1 of 1 DOCUMENT

HECTOR FONTALVO, PETITIONER, v. FOOD TEAM, INC., RESPONDENT.

NO: 06WC 26500

ILLINOIS WORKERS' COMPENSATION COMMISSION

STATE OF ILLINOIS, COUNTY OF COOK

12 IWCC 565; 2012 Ill. Wrk. Comp. LEXIS 538

May 24, 2012

JUDGES: Mario Basurto; David L. Gore; Michael P. Latz

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

The Commission finds Petitioner's current cervical condition is causally related to the May 31, 2006 work accident. The Commission reached this decision based on a couple of different factors. One, the Commission notes that the parties stipulated on the Request for Hearing form that Petitioner was temporarily totally disabled from June 1, 2006 [*2] through October 22, 2009 for a total of 176-4/7 weeks. Pursuant to the Appellate Court's holding in *Walker v. Industrial Commission, 345 Ill. App. 3d 1084 (2004),* the Commission holds the parties and the Commission are bound by the previous stipulation and the Commission cannot ignore or change the stipulation entered into by the parties. Furthermore, any subsequent activities or lack thereof by the Commission and the parties has not negated the earlier stipulation of temporary total disability benefits entered into by the parties. Additionally, since there cannot be an award on an underlying benefit without first finding in favor of the threshold issue of causation, the Commission finds based on the stipulation that Petitioner's cervical condition is causally related to the May 31, 2006 work accident. Two, the Commission finds that while Petitioner had previously been deemed to be a candidate for cervical surgery, Petitioner was able to continue working after such a recommendation was made, Petitioner had not received medical treatment for his cervical condition for approximately 2-1/2 years leading up to the May 31, 2006 work accident and it was only [*3] after conservative treatment had failed to relieve Petitioner of his pain post accident that Petitioner was once again deemed to be a candidate for surgery. As such the Commission finds that the chain of events shows, regardless of the prior recommendations for cervical surgery, Petitioner was able to function in a work environment and was not receiving medical care for his cervical condition for a significant period leading up to the May 31, 2006 accident and it was only after the failure of the conservative treatment that Petitioner once again was in need of cervical surgery. For these reasons, the Commission finds that Petitioner's cervical condition and/or need for future medical care is causally related to the May 31, 2006 work accident and Respondent is ordered to pay $ 5,766.74 in current medical expenses and all causally related and reasonable and necessary medical expenses related to the recommenced two level cervical surgery. Additionally, the Commission finds Petitioner was temporarily totally disabled from June 1, 2006 through May 4, 2011 for 256-4/7 weeks at minimum temporary total disability rate of $ 225.32 for a married male with two dependents.

IT IS THEREFORE ORDERED [*4] BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $ 225.32 per week for a period of 256-4/7 weeks, that being the period of temporary total incapacity for work under § 8(b), and that as provided in § 19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $ 5,766.74 for current medical expenses and Respondent is ordered to pay all causally related and reasonable and necessary medical expenses related to the recommenced two level cervical surgery under § 8(a) of the Act.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent [*5] pay to Petitioner interest under § 19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit in the amount of $ 35,790.11 paid 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 $ 27,900.00. The probable cost of the record to be filed as return to Summons is the sum of $ 35.00, payable to the Illinois Workers' Compensation Commission in the form of cash, check or money order therefor and deposited with the Office of the Secretary of the Commission.

ATTACHMENT:

ARBITRATION DECISION

19(b)

Hector Fontalvo
Employee/Petitioner

v.

Food Team, Inc.
Employer/Respondent

Case # 06WCO26500

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Richard A. Peterson**, Arbitrator of the Commission, in the city of **Chicago,** on **May 4, 2011**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this [*6] document.

DISPUTED ISSUES

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

J. [X] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

L. [X] What temporary benefits are in dispute?
[X]Maintenance [X] TTD

N. [X] Is Respondent due any credit?

FINDINGS

On the date of accident, **May 31, 2006**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$ 2,292.25**; the average weekly wage was **$ 199.32**.

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

Respondent ***has*** paid all reasonable and necessary [*7] charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$ 35,290.11** for TTD, **$ -0-** for TPD, **$ -0-** for maintenance, and **$ 500.00** for other benefits, for a total credit of **$ 35,790.11**.

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

ORDER

The Arbitrator concludes that Petitioner has failed to meet his burden of proving that his current condition of cervical and/or right shoulder ill-being is causally related to his work-related injury of May 31, 2006. Therefore, all other issues in this case are moot and no benefits are awarded.

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

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision* [*8] *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.

August 23, 2011

Date

FINDINGS OF FACT

THE ACCIDENT

The petitioner testified that he was employed as a waiter at Glenview High School. His duties consisted of picking up trays, dishes and food, and delivering these items to and from the kitchen.

On May 31, 2006, he was retrieving a box of milk out of a walk-in refrigerator. The box weighed approximately 35 pounds. As he was exiting the walk-in refrigerator, he slipped and fell. He testified that he experienced immediate pain in his upper and lower back and both shoulders.

The petitioner was taken to the emergency room at Evanston Hospital. He complained of injuries to his head, neck, left shoulder, left arm and ribs. A CT Scan of the cervical spine was performed which identified "moderated disc and

osteophyte complex" at C5-C6 with mild central spinal stenosis. An MRI was also taken which was interpreted to be negative, down to the level of C5.

PREVIOUS INJURIES/TREATMENT

The petitioner admitted-- and the medical [*9] records corroborate -- the fact that the petitioner has had a longstanding problem with his cervical spine. The petitioner's primary treating physician is Dr. Geri Gireesan. Dr. Gireesan's records were introduced into evidence as petitioner's exhibit # 3. The petitioner's testimony (and the records), establishes that the petitioner saw Dr. Gireesan on October 22, 1998 at which time he complained of neck pain due to a work-related accident. On April 26, 1999, an MRI was performed of the petitioner's cervical spine which revealed a herniated disc at C5-C6.

On April 29, 1999, Dr. Gireesan prescribed an epidural and stated that if the petitioner did not get relief from the injection, he would be a candidate for surgery to include an anterior cervical discectomy and interbody fusion. On June 3, 1999, the previously described surgery was discussed after the first injection provided only limited relief. On November 2, 1999, Dr. Gireesan noted that surgery is "required".

On June 8, 2000 the petitioner reported to Dr. Gireesan that he had sustained another work-related accident that aggravated his neck. On July 1, 2000, a second cervical MRI was performed. The herniation at C5-C6 was once [*10] again visualized but appeared to be slightly larger.

On November 25, 2002, the petitioner saw Dr. Gireesan and reported a third work-related accident. He complained of severe pain in his neck at that time. On January 24, 2003, another cervical MRI was performed. The herniated disc at C5-C6 was once again identified along with end plate spurring and facet arthritis causing moderate canal stenosis. On March 24, 2003, Dr. Gireesan again discussed the proposed surgery with the petitioner. On May 28, 2003, Dr. Gireesan took the petitioner off of work due to neck pain. He had been working light duty up until that point.

On August 11, 2003 Dr. Gireesan again discussed surgery with the petitioner and indicated that his office would seek approval or same from the insurance company. On December 8, 2003, Dr. Gireesan noted that the petitioner needed the surgery. The petitioner had returned to work on a light duty basis, however, his employer eventually put him to work in a heavy duty capacity and the petitioner "had to terminate his occupation".

POST INJURY MEDICAL TREATMENT-CERVICAL

Following his visit to the emergency room, the petitioner again returned to see Dr. Gireesan. On June 5, 2006, [*11] the petitioner informed Dr. Gireesan that he had experienced another work-related injury on May 31, 2006. The doctor diagnosed the petitioner with "discogenic neck pain" and a possible rotator cuff injury.

On July 17, 2006, Dr. Gireesan reviewed the CT Scan from Evanston Hospital taken on May 31, 2006 and concluded that it was "normal". His diagnosis regarding petitioner's neck was once again "discogenic neck pain".

On August 21, 2006, yet another MRI of the cervical spine was performed. A disc "bulge" was identified at C5-C6 with some stenosis, along with other modest findings. On September 5, 2006, Dr. Gireesan reported that the petitioner was suffering from "intervertebral disorder" at C5-C6 with bilateral stenosis. There is no mention made of any surgery.

On November 6, 2006, Dr. Gireesan noted that the petitioner's neck pain was improving with surgical traction and physical therapy. On December 18, 2006, Dr. Gireesan recommended epidural injections and noted that if the injections did not relieve petitioner's pain, surgery consisting of an anterior surgical discectomy and interbody fusion would be scheduled.

On July 26, 2007, the petitioner advised Dr. Gireesan that he would [*12] like to have surgery. On February 19, 2008, yet another cervical MR1 was performed. The radiologist's notes indicate that there were no significant changes since the August 2006 MRI. The findings at C5-C6 were described at as "persistent degenerative disc disease".

POST ACCIDENT TREATMENT-RIGHT SHOULDER

Dr. Gireesan referred the petitioner to Dr. Stephen Gryzlo for diagnosis and treatment of petitioner's right shoulder. The petitioner saw Dr. Gryzlo for the first time on October 30, 2006. He diagnosed the petitioner with a right partial rotator cuff tear. He initially prescribed physical therapy and injected the shoulder.

Eventually, Dr. Gryzlo found it necessary to perform surgery on the petitioner's shoulder. On December 2, 2008, Dr. Gryzlo performed a right shoulder arthoscopy, debridement and decompression. The petitioner continued to follow-up with Dr. Gryzlo following his shoulder surgery. He last saw Dr. Gryzlo on October 5, 2009. At that time, the petitioner reported that he had some pain in his shoulder. The doctor noted that the petitioner's discomfort was probably related to some mild weakness. He suggested that the petitioner return to physical therapy for a short period. [*13] The doctor noted that the petitioner was "reasonably pleased" and that he would see the petitioner back after completion of his physical therapy.

The petitioner, however, never went to physical therapy and never returned to see Dr. Gryzlo. The petitioner did not make any attempts to seek any additional treatment to his shoulder until March of 2011. At that time, he attempted to return to Dr. Gryzlo, however, his visit was not authorized by respondent's insurance company and petitioner has thus not been able to see Dr. Gryzlo.

RESPONDENT'S IMEs

Dr. Kathleen Weber

The petitioner was examined by Dr. Weber on December 19, 2007. Her report was introduced into evidence as petitioner's Exhibit # 12. Dr. Weber's opined that if the petitioner's right shoulder symptoms persisted, arthroscopic debridement with a possible rotator cuff repair maybe appropriate. The doctor also concluded that the petitioner's subjective complaints regarding his cervical spine were inconsistent with the MRI taken on August 21, 2006.

Despite the fact that the doctor did not have Dr. Gireesan's records that pre-dated the accident at issue, Dr. Weber gave the opinion that petitioner must have had a pre-existing problem [*14] with his cervical spine. It was her opinion that petitioner sustained an aggravation of a pre-existing problem which had resolved. The doctor also concluded that the petitioner demonstrated significant Waddell signs and inconsistent patterns of motor strength and sensation. Finally, Dr. Weber opined that the petitioner had reached maximum medical improvement in regards to his cervical spine.

Dr. Boone Brackett

Dr. Brackett examined the petitioner on December 5, 2006. His report was introduced into evidence as petitioner's Exhibit # 11. Dr. Brackett expressly stated in his report that the petitioner had "...No prior history of any pre-existing conditions or prior injuries". He thus concluded that there appeared to be a causal relationship between the fall of May 31, 2006 and the petitioner's current complaints. Based upon his evaluation, the doctor also felt that the petitioner may need to undergo surgery consisting of an anterior cervical discectomy and fusion at the C5-6 level.

Dr. Brackett prepared a supplemental report dated November 9, 2009. This reported was introduced into evidence as petitioner's Exhibit # 11. Dr. Brackett had been asked to review Dr. Gireesan's records dating [*15] back to the late 1990s. Upon review of the records, the doctor commented that the petitioner's cervical degeneration/herniation at C5-C6 dated back to at least April of 1999. He also offered the opinion that the incident of May 31, 2006 was "not in any way causative or aggravatory of his pre-existing condition of cervical arthrosis/herniated disc at C5-C6." Finally, Dr. Brackett made it clear that there was no evidence that the injuries at issue were either the cause of or an aggravation of petitioner's cervical condition.

DR. GIREESAN'S DEPOSITION

Dr. Gireesan testified that it was his opinion that the injury at issue aggravated petitioner's pre-existing condition and that petitioner's current state of ill-being is related to that aggravation (PetEx2,p37). However, the doctor admitted that he treated the petitioner in April, 1999, and diagnosed a herniated disc at C5-C6 level. (PetEx2,p8) He noted, at that time, that, if an epidural did not provide relief to the petitioner, he would be a candidate for surgery to include an anterior cervical discectomy and interbody fusion. (PetEx2,p39) That surgery was "...the same exact procedure that you (Dr. Gireesan) are recommending now..." [*16] (PetEx2,p39)

The doctor also testified that on October 2, 1999, he felt that the petitioner needed the previously referenced surgery. (PetEx2,p39) Dr. Gireesan testified that on July 18, 2000, he again diagnosed Petitioner with a herniated disc ant C5-C6 and gave him 2 options of cervical epidural injections or cervical surgery. (PetEx2,p12) The doctor also testified that on March 24, 2003, he once again indicated that the proposed surgery was necessary. (PetEx2,p13) In fact, the doctor felt that in addition to the discectomy and fusion at C5-C6, it may be necessary to fuse C6 and C7 as well (PetEx2,p43).

The doctor again recommended the same surgery on August 11, 2003, (PetEx2,p43). Also, on December 8, 2003, the doctor recommended the exact same surgery due to the fact that the petitioner reported that he was in too much pain to work and had to quit his job. (transcript at pg. 44).

The doctor admitted that as of December 8, 2003, he believed that the petitioner needed surgery at C5-C6 consisting of a discectomy and interbody fusion. The doctor also testified that he next saw the petitioner on June 5, 2006 at which time petitioner reported the May 31, 2006 accident. (PetEx2,p44). [*17] The doctor acknowledged reviewing the CT scan from the hospital that was taken on May 31, 2006. The doctor testified that he believed that the CT scan was normal (transcript at pg. 45-46).

The doctor admitted that after reviewing the CT scan that had been performed on May 31, 2006, his diagnosis was discogenic neck pain and not a herniated disc. (PetEx2,p46-47). The doctor did not recommend surgery when he saw the petitioner on June 5, 2006 (PetEx2,p48).

Dr. Gireesan admitted that he ordered another MRT of the cervical spine which was performed on August 21, 2006 (PetEx2,p49). Dr. Gireesan admitted that when he saw the petitioner following the MRI, on September 5, 2006, he did not recommend surgery. (PetEx2,p51). The doctor testified that the petitioner was doing "reasonably well" on September 5, 2006 and that he did not require surgery at that time (PetEx2,p52). The doctor also admitted when he saw the petitioner on November 6, 2006, the petitioner told him that he was improving (PetEx2,p53).

Most importantly, the doctor admitted that the petitioner's condition as of November 6, 2006 was better than it was on December 8, 2003 (PetEx2,p53). In addition, Dr. Gireesan admitted that [*18] MRIs of the cervical spine taken on February 19, 2008 and June 30, 2009 were basically the same as the MRI of August, 2006.

Dr. Gireesan admitted that the surgery he is currently recommending is the exact same procedure he recommended a number of times prior to the May 31, 2006 accident (Petx2,p57-58). Also, Dr. Gireesan admitted that when he looks at all of the films, he cannot point to anything and identify an objective change that he believes resulted as a consequence of the May 31, 2006 accident (PetEx2.p59-60). Therefore, Dr. Gireesan admitted that he is primarily making his current recommendation for surgery based upon the petitioner's subjective complaints (PetEx2.p60). Yet the doctor admitted that when he saw the petitioner the last time before the May 31, 2006 accident (in December, 2003) petitioner was complaining of significant symptoms and the doctor wanted to perform surgery at that time (PetEx2,p61). Yet the doctor did not recommend surgery on June 5, 2006, July 17, 2006, August 21, 2006, September 5, 2006 or November 6, 2006.

Based on the evidence in the record, the Arbitrator finds that Petitioner was not a credible witness at trial. He admitted to creating a false [*19] document to give to his landlord in Indianapolis in order to secure a lease. The document represented that the petitioner was employed by a construction company. The petitioner testified that he was not so employed but simply produced the document in order to obtain a lease.

CONCLUSIONS OF LAW

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO F, IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR CONCLUDES AS FOLLOWS:

Dr. Bracken's initial report dated December 14, 2006, makes it clear, however, that he believed that the petitioner had "no prior history or any pre-existing conditions or prior injuries". Dr. Bracken's supplemental report dated November 9, 2009 makes it crystal clear that Dr. Bracken does not believe that the petitioner's current cervical problems were in any way caused or aggravated by the event of May 31, 2006.

In addition, Dr. Weber believed that the petitioner's cervical problems were pre-existing. She believed that the petitioner may have sustained an aggravation of his pre-existing problem but it had resolved. Dr. Weber did not feel that any further treatment to the cervical spine was necessary at the time of [*20] her examination.

Dr. Dr. Gireesan opined that the accident aggravated petitioner's pre-existing cervical condition to the extent that surgery is now necessary. However, Dr. Gireesan's detailed testimony concerning the objective factors of Petitioner's injury removes any credibility of that opinion. Dr. Gireesan testified that on April, 1999, he diagnosed Petitioner with a herniated disc at C5-C6 level. (PetEx2,p8) He noted, at that time, that, if an epidural did not provide relief to the petitioner, he would be a candidate for surgery to include an anterior cervical discectomy and interbody fusion. (PetEx2,p39) That surgery was "...the same exact procedure that you (Dr. Gireesan) are recommending now..." (PetEx2,p39) Dr. Gireesan testified that on July 18, 2000, he again recommended the exact same surgery.

(PetEx2,p12)On March 24, 2003, he again recommended that exactly the same surgery was necessary. (PetEx2,p13) Dr. Gireesan testified that there has been no objective change in Petitioner's physical condition since Dr. Gireesan recommendation on March 24, 2003, of the surgery which is also now being recommended. Dr. Gireesan acknowledged that the only change has been in Petitioner's [*21] complaints. It could be from a change in Petitioner's physical condition; that would be a causal relationship. Dr. Gireesan, however, expressly testified that there had been no such objective change. It could be from a loss of patience by Petitioner, it could be from Petitioner no longer being optimistic that it would improve on its own, it could be from Petitioner becoming less able to live with the same level of pain or it could even be from Petitioner developing a secondary gain incentive. None of those possibilities would be a causal connection to his May 31, 2006, work related accident.Dr. Gireesan's detailed factual testimony destroys any credibility of his opinion of causal connection. It also provides support and gives credibility to the December 19, 2007, opinion of Dr. Weber. She opined that the petitioner's subjective complaints regarding his cervical spine were inconsistent with the MRI taken on August 21, 2006, and gave the opinion that petitioner must have had a preexisting problem with his cervical spine. It was her opinion that petitioner sustained an aggravation of a preexisting problem which had resolved. The doctor also concluded that the petitioner demonstrated [*22] significant Waddell signs, and inconsistent patterns of motor strength and sensation. Finally, Dr. Weber opined that the petitioner had reached maximum medical improvement in regards to his cervical spine.

Based on the foregoing, the Arbitrator concludes that Petitioner has failed to meet his burden of proving that his current condition of cervical ill-being is causally related to his work-related injury of May 31, 2006.

As for the petitioner's right shoulder, petitioner last saw Dr. Gryzlo on October 5, 2009. At that time, he was told to undergo additional physical therapy. Petitioner chose to not do so. The petitioner then made no attempt whatsoever to seek any treatment of any kind for his right shoulder until March, 2011, approximately 18 months later. His efforts to seek additional treatment appeared to correspond to the scheduling of the hearing in this matter. Petitioner's removal of himself from treatment and not seeking treatment for 18 months destroys any credibility in any attempt to argue that his current condition of shoulder ill-being is causally related. Based on the foregoing, the Arbitrator concludes that Petitioner has failed to meet his burden of proving that his [*23] current condition of Based on the foregoing, the Arbitrator concludes that Petitioner has failed to meet his burden of proving that his current condition of right shoulder ill-being is causally related to his work-related injury of May 31, 2006.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING ALL OTHER ISSUES IN THIS CASE, THE ARBITRATOR CONCLUDES AS FOLLOWS:

The Arbitrator concluded above that Petitioner has failed to meet his burden of proving that his current condition of cervical and/or right shoulder ill-being is causally related to his work-related injury of May 31, 2006. Therefore, all other issues in this case are moot.

Legal Topics:

For related research and practice materials, see the following legal topics:
Workers' Compensation & SSDIAdministrative ProceedingsClaimsTime LimitationsNotice PeriodsWorkers' Compensation & SSDICompensabilityCourse of EmploymentGeneral OverviewWorkers' Compensation & SSDICompensabilityInjuriesNormal Exertion

C

04 I.I.C. 0614, 01 IL.W.C. 34521, 2004 WL 2579306 (Ill.Indus.Com'n)

Industrial Commission of Illinois
State of Illinois
County of Will

DAVID HIR, Petitioner,
v.
CITY OF JOLIET, Respondent.

No. 01 W.C. 34521, No. 04 I.I.C. 0614

September 17, 2004

DECISION AND OPINION ON REVIEW

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

After considering the entire record, the Commission modifies the Decision of the Arbitrator by finding that Petitioner is entitled to Section 19(k) penalties in the amount of $18,479.16, which represents 50% of the awarded unpaid temporary total disability benefits totaling $36,958.36. The Commission finds this award to be consistent with the Arbitrator's conclusion that Petitioner's violation of Respondent's residency requirement did not provide Respondent with a permissible basis for suspending the payment of benefits. This award is also consistent with Respondent's refusal to accommodate the light duty restrictions imposed by both Petitioner's physician, Dr. DePhillips, and its own examiner, Dr. Mather. Respondent argued that it acted reasonably because it suspended TTD in response to an order issued by the Board of Fire and Police Commissioners. Respondent failed, however, to support this argument with either statutory or case law. The Commission declines to award additional Section 16 fees equivalent to 20% of the awarded 19(k) penalties because this would constitute an impermissible award of penalties

on penalties under Scott v. Industrial Commission, 184 Ill.2d 202, 211 (1998). The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $706.67 per week for a period of 121.57 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $908.10 for medical expenses under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner additional compensation of $18,479.16 as provided in §19(k) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner additional compensation of $2,500.00 as provided in §19(l) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to the attorney for the Petitioner legal fees in the amount of $7,391.66 as provided in §16 of the Act; the balance of attorneys' fees to be paid by Petitioner to his/her attorney.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired 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 Industrial Commission of Illinois in the form of cash, check or money order therefor and deposited with the Office of the Secretary of the Commission.

Susan O. Pigott

Paul W. Rink

David R. Akemann

Attachment 1

NOTICE OF 19(b) DECISION OF ARBITRATOR

David Hir, Employee/Petitioner

v.

City of Joliet, Employer/Respondent

Case No. 01 WC 34521

On December 17, 2003, an arbitration decision on this case was filed with the Illinois Industrial Commission in Chicago, a copy of which is enclosed.

In no instance shall this award be a bar to subsequent hearings and determination of additional benefits.

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

Attachment 2

STATE OF ILLINOIS

COUNTY OF WILL

19(b) ARBITRATION DECISION

DAVID HIR, Employee/Petitioner

v.

CITY OF JOLIET, Employer/Respondent

Case No. 01 WC 34521

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 Leo Hennessy, arbitrator of the Industrial Commission, in the city of Joliet, on September 11, 2003. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues circled below, and attaches those findings to this document.

DISPUTED ISSUES

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: Vocational Rehabilitation

FINDINGS
On May 13, 2001, the respondent City of Joliet *was* operating under and subject to the provisions of the Act.
On this date, an employee-employer relationship *did* exist between the petitioner and respondent.
On this date, the petitioner *did* sustain injuries that arose out of and in the course of employment.
Timely notice of this accident *was* given to the respondent.
In the year preceding the injury, the petitioner earned $55,120.00; the average weekly wage was $1,060.00.
At the time of injury, the petitioner was 29 years of age, *married* with four children under 18.
Necessary medical services *have* been provided by the respondent. (IN PART)
To date, $48,952.57 has been paid by the respondent on account of this injury.

ORDER

The respondent shall pay the petitioner Temporary Total Disability benefits of $706.67/week for 121-4/7 weeks, from May 14, 2001 through September 11, 2003, 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 $ 908.10 for medical services, as provided in Section 8(a) of the Act.

The respondent shall pay $2,500.00 in penalties, as provided in Section 19(l) of the Act.

The respondent shall pay $7,391.66 in attorneys' fees, as provided in Section 16 of the Act, with the balance of Petitioner's attorneys fees to be paid by Petitioner to his attorneys.

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

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest of 0.98% 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.

Date December 13, 2003

Illegible signature
Signature of arbitrator

Date filed: ??(it,ibd,d112404)

With reference to (F) (causal connection), the Arbitrator finds as follows:
Petitioner DAVID HIR was a 29-year old police officer employed by Respondent CITY OF JOLIET. His past medical history includes two minor low back strains as a member of his high school football team in the late 1980s. On those occasions, he received a few weeks of chiropractic treatment and missed a few team practice sessions. Thereafter, he experienced no symptoms, injuries or medical treatment with reference to his low back until May 13, 2001.

Petitioner was hired by the City of Joliet in 1996. He attended twelve weeks of training, passed a pre-employment physical examination and completed a state physical fitness test. In September 1996, he received certification as a law enforcement officer.

Petitioner's job duties as a police officer included enforcing laws and affecting arrests. In the performance of his work, he was required to physically subdue perpetrators, fight with subjects, kick in doors, climb fences and engage in foot chases. He often had to quickly enter and exit a patrol vehicle, and he received physical training on a regular basis.

On May 13, 2001, while responding to a violent domestic disturbance, Petitioner was attempting to arrest a male suspect. After maneuvering the suspect onto a couch, Mr. Hir stood over the man and attempted to gain physical control of him. At that moment, the suspect's wife, who stood nearly six feet tall and weighed between 275 and three hundred pounds, jumped onto Mr. Hir's back, then kicked him several times in the low back. Petitioner felt a pop in his low back, which began to tighten up.

Ultimately, Mr. Hir and two other officers were able to subdue and handcuff on the female suspect and complete their assignment. Later that day, he notified his supervisor, Sergeant MacDonald, of the incident and completed an on-duty injury report relating to his back injury.

On May 14, 2001. Petitioner contacted Health Service Systems and scheduled an appointment for the following day with Dr. Maimoona Aijaz. On May 15, 2001, he saw Dr. Aijaz. He described the events of May 13, 2001 and complained of soreness in his back with occasional radiating pain down the right leg. Dr. Aijaz diagnosed musculoskeletal low back pain and prescribed physical therapy, medication and heat packs. She advised the patient to refrain from work and instructed him to return to the clinic in one to two weeks (PX 3).

Petitioner chose Dr. Ted Cook, a chiropractor, as his second treating physician. Dr. Cook treated the patient chiropractically from May 18 through June 15, 2001 (PX 5). Plain X-rays of the lumbar spine on May 21, 2001 at St. Joseph Hospital revealed bilateral spondylolysis at L4, with a mild Grade One

spondylolisthesis with L4 positioned five millimeters anterior to L5. Mild anterior wedging was seen at T10, T11 and T12 compatible with mild fracture deformities. A bone scan on the same date demonstrated abnormal increased activity at the left L4-5 spondylolysis suggesting active bone deposition. Increased activity was also seen at the lower thoracic spine. The nuclear radiologist, Dr. Gregory P. Jackson, suggested clinical correlation to rule out acute vertebral fractures (PX 4).

On May 26, 2001, Dr. Cook referred the patient to Dr. Mukund Komanduri, an orthopedic surgeon (PX 5). Dr. Komanduri first saw Petitioner on June 1, 2001. On physical examination, the patient had discomfort on full extension of the lumbar spine. The straight leg raising test was positive at fifty degrees bilaterally with radiating pain down both legs. Dr. Komanduri reviewed the radiographs and bone scan and diagnosed a spondylolytic fracture with radicular complaints secondary to traumatic injury. He prescribed a hard, plastic thoracolumbar spinal orthosis (TLSO) for stabilization (PX 8; PX 9). On June 4, 2001, Dr. Komanduri ordered a lumbar MRI, which revealed a dehydrated disc at L4-5 with facet arthritis bilaterally at L4-5, more so on the left (PX 4).

Petitioner returned to Dr. Cook, who referred him to Dr. George DePhillips, a neurosurgeon. On June 12, 2001, Dr. DePhillips prescribed a series of epidural steroid (ESI) injections and advised the patient to continue wearing the TLSO brace for eight weeks, followed by physical therapy for lower back strengthening (PX 10; PX 16 at 9-14. Dep. Exh. 2). Were conservative treatment to fail, the doctor opined that Mr. Hir might be a candidate for lumbar spinal fusion (PX 10).

Following the first ESI, no relief was obtained. Before considering surgery, Dr. DePhillips on July 12, 2001 recommended a second neurosurgical opinion (PX 10). Petitioner returned to Dr. Cook, who ordered a lumbar CT scan on July 11, 2001 and referred him to Dr. Daniel Harrison (PX 12). The CT scan revealed pars defects at L5. The radiologist, Dr. M. Buchler, opined that the traumatic incident re-injured existing spondylolytic pars fractures at that level (PX 7).

Petitioner saw Dr. Harrison on July 23, 2001. On review of diagnostic films, Dr. Harrison diagnosed an L4 pars fracture. The doctor was "skeptical that he is going to get significantly better" with conservative treatment. He discussed with Mr. Hir the possibility of lumbar spinal fusion with instrumentation. However, before considering surgery, Dr. Harrison recommended a repeat MRI, which took place on July 25, 2001. The MRI revealed bulging and degenerative changes at L4-5 and L5-S1. Decreased signal was observed at T11-12, T12-L1 and L4-5 secondary to desiccation (PX 12).

Dr. Harrison saw Petitioner again on August 8, 2001. He prescribed a myelogram followed by potential surgical intervention, which would involve nerve decompression at the neuroforaminal level and probable spinal fusion with instrumentation (PX 12).

Petitioner returned to Dr. DePhillips on September 7, 2001. The patient indicated that he did not desire surgery and would instead attempt to live with his pain. Dr. DePhillips "declared maximum medical improvement" and ordered a functional capacity evaluation, which was performed on September 19, 2001 at the Athletic and Therapeutic Institute. The patient's lifting abilities ranged from nineteen to 36 pounds. His workday tolerance was no more than six hours, and frequent lifting was not recommended.

The therapist, Gregory F. Steil, found that the FCE results were valid, and that the patient's abilities did "not meet the demands" of a police officer. Return to work as a police officer was "not recommended" (PX 10).

Petitioner saw Dr. DePhillips on September 21, 2001. He reiterated his decision to forego spinal fusion, electing instead to live with his pain. Dr. DePhillips discharged him from care within the restrictions imposed by the FCE; viz., occasional lifting up to 35 pounds, no frequent lifting, sitting no more than 45 minutes, standing no more than thirty minutes, and only minimal bending, stooping, squatting and crouching. "If the patient's symptoms worsen in the future," reported Dr. DePhillips, "he will return to see me at which time we will consider a spinal fusion and decompression" (PX 10).

Dr. Stephen Mather, an orthopedic surgeon, examined Petitioner at Respondent's request on July 2, 2002. Physical examination revealed tenderness at L4-5. Range of motion of the low back was diminished on both flexion and extension, with central back pain radiating down the right L4 dermatomal distribution. A positive femoral stretch with low back pain was round on the right. The patient ambulated with a slight limp due to low back pain radiating to the right posterior hip. Review of diagnostic studies revealed spondylolysis with pseudoarthrosis material around the bilateral L4 nerve root (PX 13). Dr. Mather opined as follows:
Mr. Hir sustained a legitimate work-related injury on May 13, 2001. His back history is "clean." The patient had a pre-existing condition that was aggravated by the work injury, which resulted in some annular tears and bulging of the L4-5 disc, as well as disruption of the pseudoarthrosis material causing his back and right leg pain.
I strongly recommend spinal fusion for this patient. I do not recommend any conservative treatment. He is going to require laminectomy, posterior fusion at L4-5, interbody fusion at L4-5 with a cage, and instrumentation. I believe a posterolateral fusion alone with laminectomy is probably not going to make his back pain significantly better because of his large size, and there would be the probable need to "redo" the surgery as posterolateral fusion in this type of individual typically does not heal well even with instrumentation unless combines with a cage procedure.
(PX 13). Before considering surgery, Dr. Mather recommended lumbar discography to ascertain objectively whether Petitioner's spondylolysis and disc bulging represent the source of his symptoms. In the event Petitioner elected to forego the recommended cage fusion, Dr. Mather would find that he has reached maximum medical improvement. In that event, Dr. Mather would impose permanent work restrictions on the patient more severe than those set forth in the FCE. Dr. Mather suggested light duty, six hours per day, with no lifting in excess of fifteen pounds (PX 13). Because Petitioner was referred to Dr. Mather by Respondent, the doctor's findings, opinions and conclusions constitute admissions attributable to Respondent under the agency doctrine announced by our Supreme Court in Nollau Nurseries, Inc. v. Industrial Comm'n, 32 Ill.2d 190, 204 N.E.2d 745 (1965) and Keystone Steel & Wire Co. v. Industrial Comm'n, 42 Ill.2d 273, 246 N.E.2d 228 (1969).

Dr. DePhillips stated that in his opinion, the injuries sustained on May 13, 2001 exacerbated a pre-existing but asymptomatic spondylolysis at L4-5, causing it to become symptomatic (PX 16 at dep. Exh. 2). The doctor explained that spondylolysis is a disruption of the pars interarticularis - the bony attachment between two vertebrae. Mr. Hir likely had an old pars fracture at L4 with pseudoarthrosis, or

incomplete healing. When the female suspect jumped on his back on May 13, 2001, it created a compressive load on the lumbar spine that caused an exacerbation of the pre-existing condition and rendered it symptomatic (PX 16 at 1-14). According to Dr. DePhillips, the injuries are permanent in nature, and Petitioner will suffer chronic pain as a result of the injury, which has rendered him permanently partially disabled (PX 16 at Dep. Exh. 2).

Based upon the records and reports of Drs. Aijaz, Cook, Komanduri, Harrison and Mather, the records, reports and testimony of Dr. DePhillips, and the testimony of Petitioner, the Arbitrator finds that Petitioner's current condition of ill-being is in all respects causally related to the injuries he sustained on May 13, 2001.

With reference to (J) (medical expenses), the Arbitrator finds as follows:
The following unpaid medical bills were admitted in evidence:

Exhibit	Provider	Date(s)	Purpose	Amount
PX 1	Dr. Aijaz	05-15-01	office visit (balance due)	$46.84
PX 2	RS Medical	06-29-01 to 03-28-02	TENS unit and supplies	$861.26
Total unpaid medical bills:				$908.10

The Arbitrator finds that these expenses were reasonable, necessary and causally related to the injuries sustained. Respondent shall pay the sum of $908.10 for reimbursement of unpaid medical expenses.

With reference to (K) (TTD) and (N) (vocational rehabilitation), the Arbitrator finds as follows:
The parties stipulated on the Request for Hearing that Petitioner was temporarily totally disabled from May 14, 2001 through January 2002. Petitioner's eligibility for TTD from January 2002 to present remains in dispute.

Petitioner began losing time from work on May 14, 2001. On May 15, 2001, he saw Dr. Aijaz, who advised him to refrain from work (PX 3). He then came under the care of Dr. Cook, who referred him to Drs. Komanduri and DePhillips, both of whom were of the opinion that Petitioner was unable to return to work as a police officer (PX 5; PX 8; PX 9; PX 10; PX 16 at 17, Dep. Exh. 2). On September 21, 2001. Dr. DePhillips released the patient to return to work within the restrictions imposed by the FCE, which precluded performance of the full duties of a police officer (PX 16 at 25-26, Dep. Exh. 2). Dr. Mather, the spinal surgeon retained by Respondent, opined on July 2, 2002 that Petitioner should be placed on work restrictions even more severe than those imposed by the FCE; viz., light duty for six hours per day with no lifting in excess of fifteen pounds (PX 13).

Following the September 19, 2001 FCE, Petitioner received a telephone call from Kathy Grossklaus, timekeeper for the City of Joliet inquiring about his off-work status. Mr. Hir advised that Dr. DePhillips had released him to return to work with restrictions, and he requested that the city furnish light work

within the restrictions set forth by Dr. DePhillips. Grossklaus requested the restrictions in writing, and Petitioner agreed to have Dr. DePhillips fax them to Grossklaus. Petitioner testified that Dr. DePhillips did fax the written restrictions to the city timekeeper. However, no offer of light work was ever made by Respondent.

Petitioner received weekly compensation benefits from Respondent through approximately August 8, 2002, following which his TTD benefits were suspended without notice or explanation. He telephoned Respondent's timekeeper, who informed him that he had been "suspended without pay." The timekeeper referred him to Deputy Chief William Fitzgerald, who confirmed that Petitioner had been "suspended without pay." Fitzgerald referred Petitioner to the human resources department, where an unknown female advised that she had been instructed not to release his checks. She referred Petitioner to assistant corporation counsel Mary Kucharz, who informed Petitioner that he had been suspended without pay, and that his TTD had been suspended.

Mr. Hir ultimately learned that Respondent's basis for suspending payment of TTD was that he had relocated to Florida, in apparent violation of a city residency ordinance. Respondent initiated termination proceedings against Petitioner, and a hearing was scheduled to take place in September 2002 before the Board of Fire and Police Commissioners. Rather than face termination. Mr. Hir agreed to resign his position in August, 2002 in exchange for Respondent's agreement to maintain his insurance benefits, pay his accrued vacation time, and refrain from seeking reimbursement of TTD and other benefits voluntarily paid to him from January, 2002 to date. Petitioner explained that he elected to resign because he knew he would be hindered in seeking work within his restrictions if he had to explain a termination to prospective employers, and because he feared having to repay the city for benefits he received from January through August 2002.

Respondent retained Robert Cavico, a Florida-based vocational rehabilitation counselor, to work with Petitioner. Cavico wrote Dr. DePhillips on November 25, 2002 and requested a prescription for physical therapy and work hardening (PX 17). On December 11, 2002, at Cavico's request, Dr. DePhillips prescribed two weeks physical therapy and two weeks of work hardening (PX 18). Petitioner presented at a Health South facility in West Palm Beach, Florida. However, instead of physical therapy and work hardening, a repeat FCE was performed. The physical therapist, Sandy Berg, found the patient capable of occasionally lifting up to forty pounds from floor to knuckle level, with occasional sitting, walking, crawling, squatting, pushing, pulling, kneeling, stair climbing and overhead lifting. The patient declined testing with reference to his tolerance for static trunk bending and crouching. He demonstrated consistent performance and appropriate physiological responses throughout the test (PX 19).

From August 26 through October 18, 2002, Mr. Hir made some 81 job contacts seeking work within his restrictions (PX Group 15). He attempted work for three different employers. From November 23, 2002 through January 25, 2003, he worked for Xentel, Inc., a telemarketing firm, earning $8.00 per hour. He earned a total of $1,535.00 over a period of 64 days, or 9-1/7 weeks, for an average of $167.89 per week (PX Group 20).

Mr. Hir left the telemarketing job when he found another position as a security guard at Jupiter Ocean and Racquet Club Condominium Association, again earning $8.00 per hour. He worked there from January 29 through March 5, 2003, but he earned a total of only $354.38 during that time, for an average of only $70.88 per week for five weeks (PX Group 21). He testified that the security guard job required too much walking and climbing stairs. As a result, he was unable to complete a shift. He left the job because it required him to work beyond his physical restrictions

Petitioner next found work at Kookaburra's Pet Shop, whose corporate name is Discount Vet Supply, Inc., earning $10.00 per hour handling tropical fish. There he worked from April 7 through May 23, 2003, a period of 47 days or 6-5/7 weeks, during which he earned a total of $1,524.10, for an average of $227.00 per week (PX Group 22). He was fired when his co-workers complained to the store manager that they were being required to do extra work due to Mr. Hir's work restrictions. Following his termination by Kookaburra's Pet Shop, Mr. Hir enrolled in real estate school.

Petitioner currently notices pain in his low back with occasional numbness down both legs, more so on the right, especially on walking, and bending. Extension of the lumbar spine causes shooting pain radiating from the low back down the right leg. He is unable to carry his wallet in his back pocket due to back and leg pain. He cannot lift his three-year old son, who weighs 36 pounds, without pain.

David Gerdes, Chief of Police for the City of Joliet, testified for Respondent. Chief Gerdes stated that he advised Petitioner on August 8, 2002 that he was terminated for violating the residency ordinance. He advised Petitioner that he had a right to appeal the termination, either to the Board of Fire and Police Commissioners or to a union arbitration. Petitioner elected not to appeal.

Michael Supan, Human Resources Director for the City of Joliet, testified for Respondent. Supan stated that Petitioner was suspended without pay in September 2002, pending a hearing on the ordinance violation. No hearing took place because Petitioner voluntarily resigned his job and the city accepted his resignation. Supan testified that if Petitioner was living outside the city limits, he was in violation of the residency ordinance. On cross-examination, Supan agreed that he is responsible for issuing TTD checks to Respondent's injured employees. Supan stated that Petitioner's violation of the residency ordinance constituted Respondent's sole basis for terminating payment of TTD.

Susan Entenberg, a certified rehabilitation counselor, performed a vocational rehabilitation evaluation of Petitioner. Based upon the restrictions imposed by Dr. DePhillips, Dr. Mather and the two FCE therapists, Ms. Entenberg opined that Petitioner is unable to return to his past work as a police officer (PX 23 at 25-28; RX Group 8). His previous jobs provide no skills transferable to lighter work. As a result, he is limited to light, entry-level, part-time jobs (PX 23 at 29; RX Group 8).

Ms. Entenberg recommended a job search with supportive rehabilitation efforts (PX 23 at 29-31; RX Group 8). If Respondent cannot accommodate Mr. Hir with lighter work, the jobs for which he qualifies include security monitor, cashier or telemarketer. These are entry-level, part-time positions that pay between $7.00 and $10.00 per hour, usually four to six hours per day. If Petitioner were unable to secure work after job placement efforts, Ms. Entenberg would find that he is a candidate for retraining (PX 23

at 29-30). Ms. Entenberg stated that Petitioner's unsuccessful attempt at becoming re-employed bolster her recommendation that he receive assistance from a professional rehabilitation specialist. She advises a formal job placement program with rehabilitation resources, and payment of maintenance benefits until he becomes re-employed (PX 23 at 30-31; RX Group 8).

Ms. Entenberg testified that to the best of her knowledge, the City of Joliet has never offered to re-employ Petitioner within his medical restrictions. She further testified that to the best of her knowledge, there has been no attempt by any vocational rehabilitation professional, agency or vendor to secure work for Mr. Hir within his restrictions (PX 23 at 31-32).

The Record contains no evidence that Respondent has ever offered light work to Mr. Hir within his restrictions.

The Arbitrator finds that Petitioner is unable to return to his pre-injury line of work as a law enforcement officer. This determination is based upon the opinions of Drs. DePhillips and Mather, the two functional capacities evaluations, and the reports and testimony of Susan Entenberg.

The Arbitrator further finds that the issue of vocational rehabilitation has been fairly raised by the Record. Based upon the uncontroverted testimony of Susan Entenberg, Petitioner is entitled to receive vocational rehabilitation in the form of direct job placement with the professional assistance of a vocational rehabilitation counselor. Accordingly, Respondent shall provide and pay for the prescribed plan of vocational rehabilitation recommended by Ms. Entenberg. Petitioner may accept the assistance of a vocational rehabilitation counselor chosen by Respondent, or he may select a rehabilitation provider of his own choosing. Costello v. Baxter Healthcare, 95 IIC 451; *see*Thut v. Mike Nicholas, Inc., 89 IIC 392; **Avenarius** v. Consolidated Freightways, 86 IIC 1498. Respondent shall pay weekly vocational maintenance benefits under §8(a) of the Act at the TTD rate during the pendency of the vocational rehabilitation plan.

Should job placement efforts fail, Ms. Entenberg testified that Petitioner would be a candidate for retraining. Accordingly, in the event Petitioner engages in a diligent job search for a reasonable period of time under the supervision of a qualified vocational rehabilitation specialist, and is nevertheless unable to secure suitable employment within his restrictions, either party may file a motion seeking implementation of a supplemental plan of vocational rehabilitation that contemplates retraining.

Respondent's only claimed defense to its liability for payment of TTD is Mr. Hir's alleged violation of a residency ordinance. The Arbitrator finds that violation of the ordinance does not constitute a permissible basis upon which to terminate payment of TTD where, as here, Respondent never offered to employ Mr. Hir within the restrictions set forth by Dr. DePhillips, Dr. Mather or either of the functional capacity evaluations. While Respondent may have had a legal basis to terminate Petitioner's employment, it lacked any legal basis upon which to terminate payment of TTD.

The fact that Dr. DePhillips found Petitioner to have reached maximum medical improvement on September 7, 2001 likewise does not disqualify him from receiving TTD, for several reasons. First, Dr.

DePhillips prescribed a course of physical therapy and work hardening on December 11, 2002, over fifteen months after he first declared maximum medical improvement. Dr. DePhillips' stated purpose in ordering physical therapy was to increase the patient's functional capacity (PX 16 at 46). The fact that Dr. DePhillips sought to increase the patient's functional capacity in December 2002, casts doubt on whether Mr. Hir had reached maximum medical improvement in September 2001.

Second, even if Petitioner has reached a state of maximum medical improvement in September 2001, he has not yet completed the prescribed program of rehabilitation recommended by Ms. Entenberg. Accordingly, the nature and extent of his permanent disability cannot yet be determined. *See*Hunter Corp. v. Industrial Comm'n, 86 Ill.2d 489, 427 N.E.2d 1247, 1252 (1981).

Third, even if Petitioner's condition has stabilized such that he would no longer be entitled to receive TTD benefits under §8(b) of the Act, his inability to return to his regular work entitles him to receive vocational maintenance benefits under §8(a) of the Act during the pendency of the prescribed vocational rehabilitation program, payable at the weekly TTD rate. *See*Connell v. Industrial Comm'n, 170 Ill.App.3d 49, 523 N.E.2d 1265, 1269 (1988) (maintenance awarded at weekly TTD rate during pendency of vocational rehabilitation program for employee whose physical condition stabilized but was unable to return to pre-injury work).

Finally, Petitioner's earnings during his brief failed work attempts do not disqualify him from receiving TTD. He worked intermittently and sporadically for three different employers over periods totaling 19-6/7 weeks, during which he earned a total of $3,413.48, for an average of only $171.90 per week. The governing case law holds that such occasional earnings do not rise to the level of gainful employment sufficient to render him ineligible for TTD. Mechanical Devices v. Industrial Comm'n, 2003 Ill. App. LEXIS 1325 (October 29, 2003) (driving YMCA shuttle bus fifteen hours per week did not preclude TTD award); *see*J.M. Jones Co. v. Industrial Comm'n, 71 Ill.2d 368, 375 N.E.2d 1306 (1978) (driving school bus three hours per day for seven months did not preclude TTD award; Zenith Co. v. Industrial Comm'n, 91 Ill.2d 278, 437 N.E.2d 628 (1982) (operating hot dog wagon 1-1/2 hours per day for six months did not preclude TTD award).

Based upon the foregoing, the Arbitrator finds that Petitioner is entitled to receive the sum of $706.67 per week from May 14, 2001 through September 11, 2003, the date of arbitraton, representing 121-4/7 weeks, as provided in §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 §19(b) of the Act.

With reference to (L) (penalties and attorneys' fees), the Arbitrator finds as follows:

Respondent's only stated basis for terminating payment of TTD was Petitioner's alleged violation of a residency ordinance. The Arbitrator finds that Respondent has failed to sustain its burden of demonstrating a reasonable basis for terminating payment of weekly compensation benefits. Respondent has engaged in unreasonable an vexatious conduct violative of §19(l) and §16 of the Act. Accordingly, the Arbitrator hereby awards penalties and attorneys' fees as follows:

Penalties are awarded under §19(l) of the Act in the amount of ten dollars ($10.00) per day for each day payment of TTD has been refused or delayed, to a statutory maximum of $2,500.00. As over 250 days have elapsed since Respondent suspended payment of TTD on August 8, 2002, the sum of $2,500.00 is awarded under §19(l) to be paid by the Respondent.

Attorneys' fees under §16 of the Act are awarded in the amount of (20%) of the unpaid TTD to date. Twenty percent of the $36,958.31 in unpaid TTD comes to $7,391.66. The balance of attorney fees, if any, to be paid by Petitioner to his attorneys. ($7,391.66 to be paid by the Respondent)

04 I.I.C. 0614, 01 IL.W.C. 34521, 2004 WL 2579306 (Ill.Indus.Com'n)
END OF DOCUMENT

*7 IWCC 1113; 2007 Ill. Wrk. Comp. LEXIS 1274, **

WALDEN POMELOW, PETITIONER, v. BLAW-KNOX CONSTRUCTION EQUIPMENT CORPORATION, RESPONDENT.

NO. 02WC 06643

ILLINOIS WORKERS' COMPENSATION COMMISSION

STATE OF ILLINOIS, COUNTY OF COLES

7 IWCC 1113; 2007 Ill. Wrk. Comp. LEXIS 1274

August 20, 2007

CORE TERMS: arbitrator, thoracic, outlet, carpal tunnel syndrome, syndrome, steel, temporary total disability, wrist, recommended, bilateral, physical therapy, compression, vascular, splint, cumulative, medications, maneuver, trauma, opined, mild, pain, amount of compensation, surgeon, vocational rehabilitation, partial disability, present condition, right arm, impression, electrical, permanent

JUDGES: Yolaine Dauphin; Barbara A. Sherman

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, temporary total disability, permanent disability and medical expenses, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. Commissioner Sherman, Commissioner Dauphin, and Commissioner Ulrich were all in the consideration of this case.

Petitioner introduced into evidence copies of checks and receipts purportedly for out of pocket medical expenses in the amount of $ 1,588.15 (Petitioner's Exhibit 15). Petitioner submitted medical records supporting two of his out of pocket purchases: a wrist splint and Ultracet and Vioxx medications. The medical records show that Vince Wright, P.A. prescribed a wrist splint and pain medications for Petitioner. Petitioner paid $ 21.99 for the wrist splint and $ 40.00 for his pain medications. Petitioner failed to submit appropriate documentation to substantiate the balance of his out of pocket payments, totaling **[*2]** $ 1,526.16. The Commission finds that Petitioner is only entitled to reimbursement of $ 61.99 for his purchase of the wrist splint and pain medications. Therefore, the Commission modifies the Arbitrator's award of $ 9,359.70 in

medical expenses to $ 7,833.54, reflecting the removal of $ 1,526.16, the unsubstantiated out of pocket expenses.

Before the Arbitrator, Respondent filed a Motion to Suspend Compensation Benefits and to Continue Trial Setting. Respondent argued that it had the right to suspend its obligation to pay compensation benefits under Section 12 of the Act because Petitioner refused to cooperate and attend a functional capacity evaluation and vocational rehabilitation evaluation. The Commission finds the Arbitrator properly denied Respondent's motion.

Section 12 of the Act reads:

"An employee entitled to receive disability payments shall be required, if requested by the employer, to submit himself, at the expense of the employer, for examination to a duly qualified medical practitioner or surgeon selected by the employer, at any time and place reasonably convenient for the employee, either within or without the State of Illinois, for the purpose of determining the nature, **[*3]** extent and probable duration of the injury received by the employee, and for the purpose of ascertaining the amount of compensation which may be due the employee from time to time for disability according to the provisions of this Act. An employee may also be required to submit himself for examination by medical experts under subsection (c) of Section 19." 820 ILCS 305/12 (2005).

Under Section 12, Petitioner was required to submit himself for examination to a qualified medical practitioner, such as a physician or surgeon, not to an industrial rehabilitation consultant or vocational rehabilitation expert. The Commission concludes that Respondent did not have the right to terminate Petitioner's benefits upon Petitioner's refusal to attend a functional capacity evaluation and a vocational rehabilitation evaluation.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator entered on December 23, 2005, is modified with respect to medical expenses, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay $ 7,833.54 for medical services, as provided in Section 8(a) of the Act.

IT IS FURTHER **[*4]** ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under Section 19(n) of the Act, if any.

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

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.

DATED: AUG 20 2007

ATTACHMENT

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

An *Application for Adjustment of Claim* was filed in this matter, and *Notice of Hearing* was mailed to each party.

The matter was heard by the Honorable **Stephen Mathis,** arbitrator of the Commission, in the city of **Mattoon,** on **October 27, 2005.** 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 [*5] 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. What is the nature and extent of the injury?

FINDINGS

. On **January 4, 2001,** the respondent **Blaw Knox Construction Corp.** ***was*** operating under and subject to the provisions of the Act.

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

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

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

. In the year preceding the injury, the Petitioner earned **$ 34,883.68;** the average weekly wage was **$ 670.84.**

. At the time of injury, the Petitioner was **50** years of age, ***single*** with **0** children under **18.**

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

. To date, **$ 0** has been paid **[*6]** by the respondent for TTD and/or maintenance benefits.

ORDER

. The respondent shall pay the Petitioner temporary total disability benefits of $ 447.23/week for **38 5/7** weeks, from **05/10/01** through **02/05/02,** which is the period of temporary total disability for which compensation is payable.

. The respondent shall pay the Petitioner the sum of **$ 402.50/week for a further period of [ILLEGIBLE TEXT] weeks as provided in Section 8(d)(2) of the Act, as amended, because the injuries sustained caused permanent partial disability to the extent of 50% loss to the body as a whole.**

. The respondent shall pay the Petitioner compensation that has accrued from **01/04/01** through **present,** and shall pay the remainder of the award, if any, in weekly payments.

. The respondent shall pay the further sum of **$ 9,359.70** for necessary medical services, as provided in Section 8(a) of the Act.

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

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

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

RULES [*7] REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest of 4.22% shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of arbitrator

12-16-05

Date

DEC 23 2005

ADDENDUM

In support of Arbitrator's decision regarding issue (C), did an accident occur that arose out of and in the course of the Petitioner's employment by the respondent, issue (F), is the Petitioner's present condition of ill-being causally related to the injury, and (N), nature and extent of injury, the Arbitrator finds the following facts:

Petitioner testified that he was employed by the Respondent on April 1, 1985. Respondent's factory manufactured and assembled highway pavers and blacktop equipment. Initially, Petitioner was employed as a chip and grind person for approximately one year. Petitioner's duties **[*8]** included using a rotary grinder to clean chips, slag and burrs off steel. The rotary grinder was an air powered tool that weighed approximately seven to eight pounds and was vibratory. Petitioner would be required to grind with both hands. He is right hand dominant. Thereafter, Petitioner was a tool crib attendant for approximately two years that included the distribution of tools and materials to employees. Petitioner was then employed as a burner or fabrication specialist. Petitioner's Exhibit 17 is a drawing of his work station. Essentially, Petitioner would be responsible for the picking up of steel and transportation to a burn table by use of a crane. The cutting of the steel would be performed by Petitioner with the use of a plasma cutter or gas cutter. After the steel was cut, the Petitioner would remove the steel scrap physically or by way of a hoist to a dumpster. Petitioner would also be required to rake scrap steel. Petitioner was required to grind off burrs from the steel pieces. Petitioner performed this job for at least a forty hour week, with overtime, for approximately fourteen years.

In calendar year 2000, Petitioner started to notice numbness in his right arm with **[*9]** numbness and tingling to his left hand and right hand. Petitioner initially presented himself to the Rock Springs Family Medical Center and was seen by Vince Wright, a physician's assistant on January 4, 2001. Petitioner's Exhibit 3 are the Rock Springs Family Medical Center records. Petitioner provided a history as a steel fabricator for Blaw Honx (sic) and was required to work with vibratory tools. Further, Petitioner had to grab metal that weighed up to sixty pounds and pull it, including using a rake to pull metal. The use of the rake placed pressure to the arms, shoulders, neck and chest. Vince Wright diagnosed Petitioner with suspected bilateral carpal tunnel syndrome and parastheses bilaterally of the hands.

Petitioner returned to Vince Wright on May 14, 2001, and described his symptoms as becoming worse over the last year and a half. The physical examination was positive for a Tinel's sign and Phalen's sign of the right arm with tenderness in the radial canal. Thoracic outlet syndrome was also suspected. Petitioner was referred to Dr. Edward Trudeau for an EMG.

On May 18, 2001, Dr. Trudeau performed nerve conduction studies that were positive for

median neuropathy at the right **[*10]** wrist (carpal tunnel syndrome), mild and neurapractic in electroneurophysiologic testing terms. (Pet. Ex. 6).

Petitioner returned to the Rock Springs Medical Center on May 30, 2001. Physical examination by Vince Wright continued to reveal positive Tinel's and Phalen's sign at the wrist, along with a positive Roos' sign. Vince Wright's assessment was cumulative trauma disorder directly related to work, specifically carpal tunnel syndrome and thoracic outlet syndrome. Petitioner was prescribed a cock up splint to be worn at bedtime, started on vitamin Bl and referred to Drs. Youngerman and Trachtenberg for consultation. (Pet. Ex. 3).

On June 14, 2001, Petitioner was seen by Dr. Jordan Youngerman for his bilateral carpal tunnel syndrome. Dr. Youngerman's impression was bilateral carpal tunnel syndrome - mild to moderate and possible right thoracic outlet syndrome. Dr. Youngerman recommended that evaluation and workup be performed by Dr. Trachtenberg prior to proceeding with any surgical intervention for the carpal tunnel. (Pet. Ex. 7)

Petitioner was seen on June 19, 2001 by Dr. Jeffery Trachtenberg for the right thoracic outlet syndrome. Dr. Trachtenberg's impression was that Petitioner **[*11]** was suffering from carpal tunnel syndrome, which appeared to be significantly symptomatic on the right with compression of his subclavian arteries bilaterally with abduction of his arms to 90 degrees. A lower extremity arterial study was negative for significant vascular occlusion in either upper extremity with evidence of vascular compression with Petitioner's arm abducted at 90 degrees. Dr. Trachtenberg was not sure if the symptomatology was related to this vascular compression. Dr. Trachtenberg recommended the carpal tunnel syndrome be treated initially and referred Petitioner to a physical therapy program with stretching of the neck and shoulder girdle to possibly relieve the vascular compression. (Pet. Ex. 11)

On July 20, 2001, Petitioner underwent physical therapy at Biomax Rehabilitation in Effingham, Illinois for his thoracic outlet syndrome. Petitioner was discharged from physical therapy on October 2, 2001 with continued circulation difficulties in the upper extremities. (Pet. Ex. 13).

Petitioner was seen by Dr. William Pyle, a cardiovascular surgeon, on October 30, 2001 for evaluation of the thoracic outlet syndrome. Dr. Pyle's impression was the Petitioner did not have **[*12]** thoracic outlet syndrome, but may have had an undiagnosed musculoskeletal problem of his right shoulder. Further, Petitioner had evidence for right carpal tunnel syndrome. Dr. Pyle recommended Petitioner trying alternative employment or a job change at his current employment. (Pet. Ex. 9).

Petitioner returned to Vince Wright on November 13, 2001, and was referred to Dr. David Fletcher. (Pet. Ex. 3). On October 2, 2003, Dr. Fletcher testified by way of evidence deposition marked as Petitioner's Exhibit 2. Dr. Fletcher saw Petitioner on November 30, 2001. (Pet. Ex. 2, p. 5). Petitioner had a positive provocative test for thoracic outlet syndrome, including a positive Roos' maneuver and an Adson's test. Petitioner also had a positive Tinel's over the scalene muscles that are lateral to the neck. (Pet. Ex. 2, p. 6) The positive Roos' maneuver was an indicator of compression of the median cord of the brachial plexus due to some thoracic outlet compromise. The positive Adson's test was an objective indication of vascular compromise due to thoracic outlet compromise. (Pet. Ex. 2, p. 7).

Dr. Fletcher referred Petitioner for repeat electrical studies with Dr. Trudeau. (Pet. Ex. 2, p. 8). Petitioner **[*13]** underwent repeat electrical studies on January 4, 2002 by Dr. Trudeau. These studies were positive for bilateral median neuropathy at the wrist (carpal tunnel syndrome), mild and neurapractic on either side with the right being similar to the findings of May 18, 2001 and the left being a new finding. Dr. Trudeau also diagnosed right brachial plexopathy, medial cord lesion, mild in electroneurophysiologic testing terms, consistent with neurogenic thoracic outlet syndrome presentation, new since previous study of 5/18/01 and consistent with the quite correct clinical assessment of Dr. Fletcher. (Pet. Ex. 6).

Dr. Fletcher also referred Petitioner to Dr. John Ramsey. Dr. Ramsey examined Petitioner on December 4, 2001 and January 22, 2001. In his note of December 4, 2001, Dr. Ramsey stated, "He seems to be much improved, at least from his history by no longer working his heavy job." He opined that his prior job was "certainly contributing to his problems, and if he is improved by not working there, he should look for less heavy work." (Pet. Ex. 8).

Following the electrical studies by Dr. Trudeau, Dr. Ramsey saw Petitioner on January 22, 2001. Dr. Ramsey opined that Petitioner was a good **[*14]** candidate for the first rib resection given his long history and positive physical findings. (Pet. Ex. 8).

Petitioner had also seen Dr. Susan Mackinnon on March 15, 2002. Dr. Mackinnon recommended that Petitioner undergo physical therapy to strengthen the middle and lower trapezius and serratus anterior muscles after he has had stretching exercises to regain full range of movement of the scalenes and pectoralis minor muscles on the right. (Pet. Ex. 10).

Dr. Fletcher last saw Petitioner on August 20, 2003. (Pet. Ex. 2, p. 14). His examination still revealed a positive Roos' maneuver and Adson's maneuver. The symptomatology was worse on the right side. Petitioner was reluctant to undergo the rib resection recommended by Dr. Ramsey. Dr. Fletcher opined that there was a causal relationship between the onset of the Petitioner's thoracic outlet syndrome and his work activities due to cumulative trauma. (Pet. Ex. 2, p. 18).

Petitioner returned to the Rock Springs Family Medical Center on November 1, 2004, and was seen by Vince Wright. Vince Wright wrote that Petitioner had reached maximum medical improvement and was not fit for work. (Pet. Ex. 4). Thereafter, Petitioner was seen by Dr. Robert **[*15]** Smith, a family physician and supervisor of Vince Wright, on December 6, 2004. Dr. Smith testified by way of evidence deposition marked as Petitioner's Exhibit 1, As of December 6, 2004, Petitioner suffered from bilateral carpal tunnel syndrome, worse on the right and had some degree of thoracic outlet syndrome. (Pet. Ex. 1, p. 30). Dr. Smith's understanding of the job was that the Petitioner loaded and unloaded steel for eighteen years, and this work was very consistent with Petitioner's complaint and findings with regard to thoracic outlet syndrome and carpal tunnel syndrome. (Pet. Ex. 1, p. 32). Dr. Smith further opined that Petitioner was completely disabled at this age. (Pet. Ex. 1, p. 33). Petitioner saw Dr. Smith again on May 23, 2005. Dr. Smith's diagnoses continued to be chronic right shoulder pain and right carpal tunnel syndrome. (Pet. Ex. 3).

Petitioner last worked for the Respondent on March 24, 2003. He has not returned to any form of work since that date and has not performed any job search.

The Arbitrator finds that the Petitioner sustained an accident that arose out of and in the course of the Petitioner's employment by the Respondent due to the cumulative trauma **[*16]** of his job. Further, Petitioner's present condition of ill-being is causally related to the cumulative trauma, including the bilateral carpal tunnel syndrome and thoracic outlet syndrome.

With respect to nature and extent of the injury, the Arbitrator finds that Petitioner has not proven by a preponderance of the medical evidence that his medical condition makes him unemployable; however, the medical evidence does demonstrate that Petitioner is unable to return to his former employment and has sustained significant permanent partial disability to the body as a whole given the multiple injuries sustained. Thus, the Arbitrator orders the Respondent to pay the Petitioner the sum of $ 402.50 per week for a further period of 150 weeks as provided in Section 8(d)(2) of the Act, because the injuries sustained caused permanent partial disability to the extent of 30% loss of use of the body as a whole.

In support of Arbitrator's decision regarding issue (J), were the medical services that were provided to Petitioner reasonable and necessary, the Arbitrator finds the following facts:

Petitioner's Exhibit 14 is the Rock Springs Family Medical Center bill. The charges related to

Petitioner's injuries **[*17]** total $ 768.00. Petitioner's Exhibit 15 are the out of pocket expenses of Petitioner in the amount of $ 1,588.15 towards related medical expenses.

Petitioner's Exhibit 16 is a lien issued by Primax Recoveries, Inc. for payments made by CIGNA HealthCare in the amount of $ 7,003.55 for payment of related medical expenses. The Arbitrator awards the Petitioner the sum of $ 9,359.07 for payment of the medical bills to Rock Springs Family Medical Center, reimbursement of out of pocket expense by Petitioner and for the Primax Recoveries, Inc. lien. These medical expense are reasonable and necessary medical expenses for the care and treatment of Petitioner's injuries.

In support of Arbitrator's decision regarding issue (K), what amount of compensation is due for temporary total disability, the Arbitrator finds the following facts:

Petitioner was seen at the Rock Springs Family Medical Center on May 10, 2001, by Vincent Wright, a physician's assistant. Petitioner was taken off work for the next three weeks until testing was completed by Dr. Trudeau. On May 30, 2001, Petitioner returned to Rock Springs Family Medical Center and was restricted from work. On July 23, 2001, Petitioner was kept **[*18]** off work for at least another four to six weeks to complete physical therapy. On August 30, 2001, Petitioner was kept off work, and Vince Wright recommended that the employer perform an ergonomic change in Petitioner's job function. On October 1, 2001, Petitioner was restricted for another four weeks off work. On December 21, 2001, Petitioner's restrictions allowed him to perform light duty from 12/14/01 through 1/21/02 with reduced use of the right arm with a weight lifting limit of five pounds. Petitioner was not provided work within his restrictions. On February 5, 2002, Petitioner was seen again by Vince Wright who released him to return to work as of February 5, 2002.

The Arbitrator finds that Petitioner was temporary and totally disabled from May 10, 2001 through February 5, 2002 and Respondent is ordered to pay temporary total disability benefits of $ 447.23 per week for 38 5/7 weeks, which is the period of temporary total disability for which compensation is payable.

Legal Topics:

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

Workers' Compensation & SSDI > Administrative Proceedings > Claims > Time Limitations > Notice Periods

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

Source: **Legal > States Legal - U.S. > Illinois > Find Statutes, Regulations, Administrative Materials & Court Rules > IL Workers' Compensation Decisions**
Terms: **walden and pomelow** (Suggest Terms for My Search)
View: Full
Date/Time: Thursday, November 29, 2012 - 2:00 PM EST

1 of 1 DOCUMENT

SANDRA RAINFORD, PETITIONER, v. JEWEL FOOD STORES, RESPONDENT.

NO. 02WC 38458

ILLINOIS WORKERS' COMPENSATION COMMISSION

STATE OF ILLINOIS, COUNTY OF COOK

7 IWCC 1624; 2007 Ill. Wrk. Comp. LEXIS 1802

December 12, 2007

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

OPINION: [*1]

DECISION AND OPINION ON REVIEW

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

The Commission finds that in addition to Petitioner's right foot condition, Petitioner's low back condition is causally related to the September 30, 1999 work accident. More specifically, while using crutches after her right foot surgery, Petitioner fell and sustained a low back strain as well as aggravated her pre-existing lumbar spondylosis and L5-S1 degenerative disc disease. Said conditions resulted in conservative medical treatment being administered to the low back as evidence by Drs. Coleman's, Miller's, King's and the physical therapist's medical records. The Commission notes that Petitioner has a separate, independent pending workers' compensation [*2] claim for her back. However, Petitioner included medical expenses related to her back in this claim in addition to medical expenses related to her right foot. Having reviewed all of the medical expenses the Commission finds with the exception of a $ 68.00 charge from the Orthopedic Center the Commission found supporting treatment records to show that the medical bills relate to and are reasonable and necessary for the treatment of Petitioner's right foot or low back condition. As such the Commission awards $ 10,809.37 in medical expenses. In addition the Commission finds that $ 1,530.08 out-of-pocket medical expenses paid by the Petitioner are causally related to and are reasonable and necessary for the treatment of the injuries derived from the September 30, 1999 accident. Lastly, the Commission notes that on page two of her decision the Arbitrator found that the Petitioner was temporarily totally disabled from May 25, 2000 through June 24, 2002 for 102-3/7 weeks and on page ten of her decision she held that this same period totaled 108-5/7 weeks. The Commission finds that the correct total for the temporary total period is 108-4/7 weeks.

IT IS THEREFORE ORDERED BY THE COMMISSION [*3] that Respondent pay to Petitioner the sum of $ 291.18 per week for a period of 108-4/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $ 10,809.37 for medical expenses and $ 1,530.08 for out-of-pocket expenses under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $ 262.06 per week for a period of 116.25 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 75% loss of use of the right foot.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $ 42,200.00. 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 [*4] order therefor and deposited with the Office of the Secretary of the Commission.

ATTACHMENT

ILLINOIS INDUSTRIAL 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 Kathleen A. Hagan, Arbitrator of the Industrial Commission, in the city of Chicago, on September 2, 2004, October 17, 2005 and November 14, 2005 (no record 11-14-05). After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues indicated below, and attaches those findings to this document.

DISPUTED ISSUES

A. Was the Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. Was there an employee-employer relationship?

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

D. What was the date of the accident?

E. Was timely notice of the accident given to the Respondent?

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

G. What were the Petitioner's earnings?

[*5] H. What was the Petitioner's age at the time of the accident?

I. What was the Petitioner's marital status at the time of the accident?

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

K. What amount of compensation is due for Temporary Total Disability?

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

M. Should penalties or fees be imposed upon the Respondent?

N. Is the Respondent due any credit?

O. Other: Travel Expenses

STIPULATED FINDINGS

. On 09/30/99, the Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

. In the year preceding the injury, the Petitioner earned $ 22,712.04; the average weekly wage was $ 436.77.

. At the time of injury, the Petitioner was 56 years of age, married, with 0 children under 18.

. Necessary medical services *have* in part been provided [*6] by the Respondent.

. To date, $ 32,320.98 has been paid by the Respondent on account of this injury.

ORDER

. The Respondent shall pay the Petitioner Temporary Total Disability benefits of $ 291.18/week for 102-3/7 weeks, from May 25, 2000 through June 24, 2002, which is the period of Temporary Total Disability for which compensation is payable.

. The Respondent shall pay the Petitioner the sum of $ 262.06/week for a further period of 116.25 weeks, as provided in Section 8 (e)of the Act, because the injuries sustained caused the permanent disability of Petitioner's right foot to the extent of 75% thereof.

. The Respondent shall pay necessary medical services and out of pocket expenses related to the right foot through June 24, 2002 and for Bextra prescription thereafter, as provided in Section 8(a) of the Act.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest of 4.58% [*7] 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

Date:

January 30, 2006

STATEMENT OF FACTS

The Petitioner claims injury to her right foot as a result of an accident at work on September 30, 1999. At the time of the incident the Petitioner had a pending worker's compensation claim for her right shoulder, left wrist and back. These claims are currently pending before Arbitrator Black and the Petitioner is being represented by a different attorney. On September 2, 2004 the Petitioner's attorney clearly stated that the Petitioner's claim in this case is solely based on the injury to her right foot.

The Petitioner, Sandra Rainford, has been employed by Jewel Food Stores since November of 1982. Petitioner's past medical history reveals that she underwent a triple arthrodesis of the right ankle (hindfoot) in 1983. (PX1, RX6). On September 30, 1999, the Petitioner was employed as a grocery receiver. Her duties consisted of checking in vendors

and their products, verifying the product against the vendor's [*8] bill and creating a bill for Jewel. While the Petitioner was scanning in product, another employee lost control of a pallet jack and ran over the Petitioner's right foot.

The Petitioner continued working and first sought treatment on December 9, 1999, with Dr. Brian E. Coleman of Orthopedic Centers. (PX1). Petitioner acknowledged this was the first medical treatment she sought for her foot. Petitioner provided a consistent history of injury. She stated that the foot was swollen and caused her persistent pain. Dr. Coleman observed that the Petitioner undoubtedly had a soft tissue injury, and he diagnosed her with neuropraxia of the right foot and possible stress fracture of the 2nd and 3rd metatarsals. Dr. Coleman stated that if no clinical improvement occurred within a month, an MRI would be considered to rule out a stress fracture or bony contusions. Petitioner was started on anti-inflammatory medications and physical therapy. (PX1). The Petitioner continued to work full duty.

Petitioner presented to Accelerated Rehabilitation Centers on December 29, 1999 for her initial physical therapy evaluation, as recommended by Dr. Coleman. Petitioner noted the swelling had improved but she [*9] still experienced constant discomfort, which worsened with walking and standing. At this time, Petitioner continued to work and was reportedly standing throughout her shift, which lasted six hours. (PX2).

On January 20, 2000, the Petitioner returned to Accelerated Rehabilitation Centers. Petitioner reportedly progressed fairly well in regards to her strength, and her pain appeared to have somewhat improved. However, Petitioner claimed to still have difficulty with prolonged standing and weight bearing at work. (PX2). Petitioner returned to Dr. Coleman's office later that day. Minimal improvement over Petitioner's right foot was noted. (PX1).

An MRI was taken on Petitioner's right midfoot at Diagnostic Specialties Center on January 26, 2000. The report from the MRI diagnosed Petitioner with degenerative changes involving the navicular cuneiform and cuneiform metatarsal base articulations. There was no evidence of a focal soft tissue mass. (PX3).

At a February 7, 2000 appointment with Dr. Coleman, Petitioner received a cortisone injection at the symptomatic level. Dr. Coleman commented that the MRI was "essentially negative." He diagnosed Petitioner with right foot neuritis and tendinitis. [*10] (PX1).

Petitioner received another cortisone injection during her follow-up appointment with Dr. Coleman on March 16, 2000. Dr. Coleman noted that Petitioner had a reported 30-35% improvement from the previous cortisone injection to her right foot. Physical examination revealed moderate tenderness to palpation of the midfoot. (Pet. Ex. 1).

Dr. Coleman recommended surgery based on Petitioner's failure to improve with conservative care. An excision of exostoses and nerve decompression was scheduled for May 23, 2000, pending authorization from her insurance carrier. Dr. Coleman designated the surgery as "optimal treatment." (Pet. Ex. 1).

Petitioner returned to Dr. Coleman's office on May 25, 2000. Dr. Coleman acknowledged that Petitioner had initially been approved for surgery, then not approved, and was currently pending a second opinion per Dr. George Holmes. Petitioner reportedly had increased pain and swelling over her right foot and presented with a significantly antalgic gait, and 3+ swelling and tenderness to palpation of the midfoot area. Dr. Coleman removed Petitioner from work for three weeks and placed her in a brace to immobilize the foot and ankle. He also provided inflammatory [*11] medication. (Pet. Ex. 1).

Petitioner presented to Dr. Coleman's office on June 15, 2000. Dr. Coleman noted that in the first x-ray, Petitioner had some spurring, suggestive of early degenerative changes of the right midfoot. Dr. Coleman opined that the Petitioner's problem was multi-focal, in the form of osseous as well as soft tissue from her injury. Dr. Coleman noted that Petitioner did not have an unstable Lisfranc injury, however, he agreed with the recommendations made by Dr. Holmes for a triple phase bone scan and EMG to the right lower extremity. Dr. Holmes had opined that a significant component of the Petitioner's problem was a progressive arthritic condition to the right mid foot. (Pet. Ex. 1).

A triple phase bone scan was conducted at St. Anthony Medical Center on June 21, 2000. (Pet. Ex. 4). The impression was multiple degenerative or traumatic changes in both feet, which were more marked in the left second and third cuneiforms. (Pet. Ex. 4). The Petitioner underwent an EMG on June 30, 2000 at Northern Indiana Neurological Institute. The results were negative. (Pet. Ex. 5).

Petitioner presented to Dr. Coleman's office on July 13, 2000. Dr. Coleman recommended surgical [*12] exploration, nerve decompression, and exostosis or midfoot arthrodesis depending on the intra-operative findings. (Pet. Ex. 1).

On July 25, 2000, Dr. Coleman performed surgery consisting of a midfoot arthrodesis, excision of exostoses, and nerve decompression. Interestingly, the decompression of the nerve. The postoperative diagnosis was post-traumatic arthritis of the right midfoot and nerve compression of the right foot. (Pet. Ex. 1).

Petitioner presented to Dr. Coleman's office on August 3, 2000 for her first post-operative visit. Tenderness to deep palpation was observed in Petitioner's first through third toes. The incisions were intact and there were no signs of infection or breakdown. (Pet. Ex. 1).

When Petitioner presented to Dr. Coleman on August 10, 2000, she reported that she had fallen twice and injured the 4th toe on her left foot and her right shoulder. X-rays of both the toe and the right shoulder were negative. Petitioner was referred to Dr. Diveris for evaluation of her right shoulder. An examination of the right foot showed a well healed surgical incision. (Pet. Ex. 1).

Petitioner returned to Dr. Coleman's office on September 7, 2000. The incision had healed well [*13] with no signs of infection or breakdown. The x-ray showed excellent healing at the arthodesis site and there was no evidence of hardware failure or migration. Petitioner's cast and splint were removed. Dr. Coleman recommended that she begin physical therapy and protective weight bearing with a fracture walker. (Pet. Ex. 1).

On September 27, 2000, Petitioner returned to Accelerated Rehabilitation Centers for physical therapy. According to the therapists notes, Petitioner reported that "she was unable to ambulate with crutches after a fall, thus, she [was] using her wheelchair for all functional mobility." Petitioner complained of low back pain, shooting pain in the left knee, and pain in the location of the screw in her right foot. Petitioner also claimed to have persistent problems with edema. Petitioner was to attend physical therapy three times a week for the next four weeks. The diagnosis was a degenerative joint disease in the right midfoot and a left knee strain. (Pet. Ex. 2).

Petitioner presented to Dr. Alexander Miller of Orthopedic Centers on October 24, 2000. Although Dr. Miller's letter indicated that Petitioner had been referred by Kemper Insurance Company, a patient work [*14] status form dated October 23, 2000 clearly showed that Dr. Coleman had referred the Petitioner to Dr. Miller for low back evaluation. Petitioner reported developing back and leg symptoms consequent to falling on two occasions after undergoing right foot surgery on July 25, 2000. She had been using axillary crutches with her right lower extremity non-weight bearing when she fell. Dr. Miller diagnosed Petitioner with a lumbar strain, lumbar spondylosis, and L5-S1 degenerative disk disease. (Pet. Ex. 1).

During a follow-up appointment on November 21, 2000, Petitioner reported to Dr. Miller that her "back went out again" on November 8, 2000. She reported that as the pain began to ease off, her back went out again on November 15, 2000 during a physical therapy session. Petitioner also claimed to be experiencing bilateral radiating lower limb pain to the ankle on the right side, and to the leg on the left side. Prolonged walking or standing aggravated her pain. On examination there was no gross lower limb weakness through her right ankle. Dr. Miller acknowledged that Petitioner remained off of work primarily due to her right foot condition. (Pet. Ex. 1).

On December 4, 2000 Dr. Coleman [*15] referred Petitioner to a pain specialist. (Pet. Ex. 8). The Petitioner presented to Dr. Timothy E. King of Centers for Pain Management on January 23, 2001. Petitioner reportedly informed Dr. King that she had experienced a significant burning, numbness, and tingling on the top of her right foot after her cast was removed. Petitioner reported that these sensations were not present prior to the July 25, 2000 procedure. Petitioner was able to get up and down from a seated position but ambulated with great difficulty because of pain with pressure on the right foot. Dr. King opined that the Petitioner suffered from a local neuropathic pain process that may be related to peripheral nerve injury. He further suspected that her inability to dorsiflex her foot was pain related. Dr. King prescribed Neurontin, which was to be taken on a strict schedule. (Pet. Ex. 8).

Petitioner complained of pain in her right foot when she presented to Dr. Coleman on February 19, 2001. She claimed to be experiencing pain over the medial longitudinal arch, and the plantar aspect of all her metatarsal heads. Dr. Coleman noted a focal area of tenderness over her foot and prescribed orthotics. (Pet. Ex. 1).

When the [*16] Petitioner returned for a follow-up with Dr. King on February 22, 2001, he noted some dysesthesia on the medial aspect of the Petitioner's right foot. (Pet. Ex. 8). Petitioner also had extreme pain in her foot whenever she put pressure on it and attempted to walk. Dr. King recommended that Petitioner escalate her Neurotin for one more week. Dr. King also ordered an EMG of the right leg. In the EMG report dated March 23, 2001, it is noted that Petitioner claimed to have pain in her low back and multiple areas of both lower extremities. The EMG revealed no evidence of an active right lumbosacral radiculopathy. (Pet. Ex. 8).

Petitioner returned to Dr. King's office on April 5, 2001 and reported that the escalating dose of Neurotin had alleviated much of her pain. (Pet. Ex. 8). The Petitioner reportedly fell again with an impact to her low back and some pain in her big toe on the left side. Petitioner was given a caudal epidural steroid injection on May 9, 2001, to address the mononeuropathy of her right foot. Once again, the injection was administered despite a recent EMG that revealed the Petitioner did not have a lumbosacral radiculopathy. (Pet. Ex. 8).

Petitioner was reevaluated by [*17] Dr. King on June 6, 2001 and June 13, 2001. His office notes reflect that he expected Petitioner to reach maximum medical improvement by early September, 2001. (Pet. Ex. 8).

When Petitioner returned to Dr. Coleman's office on June 14, 2001, she complained of progressive deformity of her great toe which was causing problems in her gait. Dr. Coleman opined that Petitioner would be best served if the hardware from her July 25, 2000 operation was removed. In addition, Dr. Coleman recommended an osteotomy to correct the deformity. Accordingly, on June 26, 2001, Petitioner had a screw removed from the right foot, followed by an osteotomy of the right great toe. (Pet. Ex. 1).

Petitioner returned to Dr. King's office on August 2, 2001 at which time he acknowledged that Petitioner suffered a fall that complicated her recovery and also produced back pain. Notably, Dr. King opined that Petitioner's back complaints were limiting her recovery and interfering with her ability to become optimally functional again. (Pet. Ex. 8). As stated earlier, the Petitioner is not making a claim for permanency based on her lower back complaints.

When Petitioner presented to Dr. Coleman on August 9, 2001, "irregular [*18] areas of scar" were observed over Petitioner's preexisting scars. Dr. Coleman recommended a scar massage, ultrasound, and phonophoresis during physical in therapy three times a week for three weeks. Petitioner returned to Dr. Coleman's office on September 10, 2001, stating that the pain over her right foot had not improved. Dr. Coleman recommended two more weeks of therapy. Dr. Coleman forecasted that Petitioner would reach maximum medical improvement in two weeks. (Pet. Ex. 1).

On September 24, 2001 Petitioner presented to Dr. Coleman's office complaining of various types of pain over the right lower extremity. Dr. Coleman noted the pain was consistent with her overall neuralgic problem. Dr. Coleman opined that the Petitioner had a poor prognosis. Dr. Coleman further opined that Petitioner could not tolerate a sedentary position for more than thirty minutes, and as such, he felt she was precluded from any type of driving or sit down occupation. Moreover, Dr. Coleman stated that Petitioner could not engage in any occupational, recreational, or routine activities of daily living that entailed weight bearing for more than fifteen or twenty minutes without exacerbation of her symptoms. [*19] Dr. Coleman opined that Petitioner had reached maximum medical improvement. He noted that Petitioner would not make significant improvement due to the chronicity and nature of her problems. Petitioner was authorized to return to light duty work with the stipulation that she avoid remaining seated for more than thirty minutes. (Pet. Ex. 1).

Petitioner received an epidural steroid injection from Dr. King for back pain on October 10, 2001. According to Dr. King, Petitioner reached a point of maximum medical improvement with regards to her back by October 23, 2001. The Petitioner did not receive any medical treatment to her right foot for a period of six months. (Pet. Ex. 1).

Petitioner presented to Dr. Coleman's office on April 25, 2002, complaining of pain in her great right toe, which was treated with a cortisone injection. Dr. Coleman placed the Petitioner's toe in a plantar flexion splint which was to be utilized in between sessions of passive and active motion. If no clinical improvement was achieved, there would be no further treatment rendered. Petitioner was authorized to remain off of work. (Pet. Ex. 1)

On May 13, 2002 Petitioner returned to the office of Dr. Coleman asserting [*20] there was no improvement following the cortisone injection. Dr. Coleman reiterated his opinion that Petitioner had a significant disability in the right foot, with neuralgia, arthritic changes, and scarring, which led to a permanent disability. Reportedly, any dependent position that Petitioner stayed in whether sedentary or not, exacerbated her pain after fifteen to twenty minutes. Dr. Coleman stated that the Petitioner was totally disabled and was not a viable candidate for a vocational rehabilitation. Petitioner had chronic and permanent pain and swelling that would require various sources of treatment, such as orthotic wear, cortisone injections, and chronic non-steroidal anti-inflammatory medications. (Pet. Ex. 1).

Petitioner was examined by Dr. Armen Kelikian of Northwestern Orthopedic Institute at Respondent's request on June 24, 2002. (Resp. Ex. 6). Dr. Kelikian noted Petitioner's limp, atrophy of the right calf and decreased range of motion of the right foot and right great toe. Dr. Kelikian diagnosed Petitioner with a complex type II regional pain syndrome and causally related her condition to the accident of September, 1999. Dr. Kelikian recommended a functional capacity [*21] evaluation as he saw no bar to sedentary work. (Resp. Ex. 6).

The Petitioner presented to Dr. Coleman on April 22, 2004. The Petitioner reported chronic pain over the right ankle and foot that is essentially unchanged. The Petitioner also reported improvement with Bextra and relief with hydrotherapy. The Petitioner also complained of knee and back pain. Dr. Coleman stated that the Petitioner's complaints were typical and not unusual in the patients that have had post-traumatic arthritis and problems. He indicated that the Petitioner would require an orthopedic follow-up in Florida for the knee and back but not the foot. The Petitioner was discharged from Dr. Coleman's care. (Pet. Ex. 1).

On May 3, 2004, the Petitioner presented for a second IME with Dr. Kelikian. Dr. Kelikian noted that the Petitioner's complaint of numbness in the bottom of her right foot was not consistent with the recent negative EMG. He reiterated his diagnosis of a Type II complex regional pain syndrome and found the Petitioner to be at maximum medical improvement. He recommended an FCE to determine the Petitioner's ability to work as he saw no reason why she couldn't perform sedentary work. (Resp. Ex. 6).

The [*22] Respondent requested the Petitioner to submit to a functional capacity evaluation but the Petitioner refused. The Petitioner testified at trial that she was unable to perform a functional capacity evaluation based on her discussions with Dr. Coleman. (Tr. P. 40). Dr. Coleman never opined that the Petitioner was unable to perform a functional capacity evaluation. The Petitioner testified that she traveled as a passenger to Florida and back to her home in Indiana in her Suburban. The Petitioner stated she was able to sit in her Suburban, take boat rides, shower and dress herself. Her limitations and complaints were not due to her right foot pain but for other unrelated claims. Petitioner also testified that she has been utilizing a cane since her first surgery.

During the deposition of Dr. Coleman, Dr. Coleman stated that typically problems increase after a hindfoot triple arthrodesis. He opined that the accident of September 30, 1999 aggravated Petitioner's pre-existing condition. Dr. Coleman explained that crush type injuries tend to get worse over time, eventually developing nerve pain. He also agreed with Dr. Kelikian when he stated that the Petitioner's complaints of ankle pain [*23] and were not related to her injury of September 30, 1999 and were related to her previous triple arthrodesis. Although he did not specifically diagnose the Petitioner with RSD or chronic pain syndrome, Dr. Coleman stated that the Petitioner's primary problem in her right foot was neurogenic and that was the reason he referred the Petitioner to Dr. King at the pain clinic. Dr. Coleman was not aware that Dr. King mainly treated Petitioner's back complaints. Dr. Coleman revised his no work opinion and opined that the Petitioner would be capable of performing sedentary work with flexibility for change of position. (Pet Ex 13. P. 40). Dr. Coleman stated that a new FCE at this time would be reasonable. Furthermore, contrary to what the Petitioner had testified, Dr. Coleman saw no reason she couldn't have undergone an FCE previously. He agreed that a functional capacity evaluation would have been very helpful when she reached MMI and he could not explain why he didn't order one, as that was his usual practice. (Px13).

The Petitioner underwent a functional capacity evaluation on February 2, 2005. (Pet. Ex. 11). The Petitioner was found capable of performing sedentary work. Throughout the [*24] functional capacity evaluation, the Petitioner utilized a cane and was unable to complete many of the required exercises due to her complaints of pain. For example, when required to lift from 30 to 63 inch height and return, the Petitioner complained of pain in her foot and leg and stated that she could not move it without her cane. Likewise, she failed her attempt to lift from 18 inches to floor and return because of the use of her cane in the left hand. Furthermore, the Petitioner could not perform the pushing/pulling exercise due to pain in her hands and back. She did not cite foot pain as the reason for her inability to complete the exercise. Throughout the functional capacity evaluation, the evaluator notes that the Petitioner's subjective complaints of pain that limited her evaluation.

The Petitioner was interviewed by Joseph Belmonte on February 4, 2005. (Tr. P. 9). Based on the functional capacity evaluation and the Petitioner's subjective complaints, he opined that the Petitioner was not a candidate for vocational rehabilitation. Throughout his contact of the Petitioner, the Petitioner utilized her cane.

On June 20, 2005, the Petitioner was videotaped driving her car, utilizing [*25] a drive-through teller and shopping at a grocery store. (Res. Ex. 2 and 3). This surveillance took place just weeks prior to Dr. Kelikian's final examination. The Petitioner is videotaped pushing a grocery cart to her car where she proceeds to unload her groceries. Petitioner walks without a cane or limp and is wearing flip flop gym shoes. Although she received assistance in putting some of the items in the trunk, Petitioner is seen lifting grocery bags and a gallon of bleach by herself. (Res. Ex. 3). The following day, June 21, 2005, the Petitioner was witnessed traveling in a car to a convenient store and courthouse. Again, the Petitioner was not using any supports, braces or health aids as she walks about. She is observed walking without a limp and is again wearing flip flop type shoes. (Res. Ex. 2 and 3).

On August 8, 2005, the Petitioner returned to Dr. Kelikian. (Res Ex. 6). Dr. Kelikian and the private investigator testified that the Petitioner utilized the aide of her cane. Based on the Petitioner's complaints and the functional capacity evaluation, Dr. Kelikian opined MMI and that the Petitioner was capable of performing sedentary duty as long as there were no stairs, climbing [*26] or lifting more than 10 pounds. The Respondent offered vocational rehabilitation which the Petitioner eventually refused. (Tr. P. 90).

During his deposition, Dr. Kelikian stated that the neither Petitioner's back pain nor her knee complaints were related to her injury of September 30, 1999. He also opined that the Petitioner's complaints of left leg pain were not related to her injury of September 30, 1999. Dr. Kelikian viewed the surveillance of the Petitioner and opined that the Petitioner's functional capacity evaluation was an invalid representation of her abilities in light of the surveillance videos. He stated that "there's a major inconsistency here and that the person I saw in the videotape walked totally different and more normal than the person that was in my office." (Res. Ex. 6). Furthermore, he stated that the cane was being used on the right side for a right foot injury and that a cane would be used correctly on the left side to be of any assistance with a right foot problem. Dr. Kelikian opined that the "cane was being used for some other purpose but not to help her walk." Upon further inquiry, Dr. Kelikian opined that "the patient brought in the cane for decoration." [*27] (Res. Ex. 6). He also stated that the Petitioner's ability to walk about in flip flops indicated that she did not need any support and was another inconsistency. (Res. Ex. 6).

CONCLUSIONS OF LAW

In support of the Arbitrator's decision relating to (F) is the Petitioner's present condition of ill-being causally related to the injury, the Arbitrator finds the following:

Prior to the incident on September 30, 1999, the Petitioner had undergone triple arthrodesis in 1983.

Both Dr. Coleman, the Petitioner's treating physician, and Dr. Kelikian, the Respondent's examining physician, agree that the Petitioner's stiffness in the foot and subsequent complaints of pain to the ankle, knee and leg were not related to the accident of September 30, 1999. (Resp. Ex. 6 and Pet. Ex. 13). Both physicians agree that the Petitioner suffered non-sympathetic regional pain syndrome as a result of the incident on September 30, 1999. Dr. Kelikian opined that the Petitioner had reached maximum medical improvement for her injury as of June 24, 2002 and her continued complaints were not due to the incident of September 30, 1999 but rather due to her previous triple arthrodesis. (Resp. Ex. 6).

The Arbitrator [*28] agrees with the opinion of Dr. Kelikian, the only physician who viewed the surveillance video, that the Petitioner exaggerated her complaints when she presented to the functional capacity evaluation, the evaluation of Mr. Belmonte and the independent medical examination of Dr. Kelikian on August 8, 2005. The video surveillance of the Petitioner obtained on June 20, 2005 revealed that the Petitioner is capable of driving, pushing a shopping cart, walking without a cane or limp and performing activities of normal living. (Resp. Ex. 2 and 3). Furthermore, the Petitioner was walking in flip flops which Dr. Kelikian opined was evidence that the Petitioner was capable of walking without supportive shoes. (Resp. Ex. 6).

The Arbitrator finds that Petitioner suffered a new injury to her right foot which aggravated her pre-existing arthrodesis. The Arbitrator finds that Petitioner's present condition of ill-being regarding her right foot is causally related to the accident of September 30, 1999.

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

Both Dr. Coleman, [*29] the Petitioner's treating physician, and Dr. Kelikian, the Respondent's examining physician, agree that the Petitioner's stiffness in the foot and subsequent complaints of pain to the ankle were related to the original arthrodesis and aggravated by the accident of September 30, 1999. Both physicians agree that the Petitioner suffered from a non-sympathetic regional pain syndrome as a result of the accident on September 30, 1999. Both doctors agree that Petitioner's complaints to her leg, knee, shoulder and low back are unrelated to the right foot injury sustained September 30, 1999. Dr. Kelikian opined that the Petitioner reached maximum medical improvement for her injury as of June 24, 2002. Dr. Coleman opined maximum medical improvement September 24, 2001.

The evidence indicates that the Petitioner has presented inconsistent complaints. The Petitioner exaggerated her complaints when she presented to the functional capacity evaluation, the evaluation of Mr. Belmonte and the independent medical examination of Dr. Kelikian on August 8, 2005. The video surveillance of the Petitioner obtained on June

20, 2005 revealed that the Petitioner is capable of driving, pushing a shopping cart, [*30] walking without a cane and performing activities of normal living. Furthermore, the Petitioner was walking in flip flops which Dr. Kelikian opined was evidence that the Petitioner was capable of walking without supportive shoes.

Petitioner has submitted bills for treatment and out of pocket expenses to various parts of her body other than her right foot. The Arbitrator finds Respondent liable for outstanding medical bills and out of pocket expenses related to the right foot through the date of June 24, 2002 and thereafter for prescription expenses for Bextra. The remaining bills are denied as not related. Respondent is entitled to credit for amounts previously paid.

In support of the Arbitrator's decision relating to (K) what amount of compensation is due for Temporary Total Disability, the Arbitrator finds the following:

Petitioner is alleging temporary total disability solely based on her injury to her right foot. The Petitioner's primary complaints throughout her later treatment was not to the right foot but rather to her right ankle, leg, shoulder, and back. Subsequent to her surgery to the foot, the Petitioner continued to complain of ankle pain and stiffness. Both Dr. Coleman, [*31] the Petitioner's treating physician, and Dr. Kelikian, the Respondent's examining physician, agree that the Petitioner's stiffness in the foot and subsequent complaints of pain to the ankle, knee and leg were not related to the accident of September 30, 1999. (Resp. Ex. 6 and Pet. Ex. 13).

The Respondent paid temporary total disability for the period of May 25, 2000 through May 13, 2002, the date Dr. Coleman noted maximum medical improvement for the Petitioner's condition and no return to work. In his deposition, Dr. Coleman reversed his no work opinion and agreed Petitioner was capable of returning to sedentary work with the ability to change positions.

Petitioner subsequently treated with Dr. King, however, Dr. King did not diagnose the Petitioner with any neurologic problems to the foot. During her treatment with Dr. King, the Petitioner primarily complained of back pain, which is unrelated to this claim. On June 24, 2002, Dr. Kelikian opined MMI and return to sedentary work. He recommended a functional capacity evaluation for specific restrictions. The Petitioner refused to attend the functional capacity evaluation stating that she was physically unable. However, there was no [*32] medical documentation to support her contentions. Subsequently, Dr. Coleman agreed that a functional capacity evaluation would be the best indicator of the Petitioner's physical capabilities. (Pet. Ex. 13).

The Arbitrator finds that the Petitioner's testimony as to her ability to work and the extent of her right foot disability is not fully credible as there is credible and reliable evidence that she exaggerated her complaints of pain and disability.

The Arbitrator finds that as a result of the right foot injury sustained September 30, 1999, the Petitioner is entitled to temporary total disability benefits from May 25, 2000 through June 24, 2002 for a period of 108 5/7 weeks and not thereafter. Respondent is entitled to credit for amounts previously paid.

In support of the Arbitrator's decision relating to (L) what is the nature and extent of the injury, the Arbitrator finds the following:

The Petitioner contends that she is permanently and totally disabled due to her injury to her injury to the foot that occurred. The Petitioner suffered a new injury at work which aggravated her pre-existing condition. She subsequently underwent a triple arthrodesis of her midfoot and surgery [*33] to her great toe. Petitioner was released to return to sedentary work with a recommended FCE by Dr. Kelikian. Petitioner's reasons for her refusal to attend the FCE were not supported by the medical evidence or the opinions of her treating physician. Dr. Coleman previously restricted Petitioner from working at all and revised his opinion at his deposition and agreed with Dr. Kelikian to sedentary work with the ability to change positions.

When the Petitioner finally submitted to a functional capacity evaluation, she utilized a cane and was unable to complete many of the required exercises due to her complaints of pain as noted above. Relying on the functional capacity evaluation, Joseph Belmonte opined that the Petitioner was unable to find a meaningful occupation within her limitations.

Dr. Kelikian, the only physician who viewed the surveillance video of the Petitioner opined that the Petitioner noted the inconsistencies between the ability demonstrated by Petitioner in the video and her presentation in his office weeks later.

The Arbitrator has previously noted the inconsistencies between Petitioner's performance at the FCE and her examinations and the abilities demonstrated on [*34] the surveillance video.

The Arbitrator finds that as a result of the injury suffered at work on September 30, 1999, the Petitioner has suffered the permanent loss of use of her right foot to the extent of 75% thereof.

In support of the Arbitrator's decision relating to (M) should penalties or fees be imposed upon the Respondent:

The Arbitrator denies penalties. The Respondent reasonably relied upon the opinion of Dr. Kelikian in denying the Petitioner's additional TTD. Petitioner unreasonably refused an FCE and has not looked for any type of work at all. The video surveillance of the Petitioner revealed that the Petitioner was exaggerating and misrepresenting her ability to walk without any supportive device or shoes and supports the opinion of Dr. Kelikian.

In support of the Arbitrator's decision relating to "O", mileage expenses, the Arbitrator finds the following:

The Petitioner was requested to attend an FCE during the time of year she resides in Florida. Petitioner refused to attend the IME. Petitioner agreed to an FCE in August, 2005, the time of year she resides in Indiana. Petitioner is therefore entitled to mileage expenses from her home in Indiana to Dr. Kelikian's [*35] office in downtown Chicago. Respondent is entitled to credit for an overpayment of mileage expenses.

Legal Topics:

For related research and practice materials, see the following legal topics:
Workers' Compensation & SSDIAdministrative ProceedingsClaimsTime LimitationsNotice PeriodsWorkers' Compensation & SSDIBenefit DeterminationsMedical BenefitsEmployee RightsWorkers' Compensation & SSDICompensabilityInjuriesOccupational Diseases