worker, testified though a Polish interpreter that she worked for Respondent cleaning churches, homes and offices and had been employed by Respondent since September 2007. Petitioner's husband was also employed by Respondent.
2. Respondent, Mr. Walter Obrochta, testified that Petitioner and her husband usually had a full day of cleaning from 6:00 am to approximately 4:00 pm at various job sites but on December 5, 2007 there were a few cancellations as it was the holiday season. Mr. Obrochta testified that he told Petitioner and her husband that if they wanted, they could help out another cleaning crew that evening.
3. Petitioner testified that she never drove the vehicle that was provided to her husband by Respondent. Petitioner was not paid for travel time to and from jobs. Further, the vehicle did not have any logos or decals on it.
4. Mr. Mlynarczyk, Petitioner's husband, testified that he would [*3] use the van that Respondent had loaned him for personal errands and buy his own gas when he did so. Mr. Mlynarczyk further testified that he only used the Respondent's van until he was able to purchase his own car and used his own car for travel to and from work after he did so.
5. Respondent, Mr. Walter Obrochta, testified that the van which was lent to Mr. Mlynarczyk was a personal vehicle of his and his wife which was lent to Petitioner's husband for a short time as a courtesy and was returned to him by Mr. Mlynarczyk after he was able to purchase his own vehicle.
6. On December 5, 2007, Petitioner testified she started work at 6:30 am cleaning a church with her husband. After Petitioner and her husband cleaned the church, Petitioner's husband drove them to two homes which they cleaned without incident. Petitioner testified that after Petitioner and her husband cleaned the homes, Petitioner's husband spoke with Respondent who advised there were no other cleaning assignments for them at that time but they could meet Respondent later in the evening and assist another cleaning crew on a job.
7. Petitioner and her husband drove Respondent's van back to their home around 2:30 or 3:00 [*4] in the afternoon and ate a meal. They were home for approximately an hour and a half then left to meet Respondent for a cleaning assignment that evening.
8. Petitioner testified that when she is on the job her lunch breaks are usually only ten to fifteen minutes long.
9. Petitioner testified that on December 5, 2007 she was not paid for her time at home before she went back out to undertake another cleaning assignment. Petitioner testified that she is paid by the job, not by the hour, by Respondent.
10. Petitioner testified she walked out of her home and the ground was covered with snow. She testified that she slipped behind the car and had pain in her left hand.
11. Petitioner testified that when she fell, she had not yet gotten into the vehicle and was still on her landlord's property in the driveway. Petitioner testified she was not carrying anything when she fell and only had her purse on her shoulder.
12. Petitioner called to her husband who came and helped her up. Petitioner, her husband and their landlord, who served as an interpreter for the couple, went to the emergency room in the landlord's vehicle.
13. Petitioner suffered a displaced fracture involving the left distal [*5] radius and a comminuted fracture of the ulnar styloid which was minimally displaced. Petitioner underwent open reduction of the left distal radial fracture with acute

carpal tunnel release on December 6, 2007 (PX1).
14. Petitioner testified that after she was released to light duty work from the December 5, 2007 injury she chose not return to Respondent's employ but instead found another job as an in-home care taker for an elderly woman.

To obtain compensation under the Act, a Petitioner must show by a preponderance of the evidence that she has suffered a disabling injury arising out of and in the course of her employment. 820 ILCS 305/2. Injuries sustained on the employer's premises, or at a place where the petitioner might reasonably have been while performing her duties and while at work are generally deemed to have been received in the course of the employment. The Courts have held that an injury that occurs while going to or coming from work is generally not compensable as it does not occur out of and in the course of employment. Martinez v. Industrial Comm'n, 611 N.E. 2d 545 (1993). To 'arise out of' employment **[*6]** requires that the risk be connected with, or incidental to the employment so as to create a causal connection between the employment and the accidental injury. Caterpillar Tractor Co., 129 Ill.2d 52, 58, 541 N.E.2d 665, 133 Ill. Dec. 454 (1989). The Courts have recognized three general types of risk to which an employee may be exposed: (1) risks that are distinctly associated with the employment; (2) risks that are personal to the employee; and (3) neutral risks that do not have any particular employment or personal characteristics. **Potenzo** v. Illinois Workers' Compensation Comm'n, 378 Ill. App. 3d 113, 116, 881 N.E.2d 523, 317 Ill. Dec. 355 (2007). Injuries resulting for risks personal to the employee, such as idiopathic falls, generally do not arise out of employment. Injuries resulting from a neutral risk, such as a fall with fresh ice and snow on the ground, generally do not arise out of the employment and are compensable under the Act only where the employee was exposed to a risk to a greater degree than the general public.

Petitioner testified that she fell **[*7]** on her personal driveway while walking to a vehicle to go to work. Petitioner testified she did not know if there was ice under the snow on the sidewalk and driveway. The public sidewalk and private driveway were in the same condition as it related to the ice and snow. Petitioner was not carrying anything when she fell; she had her purse on her shoulder. The Commission finds that the Petitioner failed to prove that she was exposed to a risk that was connected or incidental to her employment and therefore fails to prove that the injuries she sustained as a result of her fall on December 5, 2007 arose out of her employment.

Further, Petitioner fails to prove that the injuries she sustained due to the fall on her driveway were sustained in the course of her employment. Petitioner had not yet left her personal property when the injury occurred. She had not been exposed to the hazards of the street or automobile as she had yet to get in a car or leave her own driveway. Petitioner usually had a set schedule of cleaning jobs that she did daily that would cover the hours of 6:30 am to 4:00 pm and she did not normally take a lunch break of more than 15-30 minutes. She was never directed by **[*8]** her employer when to take a lunch break. Petitioner was not paid by the day or hour, but by the cleaning jobs she completed. On December 5, 2007 Petitioner's normal routine was disrupted by cancellations of one or more of her usual cleaning jobs. Petitioner and her husband were given the option by their employer to assist another cleaning crew on a job that evening if they wanted to make up the lost money from the cancellation. Petitioner and her husband agreed to the additional cleaning job. It was during the time off from the period between her last scheduled job and before she started the extra evening cleaning job that Petitioner fell on her own driveway. Petitioner was not on the employer's premises or at a job location where she would have been performing her work duties when she fell. While the Commission does not find Petitioner to be a traveling employee, it notes that Petitioner had not yet left her property or even entered a vehicle when she was injured, was not paid for her time between jobs or mileage for travel and was not exposed to any of the risks of a traveling employee. Even if the Commission found Petitioner to be a traveling employee, it would not circumvent the **[*9]** requirement that the injury arise out of and in the course of her employment. If the Commission were to find accident in this case, then ANY movement by Petitioner at any time during the day or night would lead to a compensable claim. Based on the

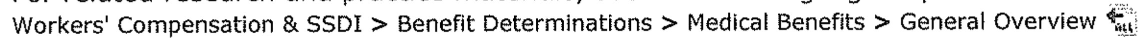
Record and for the forgoing reasons, the Commission finds the injuries sustained by the Petitioner did not arise out of and in the course of her employment with Respondent on December 5, 2007 and reverses the Arbitrator's finding of accident in this case.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on January 26, 2010, is hereby reversed. Petitioner failed to prove she sustained accidental injury arising out of and in the course of her employment on December 5, 2007. Compensation is denied.

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.

Legal Topics:

For related research and practice materials, see the following legal topics: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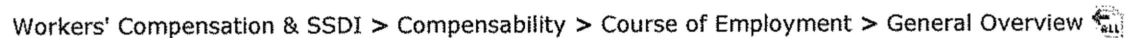
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SETTING JOLIET JOLIET IL 60432
ARBITRATOR HENNESSY, LEO ACCIDENT DATE 12/05/07
COMMISSIONER DONOHOO, DANIEL CASE FILED 01/14/08
BODY PART ARM(S) & LEG(S) LEFT

EMPLOYEE ATTORNEY
SALK, STEVEN B & ASSOC LTD
150 N WACKER DR
SUITE 2570
CHICAGO IL 60606

EMPLOYER ATTORNEY
RODDY LEAHY GUILL & ZIMA, LTD
303 W MADISON ST
SUITE 1500
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*11 IWCC 993; 2011 Ill. Wrk. Comp. LEXIS 1081, **

SANDRA LINDSEY, PETITIONER, v. AMERICAN LIBERTY SCHOOL BUS CO., RESPONDENT,

NO: 09WC 44459

ILLINOIS WORKERS' COMPENSATION COMMISSION

STATE OF ILLINOIS, COUNTY OF COOK

11 IWCC 993; 2011 Ill. Wrk. Comp. LEXIS 1081

October 11, 2011

CORE TERMS: knee, pain, arbitrator, swelling, medial, opined, tenderness, timesheet, lateral, prescribed, left knee, suprapatellar, return to work, recommended, effusion, treating, ligament, physical therapy, medication, chondromalacia, collateral, intact, leg, temporary total disability, notice, arthroscopic surgery, full range, patellofemoral, compartment, sedentary

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

OPINION: [*1]

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 11, 2011 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired **[*2]** without the

filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

The 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

ILLINOIS WORKERS' COMPENSATION COMMISSION 19(b) ARBITRATION DECISION

09WC 26619

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kathleen A. Hagan**, arbitrator of the Commission, in the city of **Chicago**, on **October 5, and October 12, 2011**. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues **[*3]** checked below, and attaches those findings to this document.

DISPUTED 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?

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

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

L. Should penalties or fees be imposed upon the respondent?

N. Other **EVIDENCE/CREDIBILITY**

FINDINGS

. On **9/29/09**, the respondent ***was*** operating under and subject to the provisions of the Act.

. On this date, an employee-employer relationship ***did*** exist between the petitioner and respondent.

. On this date, the petitioner **alleges she *did*** sustain injuries that arose out of and in the course of employment.

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

. In the year preceding the injury, the petitioner earned $ **20,695.48**; the average weekly wage was $ **397.99**.

. At the time of injury, the petitioner was **47** years of age, ***single*** with **0** **[*4]** children under 18.

. Necessary medical services ***have in part*** been provided by the respondent.

. To date, $ **zero** has been paid by the respondent for TTD and/or maintenance benefits.

ORDER

THE ARBITRATOR FINDS THAT PETITIONER FAILED TO PROVED ACCIDENT. CLAIM FOR COMPENSATION DENIED.

. The respondent shall pay the petitioner temporary total disability benefits of $ **n/a** /week for **n/a** weeks, from **n/a** through **n/a**, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the petitioner, the disabling condition is temporary and has not yet reached a permanent condition, pursuant to Section 19(b) of the Act.

. The respondent shall pay **n/a** for medical services, as provided in Section 8(a) of the Act.

. The respondent shall pay $ **n/a** in penalties, as provided in Section 19(k) of the Act.

. The respondent shall pay $ **n/a** in penalties, as provided in Section 19(1) of the Act.

. The respondent shall pay $ **n/a** in attorneys' fees, as provided in Section 16 of the Act.

. In no instance shall this award be a bar to subsequent hearing and determination of **[*5]** 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.

Signature of arbitrator
Kathleen A. Hagan

4/1/11

Date

FINDINGS OF FACT

Petitioner, a 47 year old bus driver, injured her left knee when her boot caught on a grate in the bus step and she twisted her knee at work on 2/5/09. She experienced immediate pain and swelling of the knee. Petitioner testified that she notified her supervisor/dispatcher, Doreen, of the injury.

Petitioner job duties included driving the bus, completing paperwork and assisting K-6th grade children on **[*6]** and off the bus.

Petitioner first sought emergency room treatment at Provena St. Joseph Hospital the following day. The records reveal that Petitioner provided a consistent history of accident. An x-ray revealed minimal degenerative changes with a possible small suprapatellar effusion. Petitioner was diagnosed with possible internal derangement. Medication, a knee immobilizer and crutches

were prescribed. Petitioner was restricted from working and referred for follow up care to orthopedics (Px3).

Petitioner was referred by Respondent to an insurance adjuster Debbie Mehay. Petitioner testified that Ms. Mehay referred her for treatment to Dr. Farrell. Ms. Mehay testified that she did not refer Petitioner to any physician. On cross-examination, Ms. Mehay recalled sending Petitioner to Dr. Farrell.

Petitioner next sought treatment with Dr. Farrell at Parkview Orthopaedic Group on 2/13/09. Petitioner again reported a consistent history of accident and complained of left knee pain, swelling and popping. Dr. Farrell noted a limited exam due to guarding, swelling and tenderness. He diagnosed a left knee sprain and prescribed a properly fitted knee immobilizer. He noted Petitioner's prior **[*7]** unrelated shoulder injury and difficulty using crutches. He prescribed a cane instead of crutches. He ordered an MRI and met with Petitioner's case manager, Joanne Meyer and Petitioner. He restricted Petitioner to sedentary duty with no driving (Px6).

The MRI demonstrated a small suprapatellar joint effusion and was otherwise unremarkable. All ligaments were noted to be intact and there was no bone marrow edema to suggest contusion or fracture. Dr. Farrell prescribed physical therapy and Ultram. He instructed Petitioner to continue wearing the immobilizer and remove it for PT and bathing. She was to weight bear as tolerated. Sedentary duty was continued (Px6).

Petitioner continued to follow up with Dr. Farrell. On 3/18/09, Dr. Farrell noted less pain and swelling. He observed some continued swelling in the suprapatellar area. He noted the MRI was negative except for suprapatellar effusion. Petitioner complained of increased pain with activity. Dr. Farrell provided Petitioner with a soft knee sleeve and prescribed medication. On 4/3/09, Dr. Farrell administered a cortisone injection in a median portal. He instructed Petitioner to ice her knee. On 4/17/09, Dr. Farrell noted that the **[*8]** injection had controlled the swelling although Petitioner was still experiencing some discomfort likely originating in the patellar medial compartment. He noted her knee had always been stable by ligamentous exam and she now had no evidence of lower leg swelling. Dr. Farrell noted Petitioner drives with her right limb and released her to return to work with the caveat that she return for additional treatment if her condition worsens or flares up (Px6).

Petitioner returned for follow up care on 4/28/09 with complaints of increased swelling and tenderness. Petitioner was provided with a knee sleeve to use when ambulating. Medication was prescribed and she was restricted from working. On 5/12/09, Dr. Farrell noted continued intermittent mild swelling and left knee pain and crepitus with range of motion. Petitioner knee was tracking correctly and she was able to flex and stand without difficulty. He noted that conservative efforts had been exhausted and he recommended a diagnostic arthroscopy. He released Petitioner to return to sedentary duty and prescribed Motrin 800mg and continued use of the knee sleeve (Px6).

Surgery was authorized by Respondent and performed by Dr. Farrell on **[*9]** 5/29/09. The pre-operative diagnosis post-traumatic left patellar chondromalacia. The post-operative diagnosis was left patella and distal femoral condyle chondromalacia. The undersurface of the patella was debrided and the distal femoral condyle underwent chondroplasty and debridement. Dr. Farrell noted a thorough examination of the left knee. The meniscus and ACL were inspected and noted to be intact. The lateral compartment showed no chondromalacia. The patellofemoral compartment showed normal tracking of the patella. There was no evidence of suprapatellar synovitis. There was a focal area near the medial portion of the patella with Grade III changes. In the medial compartment, there was evidence of Grade III changes fillibration in the weight bearing area of the distal condyle medially. There was no evidence of medial or lateral gutter disease. No loose bodies were noted during the procedure (Px7).

Petitioner followed up with Dr. Farrell on 6/5/09. He noted her knee was stable with restriction

only to terminal flexion. Some swelling was noted. He prescribed physical therapy and medication along with a sedentary release. On 7/2/09, Petitioner reported taking only Darvocet and noted **[*10]** some giving way episodes and weakness in her left thigh. Dr. Farrell observed some diffuse edema around the knee with full range of motion. He did note some quad weakness. He continued physical therapy and restrictions (Px6).

On 7/30/09, Petitioner reported her leg gave out on her and she fell down some steps. Dr. Farrell noted no edema, intact neurovascular status and no pain with palpation to the knee. Petitioner had full range of motion with a slight weakness of the quad. Dr. Farrell continued PT and light duty. On 8/18/09, Petitioner reported she was improving. Dr. Farrell noted mild residual swelling with full range of motion of the knee and a very stable knee. He noted no evidence of collateral instability and no sensory deficit. He recommended aggressive stair climbing over the next two weeks followed by a return to regular duty (Px6).

Petitioner followed up on 9/1/09 and reported she had completed physical therapy and was on no medication. Examination revealed full range of motion and the ability to squat and extend without difficulty. Dr. Farrell opined MMI and released Petitioner to return to full duty work as a bus driver with no restrictions. He further noted Petitioner **[*11]** has a TENS unit that she would continue to use as needed. He further noted she would follow up as needed (Px6).

Petitioner testified that she returned to work for Respondent on 8/26/09 and performed her regular job duties as a bus driver. Petitioner stated she felt she could perform her job duties and her knee felt good.

Petitioner testified that on 9/29/09 she suffered a second injury to her left knee when she was strapping a small child into a seatbelt. She stated that her knee twisted and popped and that she felt "stabbing pain." Petitioner testified that she called into dispatch and reported her injury to "Louanne." Petitioner stated that no one from Respondent contacted her about her new injury. Petitioner could not recall if she sought any emergency room treatment following her incident.

Petitioner testified that she sought treatment with Dr. Farrell the very next day, September 30, 2009, and that he restricted her from working and prescribed medication. The records of Dr. Farrell reflect Petitioner was not seen until 10/1/09. Petitioner reported a history of twisting her knee while strapping in a child and developing pain and swelling in her left knee "a few days earlier". **[*12]** She reported hearing a pop when she twisted her knee and that she had had difficulty walking since the injury. Examination revealed some swelling in the suprapatellar region of the knee. Petitioner reported tenderness to palpation of the patellofemoral joint line. The collateral ligaments appeared intact. Dr. Farrell noted left knee effusion with previous diagnosis of chondromalacia. On this date, Dr. Farrell restricted Petitioner from working until 10/12/09. He recommended she apply ice and an Ace wrap and continue the Relafon previously prescribed. He noted that if her symptoms continued, He would recommend an MRI or possibly a cortisone injection (Px6).

The records of Dr. Farrell contain billing charges for subsequent office visits on 11/2/09 and 11/24/09. The treating records of Dr. Farrell contain no supporting records for these visits. No explanation was provided for the missing records.

Petitioner testified that she continued to see Dr. Farrell and that he subsequently released her to return to work at her own request. The only release contained in the treating records if for her return to regular work on 10/12/09 given to her at the 10/1/09 visit (Px6).

Petitioner could **[*13]** not recall if she attempted to return to work on 10/12/09. Petitioner said she did return to work on whatever date the form stated. She testified that she brought her release to either "Louann" or Margo, the safety person. Petitioner testified that Respondent did not assign her a route.

Petitioner denied having a meeting with anyone at Respondent regarding timesheet discrepancies on 9/29/09. Petitioner stated she did not walk out of work on 9/29/09. Petitioner stated that she did not work on 9/30 or 10/1 because she called in sick due to knee pain. Petitioner testified that she was terminated by Respondent on 10/13/09, the day after she brought in her release to return to work. Petitioner stated that she was terminated because she put the hours she worked a special charter on the front of her timesheet instead of the back of the timesheet. She said Respondent accused her of stealing hours and falsifying her timesheet.

Petitioner testified that she immediately applied for unemployment and has continued to receive unemployment through the date of trial. Petitioner says she receives $ 380.00 every two weeks.

Respondent witness Keytha Levanas testified that first she met Petitioner **[*14]** in late September, 2009 when they had a meeting with Doreen Pawchak, Petitioner's manager, at the Lockport office regarding Petitioner's timesheets. Ms. Levanas stated that Ms. Pawchuk no longer works for Respondent. Ms. Levanas testified that their meeting with Petitioner was about the fact that Petitioner had recorded additional time to her timesheet for hours Petitioner had not actually worked. Ms. Levanas stated that the hours claimed had nothing to do with charter hours and were simply hours that Petitioner had not worked. Ms. Levanas stated that it was true that charter hours were paid at a different rate than regular routes and therefore were required to be kept on the back of the timesheet for that reason. On cross-examination, Ms. Levanas reiterated the fact that Petitioner's disputed hours had nothing to do with a charter and that Petitioner was claiming pay for hours she had not worked. Ms. Levanas testified that when confronted with the timesheet information, Petitioner got extremely angry and stomped out of the room. Ms Levanas stated that she did observe Petitioner walking out of the meeting but could not recall if she observed anything unusual about Petitioner gait. **[*15]** Ms. Levanas did not see Petitioner again until January 6, 2010 following the Christmas break. Ms. Levanas testified that she told Petitioner that she had assumed Petitioner had quit because the Respondent had not heard from Petitioner since Petitioner had walked out of the office after the September meeting. Ms. Levanas testified that Petitioner said nothing really and walked out without any further conversation.

Petitioner testified that following her termination from Respondent, Dr. Farrell refused to see her. On 10/27/09, Petitioner filed an Application for Adjustment of Claim alleging an accident date of 9/29/09 (Px1).

Petitioner was examined at Respondent's request by Dr. Daniel Troy on 10/28/09. This examination had been rescheduled from 8/21/09 when there had been some confusion over notice of the appointment to Petitioner. Petitioner testified that Dr. Troy was only in the room with her for 5-7 minutes and that he simply looked at her knee and told her she could go back to work. She testified that he did not tough her knee, take an x-ray or ask her any questions. Dr. Troy issued an extremely detailed 10 page report dated 11/4/09.

Dr. Troy examined petitioner and reviewed **[*16]** treating records. Dr. Troy noted no difficulty with the cervical spine with flexion, extension, lateral rotation and lateral bending. Petitioner had no difficulty with range of motion of the bilateral shoulders, wrists and hands. She had full active range of motion and full passive range of motion. She was neurologically intact with 5/5 strength throughout and no sensory or motor deficits. Hoffman was negative. Thigh and calves were noted to be soft and diffusely nontender. Deep tendon reflexes were 1+ and symmetric. There was no atrophy noted. On examination of the left lower extremity Petitioner had no pain with range of motion of the ankle and the left foot. The patellar tendon was well defined in both knees. Dr. Troy noted well healed portal incisions of both knees. Petitioner was extremely guarded when he attempted to examine the left knee. She allowed him to place her in full extension and to flex her to 130 degrees, but with great resistance. Dr. Troy noted that she was very upset he flexed it so far, but did allow him to continue the examination. She reported she was tender upon palpation of the quadriceps area, medial retinacular area, lateral retinacular area, medial collateral **[*17]** ligament, lateral collateral ligament, patellar tendon area,

proximal medial tibial plateau, and the proximal lateral tibial plateau. Petitioner reported this tenderness was all moderate to severe. Petitioner reported minimal tenderness in the popliteal region. Petitioner reported tenderness with stressing the medial and lateral collateral ligaments, but there was no instability. There was no instability anteriorly or posterior, but she did report tenderness with this test. Lachman was negative. There was no calf tenderness and a negative Homan. Calves were symmetric bilaterally. Dr. Troy opined that Petitioner's symptoms were overly magnified. Her pain was overall diffuse and she could not give any type of clinical description of where the pain was originating because her entire knee hurt on the entire aspect of the anterior knee no matter where he palpated. Plain x-rays were normal with the exception of some appreciable effusion noted in the soft tissue. The medial and lateral joint lines were well maintained as was the patellofemoral space. Dr. Troy reviewed the MRI report which demonstrated suprapatellar effusion. Dr. Troy opined that Petitioner's twisting injury of 2/5/09 aggravated **[*18]** her pre-existing chondromalacia. Dr. Troy opined a questionable re-exacerbation in late September, 2009. Petitioner was extremely painful throughout her examination although she had no objective findings. Dr. Troy opined symptom magnification and possible malingering. Dr. Troy stated that giving Petitioner any benefit of doubt, at most he would recommend two weeks of physical therapy followed by a full duty return to work. If she were still unable to do so, he recommended an FCE for validity findings (Rx2,Depx2).

Petitioner continued to receive unemployment benefits and sought treatment four months after the date of accident with Dr. Ronald Silver on 1/29/09. Petitioner testified that she was referred to Dr. Silver by a stranger who overheard her talking about her knee.

Dr. Silver testified he examined Petitioner on 1/29/10. He admitted he did not review a single treating record or test result. Petitioner provided a history of injuring her left knee in a twisting injury at work on 2/5/09. She reported she underwent arthroscopic surgery in May of 2009 and returned to work in September, 2009. Petitioner reported a re-injury to the left knee while buckling a child into a seatbelt and **[*19]** twisting her knee in "September, 2009." Her complaints included pain, swelling, stiffness and limping. Upon examination, Dr. Silver noted swelling in the knee, tenderness at the medial joint line and some patellofemoral crepitation. He noted a questionable click on McMurray's test. Ligaments were stable and motion was restricted due to her pain complaints. X-rays results were normal. Dr. Silver recommended pain medication and an MRI. The MRI was performed 2/5/10. Dr. Silver testified that the MRI confirmed his "presumptive diagnosis of torn cartilage in the knee" and revealed that Petitioner had a "torn medial meniscus." The Arbitrator notes that neither the MRI report nor any treating records of Dr. Silver were offered into evidence. Dr. Silver testified that he discussed arthroscopic surgery with Petitioner. Dr. Silver stated that his recommended surgery was denied by the workers' compensation insurance carrier. Dr. Silver opined that a tear cannot heal itself and that the only treatment is arthroscopic surgery. Dr. Silver opined a causal relationship between Petitioner's work injury on 2/5/09 and her arthroscopic surgery on 5/29/09. He testified that she had surgery to repair "torn **[*20]** cartilage." Dr. Silver opined that while Petitioner's alleged injury September 29, 2009 may have aggravated her preexisting condition, he thought it more likely it was a new injury causing a new "tearing of the cartilage of the knee" but that either way it resulted from the injury of "September, 2009." Dr. Silver opined that Petitioner was not currently able to work because of a torn meniscus in the knee. He also opined retroactively that she had been disabled from working since September 29, 2009. On cross-examination, Dr. Silver acknowledged that he had never reviewed the operative report or treating records of Dr. Farrell. He did not review the prior MRI film or report. Dr. Silver was not aware if Petitioner had been working or not in the four months prior to his exam. Dr. Silver reviewed the 11/4/09 report of Dr. Troy and noted he was in complete disagreement and that Dr. Troy was completely in error. Dr. Silver was asked to compare the two MRI reports and opined that the first MRI report revealed only swelling and the second MRI report noted a meniscal tear. Dr. Silver again stated that he thought Petitioner might not have been working when he saw her, but that he had no idea **[*21]** for how long. He was not aware that Dr. Farrell had released to full duty by Dr. Farrell on 10/12/09 (Px2).

In re-direct examination, Petitioner testified that she was examined by Dr. Troy again in March,

2010. Petitioner testified that this examination lasted 15-17 minutes and that Dr. Troy reviewed the MRI and let him examine her knee until he had to stop because she was in too much pain.

Petitioner testified that she moved to California to move in with relatives because she couldn't afford to live in Chicago. Petitioner has had no further treatment since seeing Dr. Silver. Petitioner travelled by bus from California and had arrived in Chicago two days prior to trial. Her present complaints include severe knee pain which is more painful now then when she last saw Dr. Silver. Petitioner testified that she was in the same amount of pain when she first saw Dr. Troy for examination. Petitioner described her pain feels like a knife underneath her knee cap and a burning sensation. Petitioner testified that she takes OTC Tylenol for her pain complaints. Petitioner utilizes a cane and walks with a very dramatic antalgic gait. She stated she is only able to walk short distances before **[*22]** she has to stop and rest. Petitioner testified throughout the hearing with her leg elevated and resting on a chair at a 90 degree angle. Petitioner requested a recess during the hearing so she could deal with her pain.

CONCLUSIONS OF LAW

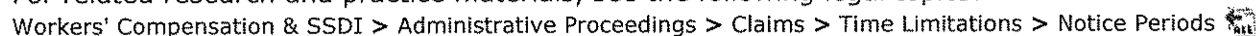
With respect to the issue of EVIDENCE, the Arbitrator concludes that Petitioner's objection to the second report of respondent's examining physician and any testimony related to that report must be upheld. Petitioner's attorney stated that he never received a copy of Dr. Troy's second report prior to the deposition. Respondent's attorney appeared for her partner at the last minute due to serious illness and could not provide proof that the report had been tendered to Petitioner's attorney 48 hours prior to the deposition. The Arbitrator must therefore sustain Petitioner's objection pursuant to Section 12 of the Act as recently discussed in **Mulligan** v. the Illinois Workers' Compensation Commission, Docket No. 1-09-2507WC, March 28, 2011. The Arbitrator notes that despite Petitioner's attorney's objection, he nevertheless questioned both Petitioner and Dr. Silver about the second examination. The Arbitrator finds it difficult to believe there could **[*23]** be any prejudice or surprise to Petitioner after reading Dr. Troy's initial examination report.

With respect to the issue of CREDIBILITY, the Arbitrator concludes that testimony regarding the alleged accident of 9/29/09 and her complaints following the alleged injury are not credible. Petitioner presented in the most dramatic fashion possible. Although seated with her leg elevated and without any weight bearing whatsoever, Petitioner moaned and groaned during testimony, continually wiped her brow and rubbed her knee. Petitioner even requested a recess to deal with her pain that was so terrible in a seated position with her leg elevated. The Arbitrator also observed Petitioner's inconsistent antalgic gait. The Arbitrator finds that Petitioner's comportment at trial is very consistent with the findings and opinions of Dr. Troy in his initial examination on 10/28/09. The Arbitrator also concludes that the testimony of Keytha Levanas regarding the timesheet discussion was very credible.

With respect to the issue of ACCIDENT & NOTICE, the Arbitrator concludes that although Petitioner provided notice of an alleged injury, she failed to prove a credible accident arising out of and in the **[*24]** course of her employment with Respondent on September 29, 2009. Claim for compensation for this claim is therefore denied.

Legal Topics:

For related research and practice materials, see the following legal topics: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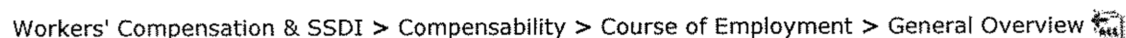
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CASE # 09    WC 044459     CONNECTED                  HEARING LOCATION
EMPLOYEE       LINDSEY, SANDRA                      IWCC OFFICE
EMPLOYER       GRAND PRAIRIE TRANSIT                100 W RANDOLPH ST STE 8-200
SETTING        CHICAGO                              CHICAGO          IL  60601
ARBITRATOR     HAGAN, KATHLEEN A                    ACCIDENT DATE 09/29/09
COMMISSIONER   BASURTO, MARIO                       CASE FILED 10/27/09
BODY PART      MULTIPLE PARTS      N/A
     EMPLOYEE ATTORNEY                         EMPLOYER ATTORNEY
   SCHACTER, JEROME & ASSOC LTD          TUCKER BOWER ROBIN & MERKER LL
   9933 LAWLER                           200 W MADISON ST
   SUITE 100                             SUITE 2900
   SKOKIE           IL  60077            CHICAGO          IL   60606
          STATUS  COMMISSION DECISION RENDERED
DECISION DATE       10/11/11
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*11 IWCC 1023; 2011 Ill. Wrk. Comp. LEXIS 1110, **

SHANNA CHRISTENSEN, PETITIONER, v. THE ANIMAL HOSPITAL OF GURNEE, RESPONDENT.

NO: 03WC 17058

ILLINOIS WORKERS' COMPENSATION COMMISSION

STATE OF ILLINOIS, COUNTY OF LAKE

11 IWCC 1023; 2011 Ill. Wrk. Comp. LEXIS 1110

October 21, 2011

CORE TERMS: pain, injection, provider, lumbar, headaches, causally, headache, doctor, underwent, treating, symptoms, leg, vocational rehabilitation, referral, extremities, elbow, sympathetic, documented, diagram, block, physical therapy, chain, neck, temporary total disability, arbitration hearing, medical treatment, percutaneous, medication, attic, stair

JUDGES: Thomas J. Tyrrell; Daniel R. Donohoo; Kevin W. Lamborn

OPINION: [*1]

DECISION AND OPINION ON REVIEW

Both parties appeal Arbitrator Andros' decision, filed on October 4, 2010, finding that Petitioner's current condition is causally connected to the accident sustained on December 6, 2002. The Arbitrator awarded Petitioner 397-5/7 weeks of temporary total disability benefits representing a period from December 6, 2002, through July 21, 2010, medical expenses in the sum of $ 496,675.18, and ordered that vocational rehabilitation be provided to Petitioner. The Arbitrator also denied penalties and attorneys' fees. The issues on review are causal connection, prospective medical treatment, medical expenses, temporary total disability benefits, vocational rehabilitation, penalties and attorneys' fees, and whether Petitioner exceeded the statutory limit of two **choices** of providers.

The Commission, after having considered the entire record, hereby reverses the Arbitrator's decision in part and affirms the Arbitrator's decision in part. The Commission affirms the Arbitrator's findings with respect to causal connection in part; the Arbitrator's finding that Petitioner is entitled to prospective medical treatment; the Arbitrator's denial of penalties and **[*2]** attorneys' fees; and the Arbitrator's award of temporary total disability benefits. The

Commission reverses the Arbitrator's decision in part, and finds as follows: that only the conditions in Petitioner's low back and legs are causally related to the accident; that Petitioner's two **choices** of medical providers were Dr. Haines and Dr. Fetter; that the treatment on and after July 31, 2003, at the Center for Pain Control was unreasonable; and that it was premature to award vocational rehabilitation.

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).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner, a 26 year old veterinary technician, testified at the first arbitration hearing on June 25, 2009, that her duties with Respondent included working at the front desk, assisting the doctors with surgical procedures, cleaning cages, medicating animals, and filling prescriptions. **[*3]** On December 6, 2002, Petitioner was carrying a small box of syringes while descending the attic's stairs when she injured herself. Petitioner described the accident as follows: "I was walking down and I got to a point where my head was up against the ceiling and I couldn't see my feet and I lost my footing and rode down seven or eight stairs on my low back and rear end. ...My right leg got caught up behind and my left elbow hit each stair as I came down." Petitioner stated that she was in "extreme pain."

Petitioner's mother picked her up and took her to see her uncle, a chiropractor named Troy Haines. Petitioner testified that Dr. Haines performed an x-ray and referred her to Dr. Fetter. Petitioner testified further that she saw Dr. Fetter about a week after the accident, and he requested an MRI, performed an x-ray on her low back, and recommended physical therapy. Petitioner underwent physical therapy at HealthSouth for approximately three months through February 2003.

Petitioner testified that she started seeing Dr. Caner at the Center for Pain Control in 2003. She also treated with Dr. Okoli, Dr. Irwin, and Dr. Kin at the Center for Pain Control. Petitioner stated that Dr. Okoli **[*4]** suggested performing a discography, which she underwent on June 4, 2003. Petitioner stated further that Dr. Okoli performed surgery on her back on July 31, 2003. Petitioner testified that the surgery was not successful, and, within three to six months, her pain was "ten times worse."

Petitioner's testimony about her other treatment with a number of doctors and at various places was disjointed. Petitioner stated that Dr. Fetter recommended physical therapy at Franklin Rehabilitation, which she underwent from September 2, 2003, to October 3, 2003. Petitioner stated further that she treated with Dr. Arber, Dr. Chhabria, and Dr. Danquilan from 2004 to 2005 at Victory Memorial Hospital, and that no one referred her to the hospital. She stated that she had surgery on November 5, 2004, after which she treated at Grand Oaks Anesthesia with Dr. Caner and Dr. Okoli. Petitioner testified that Dr. Caner referred her to Dr. Cusik, a neurologist, at Froedert Hospital in Wisconsin. Petitioner stated that in addition to seeing Dr. Cusik and Dr. Chhabria, both neurologists, she saw Dr. Citow, another neurologist, at Condell Medical Center, who performed injections in her low back. She also treated **[*5]** at Condell Acute Care Center. Petitioner also testified that she saw Dr. Alengo who diagnosed her with chronic regional pain syndrome.

Petitioner testified that she has been treating with Dr. Caner and Dr. Irwin consistently for the last four years, undergoing injections twice a month at the Center for Pain Control.

Petitioner testified that on March 5, 2008, she was involved in a motor vehicle accident after she had an episode of passing out while driving. She was taken by ambulance to Victory Memorial Hospital. She stated that there was a period of time when she continued to have episodes of passing out after March 5, 2008. She indicated that she treated at Lake Heart

Specialists for low blood pressure and low heart rate about two months after her motor vehicle accident.

Petitioner went to Eye Care for You on April 19, 2008, to get her eyes checked out. She stated that she went on her own because she was having trouble seeing. Petitioner testified that she has macular degeneration, and that "[t]hey found that Lyrica was found to cause macular degeneration."

Petitioner testified about her current condition at the time of the arbitration hearing on June 25, 2009. She experiences piercing **[*6]** pain in her back and shooting pain down both of her legs. She also discussed her eyesight issues, indicating that she cannot read and has a difficult time concentrating. Petitioner has difficulty sleeping and explained that there are occasions when she is up for four days. Petitioner testified that she has problems with sleepwalking and that her boyfriend has found her in various locations in the mornings, such as in the closet, kitchen, and basement.

On cross examination, Petitioner testified that, at Respondent's request, she saw Dr. Lemon on March 11, 2003, and Dr. Goldberg on May 21, 2004. She stated that she received a letter from the workers' compensation carrier dated March 20, 2003, indicating that her temporary total disability benefits were terminated based on her medical records and Dr. Lemon's Section 12 report. Petitioner testified that she became eligible for Social Security Disability benefits on April 16, 2007, and that Medicare paid for all of her medical bills after April 2007.

At the second arbitration hearing date on July 21, 2010, Petitioner testified that she changed treating doctors and currently treats with Dr. Lubenow at Rush Pain Center in Chicago. Petitioner **[*7]** stated that Dr. Nadanoff, her "original treating physician," referred her to Dr. Lubenow at her request. Under Dr. Lubenow's care, Petitioner underwent detoxification for 10 days, after which she underwent physical therapy at the hospital.

Petitioner testified that her treatment with Dr. Lubenow has helped her "tremendously." Presently, she undergoes physical therapy at home and she walks 1 1/2 to 2 miles a day and does light lifting. Petitioner explained that she is completely weaned off all narcotic medication. She stated that she started taking narcotic medications in June 2003 when she was treating at the Center for Pain Control. Currently, she is taking Tramadol, 50 milligrams, for pain; Remeron, which is an antidepressant that has a sleeping agent and something to calm her legs down; Valium for anxiety; and Excedrin Migraine for headaches.

Concerning her present condition, Petitioner explained that she still experiences pain in her legs, mild pain in her lower back, and headaches on a daily basis. Petitioner testified that her headaches are the worst, and she experiences pain radiating from her neck up to the back of her head and behind her eyes. Petitioner testified further **[*8]** that she has experienced headaches since her accident and that they have gotten worse in the last year.

The Commission hereby reverses the Arbitrator's decision in part and affirms the Arbitrator's decision in part. On the issue of causal connection, the Commission finds that Petitioner's low back condition and accompanying lower extremities condition are causally related to the accident; thus, only prospective medical treatment given to treat Petitioner's low back and lower extremities conditions are causally related to the accident. There is no dispute that Petitioner fell down the attic's stairs and injured herself. While there are references in Dr. Haines' records concerning low back and mid back symptoms such as on March 23, 1992, February 6, 1998, and November 29, 2000, Petitioner was able to perform her full duties with Respondent prior to her accident, and was no longer able to work after her accident. Moreover, prior to a worsening of her condition as a result of treatment at the Center for Pain Control, Petitioner's medical records reflect that she had symptoms in both her low back and lower extremities. For example, Dr. Fetter's records dated January 6, 2003, and February **[*9]** 6, 2003, reflect that Petitioner reported symptoms in her lower extremities. Dr. Levin's record dated January 17, 2003, reflects that she experienced numbness in both lower extremities.

While Dr. Lubenow indicated Petitioner's symptoms in her legs came after the IDET procedure, we find that Petitioner was experiencing symptoms in her legs prior to the IDET procedure. We conclude that Petitioner's condition in her low back and lower extremities is causally related to the work accident.

It is unclear what conditions and what diagnoses Petitioner is alleging were caused by the work accident. We limit our finding of causal connection only to the conditions in her low back and lower legs. The Commission specifically finds that Petitioner failed to prove that her headaches are causally related to the accident. The records from Dr. Haines clearly show that Petitioner suffered from severe headaches for years before the work accident. On June 23, 1995, Dr. Haines documented that Petitioner reported a headache all day; on November 22, 1995, Dr. Haines' records show that she experienced a migraine the day before which lasted all night; on December 6, 1995, Dr. Haines indicated that Petitioner **[*10]** had one headache since the last treatment and that her doctor believed that her headache resulted "from jaw"; on October 18, 1996, Dr. Haines indicated that Petitioner had a headache for three days, that she had pain at the base of her neck, and that she had taken different medications for it; Dr. Haines documented a bad headache on January 15, 1997; on October 6, 1998, Dr. Haines documented that she had a headache for three days; Petitioner had a headache again on April 12, 2000, May 15, 2000, and an all day headache on September 15, 2000; on November 10, 2000, Dr. Haines documented that Petitioner could not turn her head to the left and felt "grinding" in her neck; on November 29, 2000, Dr. Haines indicated that she had "lots" of headaches and was experiencing aching between her shoulder blades; on January 15, 2001, Dr. Haines documented that her neck was "out" and that she had headaches; on February 19, 2001, Dr. Haines indicated that Petitioner had a headache all weekend"; Dr. Haines indicated on May 22, 2001, that Petitioner had a bad migraine yesterday and today; on January 8, 2002, Petitioner reported that her migraine headache lasted for two days; on March 2, 2002, Petitioner **[*11]** reported a bad headache and vomiting; on July 17, 2002, Petitioner reported on and off headaches since Sunday; and on November 20, 2002, Petitioner reported symptoms in her neck and a headache. The evidence reflects that Petitioner suffered from severe headaches for years prior to the work accident. The Commission concludes that Petitioner's headaches and any neck symptoms resulting from her headaches are not causally related to the accident.

The Commission also finds that any eyesight issues that Petitioner has are not causally related to the accident. Dr. Lubenow testified during his evidence deposition taken on May 24, 2010, that macular degeneration is not a side effect from any of the medications Petitioner was taking. While Petitioner testified that Lyrica caused her macular degeneration, there is no medical opinion or record supporting her statement, and Petitioner has not identified any.

The Commission further finds Petitioner has failed to prove that the diagnosis of complex regional pain syndrome ("CRPS") or reflex sympathetic dystrophy ("RSD") is causally related to the work accident. Dr. Alengo, an attending doctor at Victory Memorial Hospital, diagnosed her with RSD. **[*12]** Dr. Caner testified during his deposition taken on April 30, 2009, that he does not believe that she has "raging" RSD, but does believe that she has CRPS-like symptoms that are secondary to her back condition. We find Dr. Lubenow's opinion on whether Petitioner has CRPS or RSD more persuasive than Dr. Caner's and Dr. Alengo's opinions. Dr. Lubenow testified that she never really had CRPS as a diagnosis. Dr. Lubenow indicated that high doses of narcotic medication can aggravate pain. We note that Petitioner's condition improved significantly after she underwent detoxification. Dr. Lemon indicated in his Section 12 report that on physical examination, there was no evidence of RSD. Similarly, Dr. Goldberg indicated that he did not see any evidence of RSD on exam. We conclude that Petitioner failed to prove that her diagnosis of RSD or CRPS is causally related to the work accident.

Concerning Petitioner's **choice** of providers, the Arbitrator found that "[a]ll treatment and referrals are within the chain of referrals under section 8 of the Act." The Commission disagrees with the Arbitrator and finds that Petitioner's first **choice** of provider was Dr. Haines and her second **choice** of provider **[*13]** was Dr. Fetter. On remand, a determination of which doctors are within the chain of referral of Dr. Haines and Dr. Fetter shall be made consistent with our

findings on this issue as stated below.

Respondent contends that Petitioner's first **choice** of provider was Dr. Haines, whom she saw on December 6, 2002, and the Commission agrees that Dr. Haines was Petitioner's first **choice.**

Respondent also contends that Petitioner's second **choice** of provider was Lake Forest Hospital where she was treated on December 10, 2002, arguing that there is no evidence that the hospital visit at Lake Forest Hospital was emergency treatment. The Commission disagrees with Respondent and finds that Petitioner's treatment at Lake Forest Hospital was emergency treatment and thus does not count as Petitioner's second **choice** of provider. In so finding, we note that Petitioner was still in the acute phase of her work injury. She sought emergency treatment at Lake Forest Hospital only four days after her accident for "sharp pain" in her left elbow. Dr. Nagle, the emergency room doctor at Lake Forest Hospital, indicated that Petitioner's chief complaint was elbow injury and documented the following history:

> "The **[*14]** patient is a 26-year-old right-hand dominant female, who states that on Friday 12-6-02 she was at work carrying boxes down from an attic when she lost her footing on the attic stairs and fell onto her buttocks, falling down multiple steps. She also struck her left elbow. She was seen by her uncle, who is a chiropractic surgeon and was told that she had separation of her tailbone. She has been unable to sit since that injury and is taking Ibuprofen. She has been using her arms a lot to lift herself when she gets out of bed and has complained of pain in the left elbow. This is usually when lifting. She describes it as a sharp pain, just superior to the elbow joint. She demonstrates full range of motion of the joint, but has exquisite pain and has to do a lot more with her arms because of her other injury. ... She has been unable to sit since her injury. She is scheduled to see her orthopedic surgeon (Dr. Fetter) on Thursday, but felt that she was not getting better and came in."

Petitioner had an x-rays on her left humerus and elbow which revealed no evidence of fracture or dislocation. She was placed in a sling and diagnosed with a left elbow sprain. The plan included limiting weight **[*15]** bearing, continuing ibuprofen, and to follow up with Dr. Fetter from orthopedics on December 12, 2002. She was also given Vicodin for severe pain. We find that Petitioner's treatment at the emergency room at Lake Forest Hospital was emergency treatment for a condition that resulted from the work injury shortly after the injury; and, thus Lake Forest Hospital was not a **choice** of provider.

The Commission finds that Petitioner's second **choice** of provider was Dr. Fetter. It is apparent from the emergency room records from Lake Forest Hospital on December 10, 2002, that she already had an appointment with Dr. Fetter scheduled when she presented to Lake Forest Hospital. Petitioner testified that Dr. Haines referred her to Dr. Fetter, whom she saw about a week after the accident, but her testimony is not supported by the records. Dr. Haines' notes from December 6, 2002, document that she was carrying a box from an attic at work that morning and fell down six steps, landing on her tailbone and left buttocks. Dr. Haines' subsequent notes indicate that she had an appointment on December 12 with "orthopod" and that she was planning to borrow x-rays of her back from Dr. Haines' office to show **[*16]** Dr. Fetter. We find that there is no evidence in Dr. Haines' records that he referred her to Dr. Fetter.

Moreover, there is no evidence in Dr. Fetter's records to show that Dr. Haines referred her to see him. In the orthopedic history questionnaire that Petitioner completed on December 12, 2002, in response to the query "Referred by," Petitioner left it blank. Dr. Fetter's handwritten notes from December 12, 2002, do not document a referral. Dr. Fetter's typed notes dated December 12, 2002, were addressed to an individual named Sterling Mimke at "The David Agency." There is no evidence identifying who Sterling Mimke of The David Agency is. The

workers' compensation insurance indicated in the Request for Hearing forms is Utica National Insurance Company. If The David Agency referred Petitioner to Dr. Fetter, we cannot determine what The David Agency is from this record.

The Commission concludes that Dr. Fetter was Petitioner's second **choice** of provider. Treating physicians referred by Dr. Fetter are within Dr. Fetter's chain of referral, which includes at least Dr. Levin and the providers at the Center for Pain Control. Dr. Levin's notes dated January 17, 2003, reflect that the referring **[*17]** physician was Dr. Marvin Fetter. Dr. Fetter issued a referral note on February 6, 2003, referring Petitioner to Dr. Caner and Dr. Irwin, anesthesia pain management specialist. Petitioner completed a patient intake form for Center for Pain Control dated February 13, 2003, and indicated that she was referred by Dr. Marvin Fetter.

The Arbitrator awarded prospective medical treatment with Dr. Lubenow. We find that Dr. Lubenow from Rush Pain Center, with whom Petitioner is currently treating, is not within the chain of referrals of Dr. Haines or Dr. Fetter. When Petitioner's attorney asked Dr. Lubenow during his deposition whether Petitioner was referred to him by Dr. Irwin's office, Dr. Lubenow replied, "Yes, I believe so." Later, however, Dr. Lubenow identified Dr. Naybenov as the referring physician. In Dr. Lubenow's records dated January 21, 2010, the referring physician documented was Dr. Tzvetn Naybenov. Further, at the second arbitration hearing date held on July 21, 2010, Petitioner testified that since the first arbitration hearing, she had changed treating doctors and was now treating with Dr. Lubenow. She identified Dr. Naybenov as her "regular physician" who referred her to **[*18]** Dr. Lubenow at her request. While Petitioner's treatment with Dr. Lubenow is causally related to the work accident, Dr. Lubenow is outside the chain of referrals of her two **choices** of providers and, thus, Respondent is not liable for Petitioner's medical treatment with Dr. Lubenow.

Moreover, while we find that the doctors at the Center for Pain Control are within Dr. Fetter's chain of referral, we also find that the treatment on and after July 31, 2003, at the Center for Pain Control was unreasonable. On remand, a determination shall be made with respect to the amount of medical expenses Petitioner is entitled to for the expenses incurred at the Center for Pain Control prior to July 31, 2003.

In finding that Petitioner's treatment at the Center for Pain Control on and after July 31, 2003, was unreasonable, we rely primarily on the Center for Pain Control's records. The Center for Pain Control's records reflect that Petitioner started treating at the Center for Pain Control in February 2003 and continued to treat there until April 2009. Petitioner completed a patient intake questionnaire on February 13, 2003, and the first record in evidence was with Dr. Caner from February 25, 2003. **[*19]** The latest record in evidence is from April 9, 2009, when Dr. Caner performed a caudal epidural. Petitioner continued to treat at the Center for Pain Control for a period of over six years despite evidence that her condition did not improve while she treated there.

Petitioner had a series of lumbar injections on April 24, 2003, performed by Dr. Okoli. On May 8, 2003, Dr. Okoli performed a caudal epidural steroid injection and right sided L2 transforaminal epidural steroid injection. On May 15, 2003, the notes indicate that the caudal L2 lumbar injection provided "zero help" and the plan was to schedule a lumbar discography. Dr. Okoli proceeded with the lumbar discogram on June 4, 2003, with a post operative diagnosis of lumbar degenerative disc disease and discogenic pain at L1-2 and L5-S1. A CT of Petitioner's lumbar spine was performed on June 4, 2003, which revealed no disc herniation, significant central canal or neuroforaminal stenosis at L1-2, and, at L5-S1, there was a Grade III annular disruption but no significant central canal or neuroforaminal stenosis. Despite the June 4, 2003, CT scan, despite the negative EMG testing performed by Dr. Levin on January 22, 2003, and despite **[*20]** the January 22, 2003, lumbar MRI which showed a very mild diffuse disc bulging at L4-5, Dr. Okoli went ahead and performed percutaneous discectomies at L1-2 and L5-S1 on July 31, 2003. Dr. Goldberg opined the percutaneous discectomies performed at L1-2 and L5-S1 were not indicated because Petitioner's MRI on January 22, 2003, bone scan on January 22, 2003, discogram on June 4, 2003, and CT scan did not reveal evidence of a disc

herniation. We find that the procedure on July 31, 2003, was unreasonable and unnecessary.

There is evidence that Petitioner's condition worsened after the percutaneous discectomies on July 31, 2003. At Petitioner's initial physical therapy evaluation at Franklin Rehabilitation on September 22, 2003, Petitioner reported that before the percutaneous decompression, she had constant numbness and tingling and constant pain from her midback through her low back and into her legs, right more than left. Since she had the procedure, her left leg was more painful and she had more numbness and tingling than she did in her right leg. Dr. Lubenow indicated that after Petitioner had the IDET procedure, she began having excruciating pain in both of her lower extremities. **[*21]** Dr. Lubenow stated that Petitioner seemed to have new complaints after the procedure.

The treatment that Petitioner had at the Center for Pain Control after July 31, 2003, was lengthy without evidence of any appreciable improvement in her condition. We find that treatment that she underwent after July 31, 2003, was also unreasonable. Despite the negative effects of the July 31, 2003, percutaneous discectomies, Dr. Okoli performed additional injections on October 6, 2003, while noting that Petitioner did not get sustained relief from most of her previous therapies. On October 16, 2003, Dr. Okoli indicated that Petitioner's last visit with injection treatment provided no improvement. On November 5, 2004, Dr. Caner performed a lumbar sympathetic block. On November 23, 2004, Dr. Caner noted that the lumbar sympathetic block helped increase her movement and strength but her back pain worsened. Dr. Caner performed another lumbar sympathetic block on December 3, 2004. On May 12, 2005, Dr. Kin indicated that Petitioner underwent multiple injections including lumbar facet injections, costovertebral joint injections, and lumbar sympathetic block injections all without significant relief of **[*22]** pain. Dr. Caner performed additional injections on May 17, 2005, and May 20, 2005. Petitioner indicated on May 22, 2005, in her pain diagram that she was not able to sit, lie down, stand up, or walk without feeling pain, and that she could not sleep. Despite Petitioner's complaints, Dr. Caner performed another injection on May 27, 2005. On June 17, 2005, Petitioner indicated in her pain diagram that she had severe pain, that her skin was very sensitive to touch, and that it was nearly impossible for her to sit. Dr. Caner's notes on June 17, 2005, indicated that she was status post lumbar sympathetic block which helped "for awhile" and he planned a repeat lumbar sympathetic block. On July 1, 2005, Dr. Caner performed more injections. He performed additional injections on August 12, 2005, September 9, 2005, November 4, 2005, January 6, 2006, and February 3, 2006. On February 10, 2006, Petitioner indicated on her pain diagram that she had symptoms in both hips and lower extremities and stated that whenever she lay on either hip, her whole leg went numb. On February 10, 2006, Dr. Caner performed radiofrequency thermocoagulation of the medial branch of the dorsal root bilaterally from T12 **[*23]** through L3 for a total of 16 lesions. In Dr. Caner's February 10, 2006, operative report, he indicated that Petitioner had "good relief following medial branch blocks" that she underwent on February 3, 2006, despite what Petitioner indicated in her February 10, 2006, pain diagram. On March 3, 2006, the doctor's records reflect that Petitioner had 0% relief from the injections on February 10, 2006.

The injections continued well after February 2006. Dr. Irwin performed additional injections on June 6, 2006, noting in his operative report that Petitioner's injection therapy on February 10, 2006, provided her 40% relief for five to seven days even though the March 3, 2006, notes reflect that she had 0% relief. The June 6, 2006, injections provided her with 45-60% relief of her pain for three days. Dr. Irwin performed injections again on June 13, 2006, from which she had 50% relief for two to three days; again on June 20, 2006, from which she had 50% relief for three days; again on July 19, 2006, from which she had 60% relief of pain for three to four days; again on August 1, 2006, from which she had 50% relief of her pain for one and a half weeks; again on September 26, 2006, from which **[*24]** she had 20% relief of pain for two days; and again on October 10, 2006, from which she had 40% stated relief of her pain for three to four days. The numerous injections did not provide Petitioner with any lasting relief.

It is evident from the Center for Pain Control's records that injection treatment was not an effective or beneficial form of treatment for Petitioner. On November 21, 2006, Petitioner

indicated in her pain diagram that she hurt terribly, that she could not sit for very long, that her hips were "killing" her, and that she could not take the pain anymore. On May 3, 2007, Petitioner indicated the following in her pain diagram: "Severe cramping. Pins & needles lasting for 6 or more hours. Low back & right hip are KILLING me. Severe headaches." On August 16, 2007, Petitioner indicated the following in her pain diagram: "Pain now is the worse it's ever been in the last 5 years. I cannot do the simplest things like putting socks on. Sleeping is impossible pain is so bad." Despite the fact that Petitioner was not getting any sustained or substantial relief, and despite the fact that Petitioner was reporting that her symptoms were worsening, the Center for Pain Control **[*25]** continued to perform additional procedures on her in 2008 and 2009.

The Commission concludes that treatment obtained at the Center for Pain Control on and after July 31, 2003, was unreasonable. Thus, Respondent is not liable for the medical expenses at the Center for Pain Control incurred on and after July 31, 2003.

The Commission also finds that it was premature for the Arbitrator to award vocational rehabilitation. Only Dr. Caner offered an opinion concerning vocational rehabilitation. Dr. Caner indicated that Petitioner should have the goal of returning to work and that she should coordinate with her treating physicians to meet that goal. Dr. Caner's opinion does not support awarding vocational rehabilitation at the time of arbitration. Petitioner's condition has not stabilized, she has not reached maximum medical improvement, and she is not done treating with Dr. Lubenow. While we find that it was premature to award vocational rehabilitation, our finding does not preclude an award of vocational rehabilitation at a later time.

The Commission affirms the Arbitrator's award of temporary total disability benefits representing a period from December 6, 2002, through July 21, 2010. **[*26]** Petitioner has not been able to return to work in any capacity yet.

The Commission also affirms the Arbitrator's decision to deny penalties and attorneys' fees. In affirming the denial of penalties and attorneys' fees, we note that there were not much objective findings before Petitioner underwent all of the treatment she had with the Center for Pain Control. Moreover, we find that Dr. Goldberg, Respondent's Section 12 doctor, provided credible and supported opinions.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision is reversed in part and affirmed in part. The Arbitrator's decision is not hereby adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $ 221.45 per week for a period of 397-5/7 weeks, that having been the period of temporary total incapacity for work under § 8(b), and that as provided in § 19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner medical expenses under § **8(a)** of the **[*27]** Act consistent with this decision. More specifically, on remand, a determination shall be made with respect to how much Petitioner is entitled to for medical expenses consistent with our findings with respect to Petitioner's two **choice** of medical providers and with respect to our finding that Respondent is not liable for treatment on and after July 31, 2003, at the Center for Pain Control.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of vocational rehabilitation is vacated.

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.

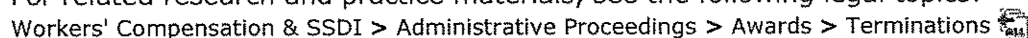
IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under § 19(n) of the Act, if any.

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. **[*28]**

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $ 75,000.00. 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 and deposited with the Office of the Secretary of the Commission.

Legal Topics:

For related research and practice materials, see the following legal topics: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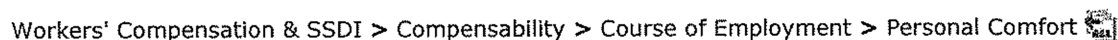
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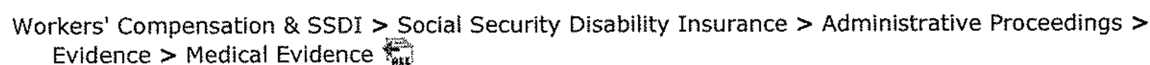
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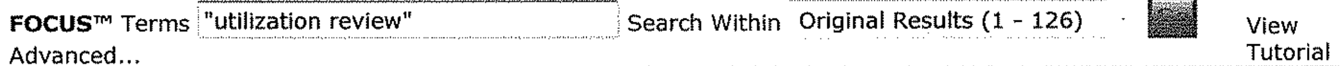


Terms: **"utilization review"** (Suggest Terms for My Search)

*11 IWCC 1025; 2011 Ill. Wrk. Comp. LEXIS 1112, **

ROBERT URBAN, PETITIONER, v. DOMINICK'S, RESPONDENT.

NO: 09WC 36728

ILLINOIS WORKERS' COMPENSATION COMMISSION

STATE OF ILLINOIS, COUNTY OF COOK

11 IWCC 1025; 2011 Ill. Wrk. Comp. LEXIS 1112

October 21, 2011

CORE TERMS: arbitrator, physical therapy, right shoulder, cervical, injection, contusion, opined, pain, shoulder, neck, prescribed, diagnosed, epidural, symptoms, sprain, recommended, causally, administered, impingement, medically, pallet, fee schedule, therapy, rotator, steroid, strain, spine, cuff, underwent, progress

JUDGES: Thomas J. Tyrrell; Daniel R. Donohoo

OPINION: [*1]

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by both Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, temporary total disability, and the nature and extent of the injury, and being advised of the facts and law, modifies the Decision of the Arbitrator with regard to causal connection, temporary total disability benefits, and medical expenses as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission hereby modifies the Arbitrator's decision with regard to causal connection and finds that Petitioner proved that his condition of ill being is causally connected to the August 21, 2009, accident. In so finding, we rely on Petitioner's credible testimony and the medical records from Anderson Physical Therapy, Dr. Nam, and Dr. Malek. We find the opinions of Dr. Nam and Dr. Malek to be more reliable than the opinions of Dr. Wehner or Dr. Casterjon's **utilization reviews.** We specifically do not rely on the treatment records from Dr. Giacchino.

We find Petitioner credibly testified **[*2]** that his shoulder symptoms improved "rather nicely and speedily" after he underwent trigger point injections and physical therapy. The treatment

records from Anderson Physical Therapy also demonstrate that Petitioner's pain ratings steadily improved throughout the course of his treatment.

The treatment records from Dr. Nam and Dr. Malek similarly demonstrate that Petitioner had ongoing symptoms that did not respond to the brief course of treatment at Concentra, but resolved with injections and physical therapy as recommended by both Dr. Nam and Dr. Malek.

On October 30, 2009, Dr. Nam noted that Petitioner experienced persistent pain radiating down his left arm and persistent right shoulder pain "despite physical therapy." He noted further that Petitioner's exam findings correlated with his MRI findings and recommended an injection. On December 4, 2009, Dr. Nam noted that the injection helped "a great deal" and recommended that Petitioner continue with three to four more weeks of physical therapy. On December 30, 2009, Dr. Nam released Petitioner from care with regard to his shoulder.

Dr. Malek noted on November 6, 2009, that physical therapy helped Petitioner's cervical symptoms and **[*3]** that overall his condition had improved. He recommended that Petitioner continue with physical therapy and consider cervical epidural steroid injections. On November 20, 2009, Dr. Malek noted that Petitioner had a good result with the epidural steroid injection. He recommended that Petitioner undergo a second injection and continue physical therapy. On December 11, 2009, Dr. Malek noted that Petitioner was feeling "significantly" better and recommended a third and final cervical injection and additional physical therapy. On December 31, 2009, Dr. Malek recommended that Petitioner continue treatment with Dr. Giacchino. Finally, on February 19, 2010, Dr. Malek noted Petitioner's cervical symptoms had stabilized due to injections, medication, and physical therapy. He related Petitioner's cervical symptoms to the August 21, 2009, accident and observed "good clinical response to conservative management with stabilization of symptoms." Dr. Malek returned Petitioner to work full duty as of February 22, 2010.

We find the records and opinions of Dr. Nam and Dr. Malek to be more persuasive than the reports of Dr. Wehner. Although Dr. Wehner eventually had access to all of Petitioner's medical **[*4]** records, when she issued her reported dated November 2, 2009, she had not reviewed treatment records from Dr. Nam. At that time, Petitioner had yet to begin treatment with Dr. Malek. Although Petitioner complained of symptoms that Dr. Nam correlated with the MRI findings, Dr. Wehner disregarded the MRI findings as being asymptomatic or the result of degenerative changes without addressing whether the accident may have aggravated or accelerated the degenerative condition. Dr. Wehner reviewed Dr. Nam and Dr. Malek's records before authoring her April 26, 2010, report. In that report, Dr. Wehner changed her November 2, 2009, diagnoses from contusions of the head, shoulder, and hand, to resolved cervical sprain/contusion, resolved shoulder sprain/contusion, and resolved hand contusion/sprain. Despite diagnosing more severe injuries, Dr. Wehner maintained her previous opinion that injections, MRIs, and more than six physical therapy visits were unnecessary.

We are similarly unpersuaded by Dr. Castrejon's **utilization review** because he did not review all of Petitioner's treatment records. In reaching his November 5, 2009, conclusion that physical therapy, injections, and an office visit **[*5]** were non-certified, Dr. Castrejon did not review records from Dr. Nam or Dr. Malek. Dr. Castrejon relied in part on an absence of treatment records other than work status reports for September 30, 2009, or October 5, 16, or 19, 2009. In our review of the medical evidence we found documentation for each of these visits save the October 5, 2009, visit to Dr. Giacchino for which there are no records in evidence. Dr. Castrejon restated his conclusions in the December 9, 2009, **utilization review,** but again failed to review records from Dr. Nam or Dr. Malek.

We specifically do not rely on the treatment records from Dr. Giacchino. Dr. Giacchino noted few specific exam findings, and his treatment records do not reflect any causation opinions.

The Commission further modifies the Arbitrator's decision with regard to medical expenses. In light of our finding that Petitioner met his burden of proving causal connection, we find that Petitioner is entitled to temporary total disability benefits for a period of 26-3/7 weeks beginning

on August 21, 2009, and ending on February 22, 2010, when Dr. Malek released Petitioner to return to work full duty.

We further modified the Arbitrator's decision with **[*6]** regard to medical expenses. We find Dr. Giacchino's treatment was reasonable and necessary to cure or relieve the effects of Petitioner's injury. We acknowledge that Dr. Giacchino's license is currently suspended for inappropriately prescribing narcotics, among other things, but find that to be irrelevant here. We see nothing in Dr. Giacchino's treatment records to indicate that he ever prescribed narcotics to Petitioner, nor do we see any evidence that his treatment was improper. In fact, on December 31, 2009, Dr. Malek noted that Petitioner received benefit from his treatment with Dr. Giacchino.

We decline, however, to award all charges from Dr. Giacchino. Some of the claimed charges lack corresponding medical records, and others appear to be duplicative. With regard to treatment rendered by Dr. Giacchino, we therefore find Respondent is liable only for non-duplicative charges with corresponding medical records, totaling $ 15,309.25.

We award the remaining medical bills as follows, subject to the fee schedule where noted: NR Anesthesia - $ 2,860.01; Advantage MRI - $ 3,500.00 subject to the fee schedule; Dr. Nam at Chicago Orthopaedic & Sports Medicine - $ 897.00, subject to the **[*7]** fee schedule; Fullerton Surgery Center - $ 15,081.21; Dr. Malek - $ 7,987.55; and Anderson Physical Therapy -$ 27,230.00, subject to the fee schedule.

Finally, we affirm and adopt the Arbitrator's decision with regard to the nature and extent of Petitioner's injury.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision is modified with regard to causal connection, temporary total disability benefits, and medical expenses.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $ 605.08 per week for a period of 26-3/7 weeks, that being the period of temporary total incapacity for work under § 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $ 544.57 per week for a period of 12.65 weeks, as provided in § 8(e) of the Act, for the reason that the injuries sustained caused the loss of use of 5% of the right arm.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $ 544.57 per week for a period of 30 weeks, as provided in § 8(d)2 of the Act, for the reason that the injuries sustained caused the loss of use of 6% of the whole person.

IT IS FURTHER ORDERED **[*8]** BY THE COMMISSION that Respondent pay to Petitioner the sum of $ 72,865.02 for medical expenses under § 8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is due a credit of $ 6,310.12 for temporary total disability benefits paid and $ 886.00 for permanent partial disability benefits paid, for a total credit of $ 7,196.12.

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 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

ILLINOIS WORKERS' COMPENSATION COMMISSION ARBITRATION DECISION

Consolidated cases: **n/a**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice* **[*9]** *of Hearing* was mailed to each party. The matter was heard by the Honorable **Lee**, Arbitrator of the Commission, in the city of **Chicago**, on **6/21/10**. 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

C. Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
F. Is Petitioner's current condition of ill-being causally related to the injury?
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?

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?

FINDINGS

On **August 21, 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 **[*10]** of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned $ **47,196.24**; the average weekly wage was $ **907.62**.

On the date of accident, Petitioner was **59** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of $ **7,196.12** for TTD $ **6,310.12** for TPD, $ for maintenance, and $ **886.00 against PPD** other benefits, for a total credit of $ **7,196.12**.

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

ORDER

Respondent shall be given a credit of $ 6,310.12 for TTDs and $ 886.00 for PPD for a total credit of $ 7,196.12.

Respondent shall pay Petitioner permanent partial disability benefits of $ 544.75/week for 12.65 weeks, because the injuries sustained caused the 5% loss of the right arm, as provided in Section 8(e)10 **[*11]** *of the Act.*

Respondent shall pay Petitioner permanent partial disability benefits of $ 544.57/week for 30 weeks, because the injuries sustained caused the 6% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule of $ 897.00 to Dr. Nam and $ 1,922.62 to Melrose Park Clinic, as provided in Section's 8(a) and 8.2 of the Act.

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

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

Signature of Arbitrator

8/16/10

Date

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner testified to being employed with **[*12]** the Respondent as a selector/general warehouse employee for 37 years. On August 21, 2009, he testified he was cleaning out trailers from the store and working by a stack of pallets, when he noticed one was unsteady. The stack was approximately 12 feet high. When Petitioner went to push the wood pallet forward, six to seven pallets weighing 40 to 80 pounds toppled on him, striking his head, shoulder, forearms, left hand, and body. Petitioner testified he was working alone, and this accident was not witnessed. He reported complaints about his right shoulder, left hand, both of his forearms, his head, neck and right leg following the incident.

Petitioner testified he reported this matter immediately to his supervisor. Petitioner sought initial medical attention at Elmhurst Memorial Hospital emergency room. Petitioner complained of headaches, right shoulder pain and neck pain. A CT of the brain and a right shoulder x-ray were unremarkable. Petitioner was diagnosed with a shoulder contusion, neck abrasion and scalp hematoma. Petitioner was discharged and referred to physical therapy. (Px6)

On August 24, 2009, petitioner presented to Concentra Medical Center, with right shoulder pain, right **[*13]** neck pain and right finger pain. (Px1) Dr. Stanley Simon's assessment was a contusion of the right shoulder, with additional contusions to the face/scalp, neck, forearm and finger. Dr. Simon prescribed cold pack treatment, and authorized petitioner to return to work, with no lifting over ten pounds, no pushing or pulling over ten pounds, no above the shoulder reaching and limited use of the right hand. (Px1)

Petitioner was seen for follow up with Concentra on August 26, 2009. Dr. Simon's diagnosis remained a right shoulder contusion/strain, cervical strain, scalp contusion and lower leg contusion. Petitioner reported overall improvement and was instructed to continue physical

therapy three times a week, for two weeks. While petitioner was authorized to work with restrictions, he testified light duty was not available. (Px1)

Petitioner elected to come under the care of Dr. Joseph L. Giacchino at Melrose Park Clinic on August 27, 2009. (Px2) Dr. Giacchino diagnosed petitioner with right shoulder derangement and cervical strain. Petitioner testified that Dr. Giacchino administered five epidural injections into his right shoulder and cervical spine at that time. Dr. Giacchino referred **[*14]** petitioner for physical therapy and dispensed medications.

Petitioner initiated physical therapy at Andersen Physical Therapy on August 31, 2009. Petitioner testified that all physical therapy was done through Andersen Physical Therapy and he only saw Dr. Giacchino for examinations at Melrose Park Clinic. Petitioner testified that Dr. Giacchino did not provide any physical therapy.

Petitioner returned to Dr. Giacchino with increased right neck stiffness and right sided pain on September 2, 2009. Abnormal neck and extremity was indicated, with no other information was documented. (Px2) Petitioner reported some improvement with physical therapy, but was ultimately referred to Dr. Ellis Nam by Dr. Giacchino. Dr. Giacchino further ordered cervical and right shoulder MRI's, with additional physical therapy for four to five weeks. (Px2) No rationale or medical criteria were indicated in his treatment records in support of the objective studies, other than Dr. Giacchino opined they were indicated. (Rx2)

The cervical MRI of September 3, 2009, demonstrated a herniated disc at C3-4. A right shoulder MRI of the same date showed acromioclavicular hypertrophy, with impingement and secondary tendinosis **[*15]** of the rotator cuff. (Px2)

Petitioner continued treatment at Melrose Park-River Grove Clinic, seeking treatment approximately every four days from September 4, 2009 through September 25, 2009. (Px2) In that time period, Petitioner was authorized off work on September 8, 2009 through September 16, 2009. (Px2)

On September 16, 2009, a **Utilization Review** (UR) report from EK Health was completed to address continued physical therapy and the cervical and right shoulder MRI scans, as prescribed by Dr. Giacchino. Dr. Steven Zonner opined physical therapy was certified for six visits. However the cervical and right shoulder MRI scans were found not medically indicated in accordance with the ACOEM Guidelines. (Px1) Specifically in addressing the cervical MRI, ACOEM Occupational Medicine Guidelines Practice Guidelines, 2nd Edition, 2004, require an "emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure". (Rx1)

In addressing the prescribed right shoulder MRI, the ACOEM Guidelines indicated the study is appropriate with "...patients **[*16]** with limitations of activity after four weeks and unexplained physical findings, such as effusion or localized pain, (especially following exercise), imaging may be indicated to clarify the diagnosis and assist in reconditioning. Primary criteria for ordering imaging studies are: emergence of a red flag (e.g. indications of intraevidence of tissue insult or cardiac problems presenting as shoulder pain), physiologic evidence of tissue insult or neurovascular dysfunction (e.g. cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the presence of edema, cyanosis, or Raynaud's phenonmena), failure to progress in a strengthening program intended to avoid surgery or clarification of the anatomy prior to an invasive procedure..." Upon review, Dr. Giacchino stated that he thought he could do whatever was necessary to treat the petitioner and stated that the petitioner could go anywhere he wanted to receive treatment. (Rx1&2)

On September 25, 2009, petitioner reported no improvement in his symptoms to Dr. Giacchino. Dr. Giacchino authorized petitioner off of work through October 19, 2009, recommended ongoing physical therapy, and medication. (Px2) **[*17]** The Arbitrator notes only off-work slips were generated by Dr. Giacchino, with no treatment indicated for petitioner's consultations with Dr.

Giacchino on September 30, 2009; October 5, 2009; October 13, 2009; and October 19, 2009. (Px2)(Rx3)

On October 30, 2009, the petitioner presented to Dr. Ellis Nam for evaluation of his right shoulder as referred by Dr. Giacchino. (Px4) Dr. Nam opined the right shoulder MRI revealed AC joint inflammatory changes, but the rotator cuff appeared to be grossly intact. He also opined the cervical MRI revealed a herniated disc at C3-4. Petitioner was diagnosed with a herniated disc of the cervical spine and right shoulder contusion of the AC joint, inflammation and impingement syndrome. Dr. Nam noted petitioner wanted to continue with physical therapy and was administered a cortisone injection into right shoulder; also not certified by UR. (Rx3) Petitioner was further referred to Dr. Malek for his neck pain and continued off work. (Px4)

Petitioner was examined by Dr. Julie Wehner, an orthopedic and Spine Surgeon of Orthopaedic and Spine Surgery Center for a Section 12 Examination on November 2, 2009. (Rx5) Petitioner now maintained while cleaning **[*18]** out trailers and standing on pallets composed of both wood and plastic, one was slippery and the pallet struck the top of his head and right shoulder. Petitioner reported abrasions on his right leg, left hand/fingers and his right ear. He also complained of numbness and tingling in his left ring and middle fingers, which commenced two weeks earlier, or about October 20, 2009. The Arbitrator notes these symptoms developed almost 9 weeks following the date of accident. (Rx5)

Physical examination revealed full range of motion of both shoulders, with mild pain with full internal rotation. Dr. Wehner opined that the cervical MRI showed a left disc herniation, with no cord compression and petitioner had no nerve compression correlating with his reported numbness and tingling in the little and ring fingers. Dr. Wehner opined the right shoulder MRI showed some acromioclavicular hypertrophy, with impingement secondary to tendonitis of the right rotator cuff. (Rx5)

Dr. Wehner diagnosed petitioner with a contusion to the head, shoulder and hand. (Rx5) Dr. Wehner opined his radiographic finding were chronic in nature, and not caused by the accident nor did they correlate with the subjective complaints. **[*19]** She opined a short course of physical therapy of between 4 to 8 visits was appropriate, followed by a transition to a home exercise program. Dr. Wehner found no medical indication of trigger point injections in the neck or shoulder based on his clinical examination. She opined there was a question based on Dr. Giacchino's notes whether petitioner was given facet joint injections completed under fluoroscopy, as pursuant to her review, there was no indication of the same. Dr. Wehner opined petitioner could return to work full duty, having achieved maximum medical improvement (Rx5)

A second UR EK Health report of November 5, 2009, opined that the physical therapy and injections as prescribed by Dr. Giacchino and Dr. Nam were not certified in conjunction with MTUS guidelines and review of the medical history. (Rx3) Reviewing physician, Dr. Joseph Castrejon explained as the Petitioner's treating physicians did not document petitioner's functional improvement with the previous physical therapy; additional therapy was not medically indicated. (Rx3) Moreover, in regard to the prescribed injections, no mention of the medical necessity for the injections was provided in the treatment notes, **[*20]** nor was it clear as to what type of injections were being requested. (Rx3) Without such information, the treatment could not be evaluated and therefore was not certified.

Petitioner next came under the care of Dr. Michael H. Malek as referred from Dr. Nam on November 6, 2009. (Px5) Dr. Malek opined the cervical MRI of September 3, 2009 demonstrated evidence of disc herniation at C3-4, central and more to the left, with desiccation and facet arthroscopy at C5-6. The right shoulder MRI evinced acromial hypertrophy impingement and secondary tendinosis of the rotator cuff. Dr. Malek diagnosed petitioner with a cervical musculoligamentous sprain with cervical radiculopathy and right shoulder injury. Dr. Malek recommended physical therapy and referred petitioner for additional right shoulder treatment with Dr. Nam. Dr. Malek authorized petitioner off of work and prescribed a muscle relaxant and pain medication; future consideration of a cervical epidural steroid injection was noted. (Px5)

On November 13, 2009, petitioner underwent a cervical epidural steroid injection as administered by Dr. Malek. (Px5)

Dr. Giacchino continued petitioner off of work through November 16, 1009. (Px2) Petitioner **[*21]** was also continuing to participating in physical therapy at Andersen Physical Therapy, consisting of electrical stimulation, hot packs, ultrasound, cervical stretch and rotator cuff exercises. (Px3)

On November 23, 2009, petitioner returned to Dr. Giacchino reporting improvement in his right shoulder following the injection administered by Dr. Nam. (Px2) Petitioner was scheduled for a second epidural steroid injection at the hands of Dr. Malek on November 27, 2009. Dr. Giacchino prescribed continued physical therapy and off work status. (Px2)

Petitioner was seen by Dr. Nam reporting improvement following the cortisone injection to his right shoulder on December 4, 2009. (Px4) His impression was right shoulder contusion, with AC joint inflammation and impingement syndrome. No indication was provided as petitioner's treatment progress. Additional physical therapy for three to four weeks for the right shoulder was prescribed, at which point a discharge was anticipated. In the interim, petitioner was to remain off of work. Petitioner underwent a second epidural steroid injection on this date by Dr. Malek. (Px5)

On December 7, 2009, Dr. Giacchino issued a disability slip authorizing petitioner **[*22]** off of work for both his neck and right shoulder condition. (Px2) Arbitrator notes petitioner was under the care of Dr. Nam for his right shoulder condition.

EK Health issued an addendum UR report of December 9, 2009 for clarification of the medical necessity of the injections initially performed by Dr. Giacchino on August 28, 2009. (Rx4) Dr. Joseph Castrejon observed cervical injections were not appropriate for the diagnosis of a cervical strain, with no indication of kind/level of injection and therefore not certified. (Rx4)

Dr. Malek's assessment remained cervical radiculopathy on December 11, 1009. (Px5) Petitioner was authorized to work modified duty, restrictions not defined. Dr. Malek prescribed continued therapy and a third epidural steroid injection; administered on December 18, 2009. (Px5)

On December 30, 2009, petitioner reported minimal to no pain about his right shoulder in follow up with Dr. Nam. (Rx4) Dr. Nam observed he was still under the care of Dr. Malek for his cervical spine. Upon examination, petitioner had full range of motion of the shoulder, also neurovascularly intact. The assessment was a right shoulder contusion, with AC joint inflammation and impingement **[*23]** syndrome. As petitioner's right shoulder pain had resolved, petitioner was released from his care. (Rx4) Petitioner returned to work on February 22, 2010 in full duty capacity.

Upon cross examination, petitioner testified he continued therapy, undergoing 78 visits at Andersen Physical Therapy, from August 31, 2009 through February 17, 2010; consisting of electrical stimulation, hot compresses and an ultrasound.

Dr. Wehner completed a second Section 12 Examination on April 26, 2010. (Rx6) At the time of the reevaluation, petitioner reported that he no longer had any pain in his neck and the numbness and tingling in his fingers had resolved. He returned to work on February 22, 2010, in a full-duty capacity. Petitioner reported left sided neck pain. Side rotation to the left increased some of the right-sided neck pain; otherwise, range of motion was normal. Upper strength was 5/5, with no atrophy and no edema.

Dr. Wehner opined that the diagnosis based on the mechanism of injury was contusions and sprains to the head, shoulder and hand. (Rx6) The right shoulder condition had resolved, as had his cervical spine, primarily. Dr. Wehner opined an appropriate course of therapy would be 6 **[*24]** to 12 visits of physical therapy, transitioning to home exercise program at that point. There was no documentation in the medical records of any progress following the extensive

physical therapy that lasted through January 2010. Hence no medical basis for physical therapy beyond 12 visits was substantiated. Dr. Wehner recommended no further diagnostic or therapeutic intervention. She again opined he should have attained MMI by November 2, 2009. While petitioner reported some mild complaints of pain with neck range of motion. Dr. Wehner opined they were not causally connected to the work injury, but related to the normal degenerative process.

Petitioner testified he had received no treatment since February 19, 2010, with no future medical appointments scheduled. Having concluded treatment, petitioner testified to continued minor complaints of pain of the cervical spine, with occasional flaring up of his shoulder pain. Petitioner further reported numbness in his left ring finger and pinky. The Arbitrator notes petitioner reported complete resolution of left hand ring finger complaints in April 2010, which developed over two months following the work incident. Petitioner admitted no surgical **[*25]** intervention was performed or prescribed. Petitioner testified to continuing to work full duty, with the Respondent. Petitioner denied any prior treatment or complaints predating the injury; however he testified to right shoulder complaints in November 2001, for which he sought treatment for six weeks, but did not lose any time from work.

The Arbitrator notes pursuant to the Division of Professional Regulation's records of licensed physicians, Dr. Joseph L. Giacchino's license to practice to medicine is presently suspended through July 31, 2011. (Rx7) Furthermore, Dr. Giacchino has been subject to disciplinary action against his license in the past. Review of Dr. Giacchino's practice record indicates he was on probation from September 8, 1989 through September 8, 1994. A summary suspension was instituted on June 4, 1987 through September 7, 1989, prohibiting him from practicing medicine. Probation was reinstituted from September 8, 1994 through September 8, 1995, with summary suspension reinstituted on April 22, 2010. Dr. Giacchino was cited for issuing numerous controlled substances to patients in his practice, without therapeutic purposes, engaging in immoral conduct with the patients **[*26]** of his practice and pre-dating prescriptions. (Rx7)

CONCLUSIONS OF LAW:

In support of the Arbitrator decision in regard to (D) if an accident occurred that arose out of and in the course of Petitioner's employment by Respondent the Arbitrator finds:

Petitioner, a selector/general warehouse employee for the respondent, testified to an injury on August 21, 2009, while working in the respondent's warehouse. He testified to cleaning out trailers from the store and working by a stack of pallets 12 feet high. He noticed one was unsteady. When petitioner pushed the wood pallet forward, six to seven pallets weighing 40 to 80 pounds toppled on him, striking his head, shoulder, forearms, left hand, and body. Petitioner testified that he immediately reported the accident to his supervisor and sought medical attention that day at Elmhurst Memorial Hospital emergency room.

Based on the foregoing, the Arbitrator finds petitioner sustained an accidental injury arising out of and the course of Petitioner's employment with the Respondent.

In support of the Arbitrator decision in regard to (F) if Petitioner's present condition of ill-being is causally related to the incident [*27] of August 21, 2009 and the nature and extent of Petitioner's injuries, the Arbitrator finds:

Petitioner came under the care of several treating physicians through the course of his care following the incident of August 21, 2009. Having reviewed the supporting medical records, the Arbitrator findings the Petitioner's final assessment is as follows: resolved cervical sprain/contusion and resolved shoulder sprain/contusion and resolved hand contusion/sprain in accordance with the following physicians' diagnoses:

At the Elmhurst Memorial Hospital emergency room on August 21, 2009, a CT diagnostic scan of the brain and a right shoulder x-ray were unremarkable, with normal examination. Petitioner

was diagnosed with a shoulder contusion, neck abrasion and scalp hematoma. (Px6) Petitioner was discharged with referral for physical therapy. The Arbitrator notes petitioner underwent no additional treatment for his head hematoma.

On August 26, 2009, Dr. Simon of Concentra diagnosed petitioner with a right shoulder contusion/strain, cervical strain, scalp contusion and lower leg contusion. (Px1) Petitioner was again discharged with a referral for physical therapy for two weeks and placed on **[*28]** a light duty work restriction in the interim. (Px1)

The following day on August 27, 2009, Dr. Giacchino diagnosed petitioner with right shoulder derangement and cervical strain, without supporting objective findings. (Px2) Dr. Giacchino administered five epidural injections into petitioner's right shoulder and cervical spine, without indication as to the level/area and/or kind of injection. Dr. Giacchino authorized petitioner off of work and prescribed ongoing physical therapy and MRI studies. Petitioner remained under Dr. Giacchino's care through his full duty discharge in February 2010; however petitioner was referred to and concurrently received treatment from Dr. Nam for his right shoulder condition. (Px4)

The cervical MRI of September 3, 2009 demonstrated a herniated disc at C3-4. A right shoulder MRI of the same date showed acromioclavicular hypertrophy, with impingement and secondary tendinosis of the rotator cuff.

Dr. Nam diagnosed petitioner with a herniated disc of the cervical spine and right shoulder contusion of the AC joint, inflammation and impingement syndrome on October 20, 2009. (Px4)

On November 6, 2009, Dr. Malek diagnosed petitioner with a cervical musculoligamentous **[*29]** sprain with cervical radiculopathy and right shoulder injury. (Px5) Continued therapy was recommended, with consideration of a conditioning program. Thereafter, Dr. Malek instilled epidural cervical injections on three different occasions, with indication provided as to the cervical level only provided at the time of the third injection at C6-7 level. (Px5) Petitioner was discharged from his care, following complete resolution of his shoulder symptoms on December 30, 2009.

Dr. Wehner completed a Section 12 Examination on November 2, 2009, with a re-evaluation on April 26, 2010. (Rx5&6) In November 2009, Dr. Wehner diagnosed petitioner with a contusion to the head, shoulder and hand. (Rx5) She opined his radiographic finding were chronic in nature, and not caused by the accident nor did they correlate with the subjective complaints. Dr. Wehner opined petitioner could return to work full duty, reaching MMI. Notwithstanding Dr. Wehner's opinion, Dr. Giacchino continued to prescribe additional physical therapy and authorize the petitioner off of work through February 2010.

Several months later in April 2010, Dr. Wehner diagnosed petitioner with contusions and sprains to the head, shoulder **[*30]** and hand following her second Section 12 Examination. (Rx6) Dr. Wehner observed the shoulder and cervical condition had resolved. Dr. Wehner again opined Petitioner should have attained MMI by November 2, 2009. Petitioner's mild complaints of pain with neck range of motion were not related to the work injury, but rather causally connected to the normal degenerative process.

The Arbitrator finds petitioner attained MMI by November 2, 2009 for his right shoulder sprain and cervical sprain and other minor conditions, requiring only conservative care and 12 weeks of physical therapy. Petitioner was neither prescribed nor underwent surgical intervention to address any of his symptoms and/or conditions. In regard to petitioner's residual mild complaints of pain with neck range of motion, the Arbitrator finds said complaints are not causally related to the work injury, but rather attributable to the normal degenerative process as opined by Dr. Wehner. The Arbitrator soundly relies upon Dr. Wehner's medical opinions as a credible and sound expert witness, citing both objective diagnostic studies in conjunction with petitioner's subjective complaints and findings upon physical examination. **[*31]**

Based on the foregoing, the Arbitrator find the Petitioner sustained the loss of use of a man to the extent of 6% thereof and a loss of use of the right arm to the extent of 5% thereof.

In Support of the Arbitrator's decision relating to (J) whether the medical services that were provided to Petitioner medically reasonable and necessary, the Arbitrator finds the following:

Pursuant to Section 8(a) of the Act, Respondent's liability for medical care is limited to that which is necessary and reasonably required to cure or relieve the effects of the accidental injury. W.J. Newman Company vs. Industrial Commission, 353 Ill. 190, 187 N.E. 137 (1933). Evidence that proposed care would be of no benefit or unlikely to be of any benefit in curing or relieving the claimant's symptoms, will result in a denial of care on the basis is not necessary and reasonable. Pemble vs. Industrial Commission, 181 Ill.App.3d 409, 536 N.E.2d 1349 (1989).

The Commission has held consideration shall be given to objective findings in determining the necessity for medical care and whether it is reasonably required **[*32]** to cure or relieve from the effects of accidental injury. Village of Homewood v. Industrial Commission, 525 N.E.2d 990 (1988). Moreover, consideration shall be given to expert testimony in accordance with other evidence, with its weight determined by the character, capacity, skill and opportunities for observation and the nature of the case and its facts. Madison Mining Company v. Industrial Commission, 138 N.E. 211 (1923).

The Arbitrator notes under Subsection (a) of 8.7 of the Act, "[u]tilization review" is synonymous with 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

Presently, the Arbitrator notes the 3 **Utilization Reviews** submitted into evidence by Respondent and completed by EK Health were in accordance with URAC guidelines; **[*33]** as such the requirement for impartiality in evaluating proposed medical care in the context of evidence based guidelines was satisfied. 835 ILCS 305/8.7. Specifically, the UR EK Health evaluations were accomplished by identifying appropriate health care services based on standards of care and nationally recognized peer review guidelines, as well as, nationally recognized evidence based standards. Therefore, the opinions rendered in reliance of the same are inherently impartial and credible.

The Arbitrator further notes that these independent and unbiased UR reports were also in agreement with the Section 12 findings of Dr. Wehner. As noted above, Dr. Wehner opined an appropriate course of therapy would be 6 to 12 visits of physical therapy, transitioning to home exercise program at that point. The UR report of EK Health opined that only 6 physical therapy sessions were medical indicated. Furthermore, as indicated in both the UR reports and Dr. Wehner's findings, there was no documentation in the medical records of any progress secondary to the extensive physical therapy, prescribed by Dr. Giacchino through January 2010; hence no medical basis for the 78 physical therapy sessions, beyond **[*34]** the certified 6 visits can be gleaned.

The opinions of EK Health of September 16, 2009 opined that the right shoulder MRI and cervical MRI were not certified due to lack of documentation of instability or weakness tint he right shoulder and no cervical examination findings such as a Spurling's sign that might indicate discogenic or neuroforaminal compromise.

In regard to the various epidural injections administered, both the EK Health URs and Dr. Wehner could not find support for the same or indication of the type of injection within Petitioner's treatment records. Therefore, all epidurals are deemed medically inappropriate and non-certified with nationally accepted standards of care.

The Arbitrator questions the veracity of Petitioner's treating physician Dr. Giacchino's treatment recommendations in light of the sparse treatment records and minimal documentation of services rendered and/or Petitioner's progress with treatment. In particular, there are no treatment notes from Petitioner's consultations with Dr. Giacchino on September 30, 2009; October 5, 2009; October 13, 2009; and October 19, 2009; only off-work slips were generated on those occasions. The Arbitrator notes off-work **[*35]** slips without supporting documentation are insufficient to support a finding of necessity of prescribed medical care, if any care was rendered. (Px2)(Rx3) Moreover, the Arbitrator questions the credibility of Dr. Giacchino given his current license suspension for issuing numerous controlled substances to petitioner without therapeutic purposes and engaging in immoral conduct with the patient of his practice to include pre-dating prescriptions. The Arbitrator also notes Dr. Giacchino's license was previously suspended for over 2 1/2 years from June of 1987 through September of 1989.

There is also a question as to excessive charges for physical therapy with no medical records supporting the same as allegedly rendered at Melrose Park/River Grove Clinic. (Px2) Pursuant to the provider charges, Petitioner underwent physical therapy at Melrose Park from August 27, 2009 through December 28, 2009, incurring $ 17,760.00 in charges as of December 30, 2009. (Px2) On cross-examination, Petitioner denied therapy was rendered at both facilities; however the medical charges contradict Petitioner's testimony. Again, without supporting medical records, the alleged treatment is unsubstantiated and **[*36]** not reasonable or necessary.

Therefore, the Arbitrator awards only the medical bills found medically appropriate in accordance with the IME opinions of Dr. Wehner and the UR reports of EK Health. Therefore, the Arbitrator finds as follows regarding the medical bills offered into evidence as Petitioner's Exhibit # 7:

. Elmhurst Emergency Medical ($ 400.43). Per agreement of parties, paid in full by respondent per the medical fee schedule (R x 8)

. NR Anesthesia ($ 2,860.01) - denied as injections were not certified by EK Health and not found medically indicated by Dr. Wehner. (R x 1)

. Advantage MRI ($ 3,500.00) - denied based on UR opinion of EK Health. (R x 16).

. Dr. Nam ($ 897.00) - awarded per the Medical Fee schedule.

. Fullerton Surgery Center ($ 15,081.21) - denied based on opinions of EK Health and Dr. Wehner that injections were not medically indicated. (R x 1-6)

. Dr. Malek ($ 7,987.55) - denied based on opinions of EK Health and Dr. Wehner that injections were not medically indicated. (R x 1-6)

. Melrose Park/River Grove Clinic/Dr. Giacchino - the Arbitrator awards the office visit charges per the Fee Schedule for 8/27/09 ($ 279.10) and 8/29/09, 9/1/09, 9/4/09, **[*37]** 9/8/09, 9/10/09, 9/15/09, 9/21/09 and 9/25/09 ($ 205.44 per visit) or $ 1,922.62. The remainder of the bill is denied based on the fact that petitioner testified that he did not receive any physical therapy at Melrose Park Clinic or with Dr. Giacchino and that all physical therapy was rendered through Andersen Physical Therapy. Moreover, petitioner testified that when he was seen by Dr. Giacchino, he did not render any treatment, other that the injections given on two occasions, and will only conduct an examination and give him off work notes. The injections administered by Dr. Giacchino are denied based on the opinions of Dr. Wehner and the UR of EK Health that said injections were not medical indicated. (R x 1-6). Finally, the Arbitrator notes that Dr. Giacchino's office notes do not reflect that any treatment or physical therapy was rendered nor do they contain any evidence of a physical examination being conducted.

. Andersen Physical Therapy ($ 27,230.00) - the Arbitrator awards 6 visits noting

that Respondent paid for this treatment per an agreement of the parties and wards the respondent a credit for these payments of $ 1,372.24. The remainder of the bill is denied based on **[*38]** the UR opinion of EK Health and the opinions of Dr. Wehner that physical therapy of 6 visits was medically appropriate. Moreover, the arbitrator notes that 78 physical therapy visits is not reasonable and necessary.

Based on the foregoing, the arbitrator awards medical of Dr. Giacchino of $ 1,922.62 and Dr. Nam per the Medical Fee Schedule, but not to exceed $ 897.00. The remainder of the medical bills are denied.

In support of Arbitrator's findings in regard to (K), what amount, if any, is due for Temporary Total Disability Benefits, and (N) whether the Respondent is due any credit, the Arbitrator finds the following:

Petitioner was examined by Dr. Wehner on November 2, 2009 and found to be at maximum medical improvement and capable of working in a full duty capacity. Therefore, the Arbitrator finds petitioner was temporarily totally disable from the August 22, 2009 through November 2, 2009. The Arbitrator awards respondent a credit for all benefits paid $ 7,961.12 and any overpayment of TTD is to be credited against the PPD award.

Based on the foregoing, the Arbitrator finds petitioner entitled to TTD for 10 3/7 weeks from 8/22/09-11/2/09 and awards respondent [*39] a credit for any overpayment of TTD.

In Support of the Arbitrator's decision relating to (M), if penalties or fees should be imposed upon the respondent, the Arbitrator finds:

The Arbitrator finds Petitioner's Petition for penalties and fees is denied. Respondent has a good faith basis for denying liability for TTD subsequent to November 2, 2009, in accordance with the Section 12 Examinations of Dr. Wehner. (Rx5&6) Dr. Wehner opined petitioner had attained MMI on November 2, 2009 and could work in a full duty capacity. Respondent paid TTD for this time period.

Moreover, respondent had a good faith basis to dispute medical treatment based on the UR opinions of EK Health and the IME opinions of Dr. Wehner. (R x 1-6)

Under the Act, Section 19(k) Penalties and Section 16 Fees are imposed where there has been an unreasonable or vexatious delay in payment of compensation, or proceedings have been instituted by the employer which are frivolous or for purpose of delay. Boker v. Industrial Commission, 141 Ill.App.3d 51, 56 (3rd Dist., 1986). The award of penalties is discretionary. In fact, the Illinois Supreme Court, in McMahon v. Industrial Commission **[*40]** , noted that the imposition of Section 19(k) and 16 attorney fees requires a higher standard than an award of additional compensation under 19(1), 183 Ill.2d 499 (1998).

Here, TTD benefits ceased on November 2; 2009, when Petitioner was opined to have reached MMI and authorized to return to work fully duty, by Respondent's IME witness, Dr. Wehner. (Rx5&6) Thus, Respondent's actions have been neither vexatious or unreasonable. Furthermore, when an employer acts in reliance upon responsible medical opinion or when there are conflicting medical opinions, penalties are not ordinarily imposed. O'Neal Bros. Constr. Co. v. Industrial Comm'n. 93 Ill. 2d 30, 66 Ill. Dec. 334. 442 N.E.2d 895 (1982). Moreover in Mechanical Devices v. Industrial Commission, attorney's fees and costs to a claimant, pursuant to 820 ILCS 305/19(k), (1), and 820 ILCS 305/16 was properly denied where evidence was tendered that the employer reasonably relied on one medical expert's opinion that the claimant's condition was **[*41]** not causally related to his injury. 344 Ill. App. 3d 752, 279 Ill. Dec. 531,

800 N.E.2d 819 (4th Dist. 2003). The court found that the employer's conduct was not vexatious or unreasonable in the circumstances. Id.

Additionally, Section 8.7(j) of the Act provides that when a denial of payment is made by an employer that is supported by a **utilization review** program, there is a rebuttable presumption that the employer shall not be responsible for payment of additional compensation under Section 19(k).

Therefore in the case at bar, considering all evidence, the Arbitrator finds that Respondent's conduct was not unreasonable or vexatious. Respondent exercised its right to have Petitioner evaluated and relied on the opinion of their IME physician, Dr. Wehner. Furthermore, Respondent compensated Petitioner for all TTD and medical treatment found both medical appropriate and causally related.

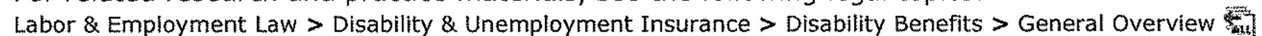
Based on the foregoing, the Arbitrator denies petitioner's petition for penalties and attorney's fees under Sections 19(k), 19(1), and Section 16 is denied.

DISSENTBY: KEVIN W. LAMBORN

DISSENT: I respectfully dissent from the decision of the majority. Arbitrator **[*42]** Lee's findings are both thorough and well reasoned. This decision is correct and should be affirmed in its entirety and without modification.

Legal Topics:

For related research and practice materials, see the following legal topics:



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