1 of 183 DOCUMENTS

MARY REDMON, PETITIONER, v. GSI GROUP, INC., RESPONDENT.

NO: 09WC 01702

ILLINOIS WORKERS' COMPENSATION COMMISSION

STATE OF ILLINOIS, COUNTY OF SANGAMON

13 IWCC 262; 2013 Ill. Wrk. Comp. LEXIS 294

March 18, 2013

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

OPINION: [*1]

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 19, 2012, is hereby affirmed and adopted.

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

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

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

The probable cost of the record to be filed as return to Summons is the sum of $ 35.00, payable to the Illinois Workers' Compensation Commission in the form of cash, check or money order therefor and deposited with the Office of the Secretary of the Commission.

ATTACHMENT:

ARBITRATION DECISION

19(b)

MARY REDMON
Employee/Petitioner

v.

GSI
Employer/Respondent

Case # **09** WC **01702**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Springfield**, on **April 19, 2012**. After reviewing all of the evidence presented, the [*3] Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES
C. [X] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
F. [X] Is Petitioner's current condition of ill-being causally related to the alleged injury?
J. [X] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [X] Is Petitioner entitled to any prospective medical care?
L. [X] What temporary benefits are in dispute?
[X] TTD

FINDINGS

On **September 15, 2007**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the alleged injury, Petitioner [*4] earned $ **17,316.00**; the average weekly wage was $ **333.00**.

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

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

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

Respondent is entitled to credit for all medical bills paid by Respondent, its workers' compensation carrier, or its major medical insurer.

ORDER

Petitioner's claim for temporary total disability benefits is denied.

Respondent shall pay reasonable and necessary medical services as further set forth in this Decision, pursuant to the Medical Fee Schedule, as provided in Section 8(a) and 8.2 of the Act. Respondent shall be given credit for any bills that have been paid by it, its workers' compensation carrier, or its major medical insurer and hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall provide, authorize, and pay for prospective medical [*5] treatment as recommended by Dr. Thomas and, if necessary, Dr. Baker as further set forth in this Decision.

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

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

June 14, 2012

Date

IN SUPPORT OF THE ARBITRATOR'S DECISION, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner was employed by Respondent for about three (3) years prior to September 15, 2007. Petitioner testified that prior to working for Respondent she had not had any prior problems with her wrists or thumbs. As of September 15, 2007, Petitioner worked as an assembler on the "cap" line which required her to use various tools to tighten bolts. There was considerable use of vibrating tools [*6] according to Petitioner. Within that job, she rotated between four (4) different stations. Petitioner testified she used vibratory tools every three to five minutes while working. PX 31 contains photographs of some of the tools Petitioner used in her job.

Petitioner testified that in mid-September of 2007 she noticed thumb and hand pain. She initially went to her family doctor, Dr. Kocher, who referred her to Dr. Stern. Petitioner also went to Steve Basham at Respondent's Human Resource Department on September 15, 2007, at which time an accident report was prepared. On cross-examination, Petitioner agreed that she did not have a specific accident that day. Her hands were bothering her and she reported it. Mr. Basham put down the date of September 15, 2007. Following this, Petitioner received some injections from Dr. Stern, a rheumatologist, and began seeing Drs. Brower and Clem at MOHA. Initially, the MOHA doctors prescribed medication and stretching exercises. In December of 2007 the MOHA doctors prescribed physical therapy on site at Respondent's plant along with anti-vibratory gloves.

Petitioner continued performing her regular job until February 2008 when she was moved to the [*7] "fan" line where she put together fiberglass fans. This required her to piece parts and motors together with bolts. Petitioner testified that her hands got worse during this time.

Petitioner testified that she finally received the anti-vibratory gloves in April of 2008. According to Petitioner, they didn't help.

In May of 2008, Petitioner moved to a new department where she pulled and scanned parts using a small scanning gun. There was also some computer work. According to Petitioner, her hands did not hurt as badly while on that job; however, she was occasionally pulled off that job and put into production where she noticed her hands would hurt more.

Petitioner testified that in June of 2008 Dr. Brower, Respondent's company doctor, took her out of production and she was transferred to a job where she drove a forklift. According to Petitioner, the only part of driving a forklift which was problematic for her involved plugging and unplugging which someone else would do for her. Petitioner was off work from September to November of 2008 for an unrelated medical condition. When she returned to work, she resumed driving the forklift and continued in that position until January 9, 2009, [*8] when she was laid off with others in a general layoff. Petitioner was still on restricted duty at the time of the lay-off.

Petitioner testified she returned to see Dr. Stern on January 29, 2009, at which time he recommended she use some gel on her hands and undergo an EMG.

Dr. Kocher referred Petitioner to Dr. Kefalas, an orthopedist, in March of 2009. She saw Dr. Kefalas on March 2, 20009, and March 30, 20009. Dr. Kefalas injected her left wrist and restricted her from repetitive work. He ordered x-rays which were negative for arthritis.

Petitioner testified that she became disenchanted with Dr. Kefalas and was referred by Dr. Kocher to Dr. Maender. He gave Petitioner thumb splints. In July of 2009, the EMG recommended by Dr. Stern was finally authorized and Petitioner underwent the EMG on September 14, 2009. When Petitioner returned to see Dr. Maender on September 21, 2009, he ordered Lyrica. Petitioner testified the Lyrica helped the tingling she was experiencing in her hands but not the pain. Petitioner was also prescribed physical therapy; however, it was not authorized.

Petitioner testified that she then chose to see Dr. Baker, a doctor whose name she obtained from her lawyer. [*9] Petitioner started seeing Dr. Baker on January 25, 2010. He examined Petitioner for complaints regarding her hands and thumbs. According to Petitioner, he ordered an MRI and, thereafter, performed injections in each hand. He also recommended a course of physical therapy but Petitioner's personal group insurance had expired and she had no way of paying for it.

Dr. Baker performed surgery on Petitioner's right hand on April 6, 2010, to repair a partial tear of the triangular fibrocartilage along with a flexor synovectomy. (Pet. Ex. 13) According to Petitioner, the surgery largely resolved her right hand symptoms. Petitioner testified that Dr. Baker recommended an EMG in October of 2010.

On November 2, 2011, Petitioner underwent an EMG test of the left upper extremity with Dr. DevlescHoward who reported that the results were normal. (Pet. Ex. 32) Petitioner returned to see Dr. Baker on November 29, 2011. At that point, he recommended that she undergo surgery on her left wrist. Petitioner testified she wanted a second opinion from Dr. Smith or Dr. Huss. Dr. Smith provided no opinion. Dr. Huss advised that he doesn't provide second opinions. Respondent's worker's compensation carrier ordered [*10] a utilization review. That evaluation was done by Dr. Darryl Thomas who concluded that Petitioner did not reasonably require surgery on her left wrist; instead, she needed to undergo more physical therapy first. (Res. Ex. 10)

Petitioner testified that she has not worked since being laid off on January 9, 2009, and she has continued to collect unemployment benefits since then. She has looked for work but hasn't found a job. Petitioner testified that as of 2007 she was living with her boyfriend. According to Petitioner, her boyfriend does most of the cooking, cleaning, and housework as he wasn't working at that time. There were, however, some things she couldn't do.

Petitioner testified that pushing or pulling down with her left hand causes pain and it feels like a rubber band is "snapping" in her left wrist when she throws a ball. Petitioner also watches how she sleeps and props her left hand on a pillow. It took Petitioner one hour to drive to the hearing site on the day of arbitration and she had to alternate her hands while driving. Petitioner also testified that she has the ability to "predict weather" with her wrists. Petitioner believes her left wrist is currently more problematic [*11] than her right wrist. The "snapping" feeling is gone in her right wrist. According to Petitioner, her right wrist feels good.

Petitioner testified that she previously underwent surgery on her right shoulder and it was the subject of a worker's compensation claim. According to Petitioner, she made a full recovery from that shoulder surgery. The only injury that continues to bother her is the pending claim regarding the alleged hand/thumb injuries.

On cross-examination, Petitioner clarified where she currently resides and who is living with her. She has four grandchildren ages 12, 9, 6, and 4. In 2007, she didn't believe she did anything for them except occasionally care for them. Her oldest grandson sometimes spent the night with her. Petitioner denied ever working at Wal-Mart.

Petitioner also explained that she did not tell Dr. Baker that her hands started hurting on September 17, 2007; rather, the doctor asked her when the accident report was filled out and she gave him that date. Petitioner had symptoms in her hands before September 15, 2007. She'd been experiencing them for a month or so and they came on gradually. Petitioner denied undergoing any treatment for her hands or fingers [*12] before September of 2007 because she didn't have a problem with them before that date. Petitioner did not recall telling the MOHA physicians her symptoms began in September of 2007. She thought she told them that was when she reported it. Petitioner didn't believe she had any symptoms from any cause before September of 2007.

Petitioner acknowledged she played softball once for Respondent. She doesn't bowl. She hasn't played pool for a long time and doesn't engage in any crafts.

Petitioner's family medical history includes diabetes; however, she hasn't been diagnosed with it. She has smoked "off and on" for twenty years, admitting that she quits and then starts again. Petitioner was injured in a motor vehicle accident years ago when she was hit by a drunk driver and suffered a concussion and bruised ribs. She made a full recovery except for headaches and some memory loss.

Petitioner remembered telling Dr. Maender that certain activities such as vacuuming, washing dishes and laundry, unscrewing jar lids, and driving, aggravate her symptoms. Petitioner acknowledged that she does not have a report from Dr. Maender stating her problems are work-related nor has she ever seen a report from [*13] him saying her problems are non-work-related. Petitioner disagrees with a note in his records stating she did not give full effort. His report had nothing to do with Petitioner's desire to go to Dr. Baker. She knew nothing about the letter he wrote to her attorney.

Petitioner testified that she hasn't physically picked up her grandkids since January of 2009 as she tries not to do things with her left wrist. Her right wrist seems fine. In August of 2010 Petitioner had an episode where her right wrist snapped. She could not recall what she was doing at the time but her wrist healed up thereafter.

Petitioner testified that she tries to be honest. She is claiming temporary total disability benefits since January of 2009; however, if she has been released to full duty, she is unaware of it but "if I have, I have."

Petitioner denied sustaining any other accidents since September 15, 2007, other than the one time her right wrist snapped.

On re-direct examination, Petitioner explained that if she picks up her grandchildren she does so using her elbows.

ShaeLynn Woods testified on behalf of Respondent. She is Respondent's workers' compensation benefits administrator. Woods testified that she [*14] has occasionally seen Petitioner outside of work. In particular, Woods saw Petitioner at the 2010 Assumption Fest in Assumption, Illinois. Petitioner had a cast on her wrist. At that time, Woods saw Petitioner loading a child onto a carnival ride. Woods was waiting in line with her own child at the time.

After hearing Woods' testimony, Petitioner testified in rebuttal. She conceded that she normally goes to the Assumption fair each year and that she was there with her daughter and grandchildren. Petitioner did not recall the incident Ms. Woods testified to.

Summary of the Medical Evidence

Petitioner was seen by Dr. Kocher on August 20, 2007, regarding bilateral thumb pain and elevated blood pressure, the former of uncertain etiology has she denied using any new tools at work or undergoing any new activities. Petitioner did report increasing pain in her thumbs, bilaterally, over the preceding several weeks. She described the pain as sharp, especially if she bumps her thumbs or hits any of her knuckles. Petitioner also described experiencing more pain with pressure over her thumbs. (PX 1) Dr. Kocher believed her bilateral thumb and hand pain could be secondary to Petitioner's underlying [*15] osteoarthritis although Petitioner had never been treated for osteoarthritis of her thumbs. Dr. Kocher ordered some x-rays and instructed petitioner to try Motrin for pain. (PX 1) X-rays were taken on August 22, 2007, and were unremarkable. (PX 1)

Dr. Kocher referred Petitioner to Dr. Stern on September 15, 2007, due to increased pain complaints in Petitioner's hands. Dr. Stern noted mild hypertrophic changes in Petitioner's DIP and PIP joints and tenderness in Petitioner's 2nd through 5th flexor tendons, bilaterally. His diagnosis was flexor tendinitis of the right and left 1st flexor tendons and early osteoarthritis of the knees and fingers. Dr. Stern recommended bilateral CMC wrist splints, prednisone, and a possible injection into the flexor tendon if Petitioner's thumb pain persisted. (PX 3)

Petitioner was examined by Dr. Brower at MOHA on November 7, 2007. Petitioner gave a history of bilateral thumb pain beginning four to six weeks earlier. She denied any trauma or new activities. Petitioner related that she had been seen by Dr. Stern. Petitioner initially believed she had arthritis but had been told she has "reflex tendonitis." Petitioner was using ibuprofen and thumb splints. [*16] On physical examination, Petitioner was noted to have a positive Finkelstein test bilaterally and minimal tenderness at the CMC joints. Dr. Brower's diagnosis was bilateral DeQuervain's. The doctor showed Petitioner some stretches she could perform. He encouraged her to not use the splints all of the time. She was to return as needed. According to the Clinical Worksheet from that visit, the nurse noted Petitioner had been told her reflex tendonitis was due to repetitive motion all the time. Petitioner was noted to be an assembler for Respondent at the Taylorville plant. She denied any repetitive motion hobbies. She initially worked on the "cap line" and currently worked on the "dive unit." (PX 5)

Petitioner returned to MOHA on November 26, 2007, and was examined by Sandra Elliott and Dr. Clem. Petitioner, who described herself as left hand dominant, reported that her condition in her hands seemed to be improving although the right hand was worse than her left hand. Petitioner also reported she was working regular duty on the drive unit line which involved some "pinch grip" which was reportedly a little difficult for her. Petitioner also reported having had trouble when working in [*17] the wiring department. Petitioner's primary discomfort was noted to be at the base

of her thumbs bilaterally, right greater than the left. Petitioner was advised she could remain on regular duty since she was doing well with varied job duties. The ibuprofen was stopped and Voltaren was to be initiated. Night-time use of the splints was recommended. If greater improvement was not noted, some light duty restrictions were going to be considered. (PX 5)

As of December 3, 2007, Dr. Brower (MOHA) examined Petitioner on site and noted that Petitioner's left hand seemed better than her right hand. Petitioner attributed her complaints to the assembly work she was performing as it improves when she is off work and gets sore after a couple of hours of work. Dr. Brower ordered therapy at Apex and they discussed trying a different type of work. (PX 5)

Petitioner began her therapy and followed up with Dr. Clem (MOHA) on December 17, 2007, reporting continuing improvement. The Voltaren was helping. Dr. Clem also gave Petitioner some Daypro. He recommended ongoing therapy and use of a bilateral Impacto and an anti-vibration glove. Dr. Clem also spoke with Shae-Lynn at GSI, via e-mail, who reported [*18] she would try to work with Taylorville to allow Petitioner to avoid certain activities to "help keep her out of harms way." Dr. Brower had previously restricted Petitioner from working with certain tools. Dr. Clem noted an area in the plant where Petitioner was lifting some boxes and experiencing problems. (PX 5, 7)

As instructed, Petitioner returned to see MOHA on January 10, 2008. Dr. Brower noted Petitioner was feeling much better after 11 therapy visits. Petitioner was to continue 4-6 more therapy sessions and her stretching exercises. Petitioner was advised to continue using the gloves with certain activities and to use ibuprofen or Tylenol as needed for pain. (PX 5)

Petitioner finished her physical therapy and returned to see Dr Clem at MOHA on February 4, 2008. She reported much improvement. Home exercises were helping quite a bit. She was not taking any medications and was working regular duty in assembly and packaging and experiencing no problems. (PX 5,7)

Sandra Elliott and Dr. Brower re-examined Petitioner on June 9, 2008. Petitioner had apparently been moved to a different job and had a re-aggravation. She was then moved to another job and was currently working "scanning [*19] at the gait [sic?]." The scanning job wasn't bothering her hands as she wasn't using any power tools, hand tools, or working with small parts. She was told to re-initiate her home exercises. Petitioner was also told she could continue working regular duty as she was currently assigned to scanning which had improved her symptoms. On her own, Petitioner had made an appointment with Dr. Stern. Dr. Brower suggested she return before that appointment to determine if it was still necessary. Petitioner was told to use ice as needed and to continue using her gloves. (PX 5)

Petitioner returned to see Dr. Clem as instructed in early June. Her hand was reportedly better. She was still working in "scanning." Dr. Clem did not see any reason for her to go to the specialist as Petitioner was doing well in "scanning" although the doctor didn't know if that was a permanent change. He was going to ask the nurse. Ibuprofen had been stopped due to elevated liver enzymes. (PX 5)

Petitioner returned to Dr. Stern's office for a re-assessment on June 21, 2008. Petitioner's primary complaints were bilateral CMC joint pain along with a burning sensation in the thenar eminences. Petitioner's left wrist was [*20] painful upon forced extension. She denied any numbness or tingling of the fingers, other than at the base of her thumb. Petitioner described performing quite a bit of work at Respondent's factory and the hand tools she used were believed to aggravate the base of her thumb. Petitioner expressed fear that she might lose her job if her hands don't improve. Dr. Stern's diagnosis was bilateral "CMC osteoarthritis. He injected both CMC joints and continued use of the splints. (PX 3)

Dr. Stern re-examined Petitioner on January 24 and 29, 2009, primarily in regard to a possible diagnosis of carpal tunnel syndrome as Petitioner was reporting increasing numbness, tingling, and a burning sensation in her thenar eminences. Petitioner reported she felt like she was losing strength in her hands. The injections had only helped for a brief period of time. Petitioner was instructed to use Voltaren Gel in the base of her thumb and to take vitamins B1 and B6. Nerve conduction studies were performed on January 29, 2009. (PX 3, 4)

Dr. Kefalas, a board certified orthopedic surgeon, examined Petitioner on March 2, 2009, regarding her bilateral thumb complaints. Petitioner reported an onset date of September [*21] of 2007 and associated her complaints with her work for Respondent as an assembler. Dr. Kefalas took x-rays and performed a physical examination. His diagnosis was bilateral thumb CMC joint synovitis for which he recommended anti-inflammatory medication and thumb spica splints. He also suggested a repeat injection as an option. Petitioner was advised she could continue working. Petitioner returned to Dr. Kefalas on March 30, 2009, with persistent thumb joint complaints. Petitioner was given an injection into her left thumb. If it helped, they planned to proceed with a right thumb injection in the future. (PX 9)

At the request of Petitioner's attorney, Dr. Kefalas faxed a note stating Petitioner could return to work without any restrictions and could perform any type of work. (PX 9)

In a letter dated April 6, 2009, and addressed "To Whom It May Concern," Dr. Clem reviewed his examination of Petitioner on June 16, 2008. At that time, Petitioner complained of bilateral hand pain. He noted Petitioner was performing scanning activities without significant problems and he released her to full duty without any restrictions. (PX 3)

Petitioner returned to Dr. Kefalas' office on April 15, 2009. [*22] Her left thumb, overall, felt quite good. Petitioner's right thumb was reportedly bothersome. She was wearing her splints and described a burning sensation in both her hands. Dr. Stern had her taking vitamin B supplements. Petitioner's right thumb was injected. She was allowed to continue regular duty and advised to consider discussing the monitoring of her vitamin B levels with Dr. Stern. (PX 9)

Petitioner was referred by Dr. Kocher to Dr, Maender, an orthopedic surgeon and she underwent an evaluation with him on May 6, 2009. Dr. Maender reviewed Petitioner's history with her. X-rays showed mild osteoarthritis of Petitioner's CMC joints. Dr. Maender recommended a change in her splint. He did not believe the numbness in her thenar pad was related to her carpal tunnel syndrome and her nerve conduction velocities were essentially normal. She was to return in six to eight weeks. (PX 11)

Petitioner returned on June 24, 2009, and there was really no change in her condition. Dr. Maender did not feel surgery was really going to help matters. If she continued to have trouble, Dr. Maender felt an FCE might be appropriate. (PX 11)

Petitioner returned to see Dr. Maender on July 20, 2009, complaining [*23] of needles and tingling sensations in the tips of her middle and ring fingers for the previous week to week and a half. She denied any numbness in her little finger or index finger. She especially noticed the symptoms while performing gripping activities. Petitioner reported that her husband had undergone an EMG which was very different than the one she had undergone. According to Petitioner, her test did not involve any needles. Dr. Maender did not find any evidence of carpal tunnel syndrome on examination but since Petitioner requested a repeat nerve conduction study and EMG, he ordered one to be done. (PX 11)

Authorization for an EMG was denied by the worker's compensation carrier. As of August 26, 2009, Petitioner felt her left hand was worse than her right hand. Petitioner expressed great concern to Dr. Maender regarding her complaints and her desire for further evaluation. Tinel's, Durkan's and Phalen's were all negative. Petitioner did have positive pain to palpation of her CMC joint and a positive grind sign on examination. Every muscle group tested showed weakness. Dr. Maender questioned whether Petitioner was giving full effort on examination. Based upon the foregoing, Dr. [*24] Maender still didn't really believe Petitioner had carpal tunnel syndrome but he continued to recommend the EMG/NCS. (PX 11)

The EMG/NCS was performed and both were negative. Petitioner followed up with Dr. Maender on September 29, 2009, still complaining of burning pain in the thenar pad of her left hand. Dr. Maender did not feel Petitioner needed surgery but suggested a trial of Lyrica for her pain. He still did not have a diagnosis for her burning pain. Dr. Maender did not feel Petitioner's burning pain was work-related since Petitioner had been off work for so long and her complaints had not improved. His office note references a letter having been sent to Petitioner's attorney regarding that. (PX 11)

Petitioner returned to Dr. Maender on October 19, 2009. The Lyrica was having a positive impact on Petitioner's pain and she was given two refills. Other than that, her condition was essentially unchanged. Petitioner reiterated her belief that her problems all began on the cap line at work. (PX 11)

In his office note of November 11, 2009, Dr. Maender discussed Petitioner's right hand pain and its relationship to Petitioner's work. He stated that when he had earlier written to her [*25] attorney in August he did not have a specific diagnosis and could not relate it to Petitioner's work activities. At this time, he believed Petitioner sustained some blunt trauma to the skin nerves in her thenar pad and that was giving her pain, most likely secondary to the repetitive work she was performed and the repetitive blunt trauma to that side of her hand. He did not feel her CMC arthritis was work-related. He did not recommend any surgery but felt she should continue the Lyrica for a short period of time. (PX 11)

Petitioner was seen in follow-up by Dr. Maender on January 13, 2010. Petitioner described intermittent left hand pain while her right hand pain was more bothersome, especially along the entire volar aspect of her wrist, along the CMC joint and dorsally. She experiences a lot of pain when bumping her wrist. She also has tingling and shooting pain, with cramps throughout her thenar muscles. She denied any numbness at the tips of her fingers.

Petitioner had been switched from Lyrica to Neurontin for insurance reasons. She expressed the desire to resume using Lyrica. X-rays were taken. Dr. Maender recommended a trial of physical therapy and a return to the Lyrica. (PX [*26] 11)

Petitioner did not return to Dr. Maender. Instead, she began treating with Dr. Baker, a physician affiliated with the Center for Cosmetic Medicine, Ltd. Dr. Baker initially examined Petitioner on January 25, 2010. He ordered a wrist MRI which was done on February 3, 2010. Thereafter, he saw Petitioner on several occasions and gave her wrist injections in an effort to try and pinpoint the source of Petitioner's problems. On March 22, 2010, Dr. Baker recommended surgery for both wrists. (PX 13)

Petitioner's wrist MRIs were performed on February 3, 2010. The right wrist MRI revealed middle increased signal and edema throughout her wrist with increased enhancement within the soft tissues of the wrist and synovium, all of uncertain etiology. (PX 16) The left forearm MRI was essentially unremarkable. The left wrist MRI showed a mild ulnar minus variants and increased signals in the region of the TFCC but no definitive discrete tears and edema within the soft tissues and enhancement seen in the soft tissues and synovium throughout the entire wrist raising concern for inflammatory arthropathy such as rheumatoid. (PX 33) Injections followed in an effort to pinpoint the source of Petitioner's [*27] pain. (PX 13)

Dr. Baker performed right wrist surgery on April 6, 2010. In the operative report, Petitioner's preoperative diagnosis is "Persistent pain, right wrist aggravated by work activities." Petitioner underwent a radiocarpal and midcarpal joint arthroscopy with debridement and capsular tightening, a flexor synovectomy of the flexor carppi radialis, and flexor synovectomy in the carpal tunnel area. (PX 18) Post-surgery, Petitioner was given a cast for her wrist and, eventually, a brace. Petitioner sought emergency care for an ill-fitting cast on April 27, 2010. The cast was adjusted to allow for better comfort. (PX 27)

Petitioner followed up with Dr. Baker thereafter. He subsequently recommended physical therapy; however, Petitioner was unable to proceed with it because her group/personal health insurance had run out in May of 2010. Dr. Baker prescribed home exercises in the alternative. In June of 2010 he prescribed work hardening which Petitioner could not undergo due to lack of insurance. (PX 13)

Over the course of the next few months, Petitioner's condition was monitored by Dr. Baker and she continued with home exercises. In October of 2010 he recommended an EMG and it [*28] was eventually authorized and performed on November 2, 2011. The study was normal. At the time of the study, Petitioner reported a good outcome from her right-sided surgery. As of November 29, 2011, Dr. Baker was recommending left wrist surgery. Throughout the time period Petitioner has been treating with Dr. Baker, he has kept her off work. (PX 13)

Dr. Baker testified by deposition taken March 2, 2011. Dr. Baker is a plastic surgeon and hand surgeon. Dr. Baker initially saw Petitioner January 25, 2010, at which time she conveyed to him that she worked on air tools on an assembly line for a number of months prior to mid-September of 2007, at which time she had an injury to her hands. Petitioner complained of burning pain and tingling in her hands and pain at the top of her thumb joints. She tried ultrasound, Lyrica and other medications but she still had difficulties. While working in the assembly line 10 - 12 hours per day and for 13 days in a row she was complaining of hand pain and the safety director gave her impact gloves to wear. She sought medical treatment and the doctor took her off the assembly line and she was moved to a scanning line and then driving a fork truck. Despite [*29] all the moves, her hands still hurt.

Dr. Baker, by history, related Petitioner's symptoms to the use of power tools at work. (PX 33, p. 27-28) Dr. Baker had no opinion regarding Petitioner's right elbow complaints and her work duties. (PX 33, p. 28) Dr. Baker also indicated that Petitioner's problems could relate to her job or to household activities or to activities such as lifting 20 to 40 pound children. (PX 33, pp. 40-41) Dr. Baker also conceded that Petitioner's synovitis could be due to natural degenerative aging changes, rather than due to activity. (PX 33, p. 42) Dr. Baker also indicated that gripping a steering wheel driving or using a vacuum cleaner could have aggravated either Petitioner's TFCC problem or her synovitis condition. (PX 33, p. 42) Dr. Baker admitted that he is an advocate for his patient. (PX 33, p. 44) Dr. Baker predicts Petitioner will recover 90% of her function of her right hand and wrist. (PX 33, p. 45)

A Peer Review Report was prepared on March 2, 2012, by Dr. Darryl Thomas, a Texas board certified orthopedic surgeon, with regard to the medical necessity of a left De Quervain's release. Dr. Thomas reviewed various treatment records pertaining to Petitioner [*30] and was of the opinion Petitioner sustained an injury on September 15, 2007, secondary to repetitive trauma. Dr. Thomas determined that the proposed surgery was not necessary as Petitioner had not first attempted a three month trial of conservative care and splinting as recommended by Official Disability Guide-

lines. According to Dr. Thomas, Petitioner had been non-compliant with splinting and there was no evidence of recent conservative care other than an injection in November of 2011. (Res. Ex. 10)

Dr. Bilyeu's records show that Petitioner complained of a left wrist injury in December 2002 associated with carrying heavy pans of food at a nursing home. She was diagnosed with a sprain and instructed to return in 7 - 10 days if not improving. She did not return. (RX 12, pp. 11-12) Petitioner completed a New Patient Information Sheet for MOHA on July 25, 2005. In the document she denied any previous injury or surgery to her wrist, elbow or shoulder. (RX 7) Petitioner underwent right shoulder surgery, per Dr. Kefalas, on October 3, 2006. (RX. 6)

Other Evidence in the Record

Respondent introduced records of two previous workers' compensation claims both of which were settled. Case [*31] # 91-WC-37765 involved a neck injury and was settled for 2.5% MAW. The second involved a right arm and shoulder injury. It is numbered 03-WC-19943 and involves a right arm injury while Petitioner worked for Moweaqua Nursing Home. That case was settled for 25% PPD to the right arm. (RX 13)

The Arbitrator concludes:

1. Petitioner was a credible witness. The Arbitrator had the opportunity to observe Petitioner while testifying. Her demeanor and the manner in which she testified suggested she was only trying to be honest and she stated as much on cross-examination. That she was seen on one occasion lifting or helping a grandchild into a carnival ride, had some medical treatment in 2002 for a left wrist injury but denied it or had forgotten about it, and denied any shoulder injuries during a pre-employment physical does not diminish her credibility in this instance. While Petitioner may have testified incorrectly on some matters (such as the history she may or may not have given to Dr. Kocher in August of 2007) this Arbitrator still finds her testimony, as a whole, to be credible and believable. While Petitioner could not explain why she answered "no" on the MOHA questionnaire regarding [*32] prior shoulder or wrist injuries or surgeries, Petitioner did testify that she thought the form was completed before her right shoulder surgery (it was). She also acknowledged injuring her shoulder in 2003 but failing to disclose that on the form. While it is true she failed to disclose the foregoing, she wasn't under oath at that time. She was under oath during this proceeding and came across as truthful. This Arbitrator does not find her failure to disclose her prior injury on a MOHA form to be so intentional as to diminish her overall credibility.

2. Petitioner sustained an accident on September 15, 2007, that arose out of and in the course of her employment with Respondent. Petitioner has sustained a repetitive trauma injury to her hands and thumbs (including her bilateral CMC arthritis, bilateral flexor tendinitis, and bilateral DeQuervain's Tenosynovitis) which manifested itself on that date. Petitioner had been noticing the gradual onset of symptoms in her hands and thumbs for the preceding two months and on that date the symptoms reached a point where she associated them with her work and reported them to her employer. As reflected in Petitioner's credible testimony and the [*33] records of the treating physicians (especially those from MOHA) there was an association between Petitioner's work duties and her complaints. Petitioner's hands were better when she was away from work and then they would wax and wane depending upon the particular job Petitioner was assigned to. Petitioner's job on and before September 15, 2007 involved repetitive work and the use of vibratory tools. The Arbitrator further notes that Ms. Woods was present throughout the hearing and testified solely regarding her seeing Petitioner at a fair. Petitioner's testimony and the events recorded in the MOHA records (communications with her and others from Respondent regarding job modifications) were otherwise unrebutted by Ms. Woods.

3. Petitioner's current condition of ill-being in her hands, wrists and thumbs is causally related to her work accident of September 15, 2007, and her work for Respondent. This is based upon Petitioner's credible testimony, the records and testimony of the treating physicians (including the physicians from MOHA and Dr. Baker), and Respondent's peer review physician, Dr. Thomas. While Dr. Maender opined that Petitioner's burning pain in her thenar pads was due [*34] to repetitive blunt trauma and her repetitive work but that Petitioner's CMC arthritis was not work-related, his opinion regarding the latter is not persuasive in light of his lack of familiarity with Petitioner's prior treating physicians and their records. The Arbitrator further notes that while other activities may have aggravated Petitioner's symptoms, they do not negate the fact that Petitioner's work duties for Respondent were also an aggra-

vating factor. Petitioner's right elbow complaints are not causally related to her work accident and/or work duties for Respondent as no doctor rendered a causal connection in support of such a conclusion. Petitioner also failed to prove she has carpal tunnel syndrome as a result of her work accident and/or work duties for Respondent.

4. Petitioner's claim for temporary total disability benefits from January 10, 2009, through April 19, 2012, the date of arbitration, is denied. Petitioner was laid off with other workers in a general layoff on January 9, 2009. While Petitioner testified she was working restricted duty at the time of her layoff, the medical records show otherwise. When last seen at MOHA in June of 2008, Petitioner was working [*35] "regular duty" in scanning. Dr. Clem was going to speak with Respondent about making the scanning job a permanent position. Dr. Stern did not impose any restrictions when he examined Petitioner on June 21, 2008, January 24, 2009, or January 29, 2009. In a note dated April 6, 2009, Dr. Clem stated that Petitioner was released to full duty as of June 16, 2008, without restrictions. There is no question that as a result of her thumb and wrist problems, Petitioner was working a different job for Respondent at the time of her lay off; however, she was working full duty in that different job. Thereafter, no doctor, including Dr. Baker, imposed any restrictions or took Petitioner off work.

5. Petitioner is awarded the following medical expenses, subject to the medical fee schedule, as they are found to be reasonable and necessary:

1. Springfield Clinic/Dr. Stern (PX 4) - $ 194.00
2. Orthopaedic Center of Illinois (PX 12) - $ 447.40
3. Center for Cosmetic Medicine, Ltd. (PX 14) - $ 9,420.06
4. Decatur Radiology Physician Serv. Corp. (PX 15) - $ 340.40
5. Decatur Memorial Hospital (PX 17) - $ 1375.26
6. Decatur Memorial Hospital (PX 21) - $ 97.35
7. Prescriptions (PX 23) - $ 26.59
8. Prescriptions [*36] (PX 24) - $ 115.00
9. Taylorville Memorial Hospital (PX 28) - $ 144.77
10. Pathology Assoc. of Central Illinois (PX 29) - $ 12.60

Petitioner is not awarded the following medical expenses:

1. Community Medical Clinic of Pana (PX 2) - $ 70.00 (bill is for services preceding the accident date)
2. MOHA bill (PX 6) - ? (no bill included in the record)
3. Apex Physical Therapy (PX 8) -- $ 0.00 (bill has been paid in full)
4. Central Illinois Bone & Joint Center (PX 10) - $ 0.00 balance (bill has been paid in full)
5. Decatur Memorial Hospital (PX 19) - $ 0.00 balance (bill has been paid in full)
6. Associated Anesthesiologists (PX 22) - $ 0.00 balance (bill has been paid)
7. Taylorville Memorial Hospital (PX 25)- $ 0.00 balance (bill is for services preceding the date of accident)
8. Clinical Radiologists (PX 26) - $ 0.00 balance (bills are for unrelated services)

While some of the bills have not been awarded because they have been paid and some bills that have been awarded reflect outstanding balances and not the full amounts, the parties stipulated that Respondent is entitled to credit for all medical bills paid by it (either through its workers' compensation carrier or major [*37] medical insurer, Blue Cross/Blue Shield) and, in turn, is to hold Petitioner harmless for same.

6. Respondent is ordered to authorize and pay for three months of conservative treatment (splinting and injections) as recommended by Dr. Thomas, Respondent's peer review physician. Should conservative treatment not resolve Petitioner's symptoms (as Dr. Thomas acknowledged it is generally only successful in the majority of cases), Respondent is ordered to authorize and pay for surgery to Petitioner's left hand

and wrist as recommended by Dr. Baker, including all necessary and reasonable pre-surgical and post-surgical care.

Legal Topics:

For related research and practice materials, see the following legal topics:
Workers' Compensation & SSDIAdministrative ProceedingsClaimsTime LimitationsNotice PeriodsWorkers' Compensation & SSDICompensabilityCourse of EmploymentPersonal ComfortWorkers' Compensation & SSDICompensabilityInjuriesGeneral Overview

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ANTHONY DICANIO, PETITIONER, v. COOK COUNTY SHERIFF'S OFFICE, RESPONDENT,

NO. 07WC 21921

ILLINOIS WORKERS' COMPENSATION COMMISSION

STATE OF ILLINOIS, COUNTY OF COOK

13 IWCC 208; 2013 Ill. Wrk. Comp. LEXIS 215

February 27, 2013

JUDGES: Charles J. DeVriendt; Yolaine Dauphin; Ruth W. White

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 22, 2012 is hereby affirmed and adopted.

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

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

The 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

Anthony Dicanio
Employee/Petitioner

[*2] v.

Cook County Sheriff's Office
Employer/Respondent

Case # **2007** WC **21921**

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert Lammie**, Arbitrator of the Commission, in the city of **Chicago**, on **September 20, 2011**. Before a decision was rendered, Arbitrator Lammie left the Commission. Upon reassignment of the case the Honorable David Kane hereby renders the decision. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES
C. [X] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
F. [X] Is Petitioner's current condition of ill-being causally related to the injury?
J. [X] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [X] What temporary benefits are in dispute?
[X] Maintenance
[X] TTD
L. [X] What is [*3] the nature and extent of the injury?

FINDINGS

On May 14, 2007, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $ 57,200.00; the average weekly wage was $ 1,100.00.

On the date of accident, Petitioner was 45 years of age, *married* with 2 dependent children.

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

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

Respondent shall be given a total credit of $ 165,516.42 for amounts paid for TTD/Maintenance under the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $ 733.33/week for 86 & 3/7ths weeks, commencing 5/15/2007 through 01/08/2009, as provided in Section 8(b) of the Act.

Respondent shall [*4] pay Petitioner permanent partial disability benefits of $ **619.97**/week for **250** weeks, because the injuries sustained caused the **50%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner maintenance benefits of $ 733.33/week for **106** weeks, commencing 01/09/2009 through 09/20/11, as provided in Section 8(a) of the Act.

The Arbitrator finds that the treatment rendered by Oakton Chiropractic and Rehabilitation Inc. to be neither necessary nor reasonably required to cure or relieve the Petitioner from the effects of the accidental injuries, and Respondent is not liable for such charges. (see attached) All bills awarded shall be paid pursuant to the medical fee schedule and Respondent shall have cr4edit for all amounts paid.

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

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

March 15, 2012

Date

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

This case was heard by Arbitrator Robert Lammie and was subsequently reassigned to Arbitrator David Kane to render a Decision.

The Petitioner Anthony was employed by the Cook County Sheriff's office as a Deputy Sheriff. On 05/14/07, the Petitioner was engaged in duties as a process server. After attempting to serve papers, the Petitioner fell as a result of broken stairs at the location. To arrest his fall, he grabbed a railing and twisted his back. His left leg began to feel numb and he had a bad pain in his lower back.

He reported his injury to his Sergeant, filled out an accident report, and was treated at the Emergency Room of Lutheran General Hospital. The next day, he saw his primary care physician, Dr. Claudia Tiwet, who diagnosed muscle spasms secondary to a fall. She prescribed medication and physical therapy.

An MRI of 06/25/07 showed a left paracentral [*6] disc herniation at L5-S1. Dr. Tiwet referred the Petitioner to Dr. Martin Herman. Dr. Herman's recorded history was consistent with a twisting accident while descending stairs.

The Arbitrator therefore finds that the Petitioner did have an accident arising out of and in the course of his employment.

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

The opinions of Dr. Tiwet and Dr. Herman each connect the Petitioner's back condition to the accident of 05/14/07. Respondent's IME's from Dr. Koutsky and Dr. Khanna also relate the Petitioner's condition to the incident of 05/14/07. Accordingly, the Arbitrator finds that the Petitioner has proved that his present condition of left paracentral disc herniation at L5-S1 is related to the injury.

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?

Petitioner claims unpaid medical bills from Oakton Chiropractic Clinic in the amount of $ 3,176.00 and Rehabilitation Inc. in the amount of $ 9,350.56. Respondent challenges the reasonableness and necessity of these bills.

Regarding [*7] Oakton Chiropractic Clinic, treatment was rendered from 10/24/07 through 03/31/08, and consisted of application of modalities and chiropractic manipulations. A total of $ 10,985.00 was billed, $ 6,423.00 was paid, and $ 176.00 was refunded. Utilization review was performed by both an orthopaedic surgeon and a chiropractor, and neither found any reason to continue the treatments beyond the initial six visits. Upon review of the medical record, the Arbitrator notes no evidence of improvement, either subjective or objective in nearly eighteen months of treatment.

Regarding Rehabilitation, Inc., the treatment occurred from 10/31/07 through 03/31/09 and consisted primarily of manual therapy and therapeutic exercises. The treatment was conducted over 17 months which were concurrent with the chiropractic therapy. The Arbitrator notes that a note dated 07/08/08 shows an increase in range of motion from 10/31/07 to 06/06/08, but had actually decreased by 07/16/08. The therapist noted on 12/05/08 that the Petitioner continued to show constant, unchanging left leg anesthesias and pain. The therapist did not expect the symptoms to change with therapy. The Arbitrator finds that any treatment by [*8] Rehabilitation, Inc. after 06/06/08, the last date for which there is any objective evidence of improvement to be unreasonable and unnecessary, and Respondent is not liable for those bills. The bills for which Respondent is liable shall be paid pursuant to the medical fee schedule and Respondent shall receive credit for all amounts paid.

What are the temporary benefits to which the Petitioner is entitled?

Since becoming injured on May 14, 2007, Petitioner has remained off work. The Petitioner underwent a lumbar surgery on September 12, 2007. Dr. Herman, Dr. Khana, and Dr. Koutsky have all indicated that the Petitioner is a candidate for future surgery, but the Petitioner has declined to have further surgery. Based on the parameters set forth in an FCE, Dr. Herman indicated that the Petitioner is permanently restricted to a medium capacity work as of 01/08/2009. Accordingly, the Arbitrator finds that 01/08/2009 was the date of the Petitioner was at maximum medical improvement.

Accordingly, the Petitioner is entitled to TTD benefits commencing 5/15/2007 through 01/08/2009.

The Respondent has not been able to accommodate the Petitioner's restrictions. The Petitioner has engaged [*9] in vocational rehabilitation, consisting primarily of job placement assistance, but has not yet been placed with another employer.

The Arbitrator finds that the Petitioner is entitled to maintenance benefits beginning 01/09/09 through 09/20/11.

What is the nature and extent of the injury?

The Petitioner has engaged in a job search, but validity checks by the vocational rehabilitation counselor have questioned the validity of his search base on lack of verifiable information on some reported job contacts, and inaccurate information on some where the Petitioner reported that the companies were not hiring or taking applications when the counselor found this to be untrue. The Arbitrator notes that both the Petitioner's and the Respondent's vocational rehabilitation counselors show that the Petitioner has transferable skills directly related to security positions, however, the Petitioner has been thwarting efforts to place him in security positions first by delaying obtaining a PERC card and then refusing to attend a 20 hour class required for the jobs. The Arbitrator finds that the Petitioner has failed to present sufficient evidence that the Petitioner is medically incapable of work [*10] in any capacity, that he has engaged in a diligent but unsuccessful attempt to find work or that because of his age, skills, training, experience, and education, he will not be regularly employed in a well-known branch of the labor market.

The Arbitrator notes that the Petitioner's treating physician, Dr. Herman limits the Petitioner to a medium duty capacity according to the limits set forth in the FCE in February, 2008. The Arbitrator notes that the in the FCE, the Petitioner showed signs of symptom magnification and failed 6 of 7 validity criteria, so the FCE shows only the minimum functions that the Petitioner is capable of performing. This, together with the Petitioner's behavior thwarting his job search leads the Arbitrator to doubt the Petitioner's credibility regarding his current condition.

Based upon the foregoing, and after considering the entire record, the Arbitrator finds that Petitioner failed to prove he is totally and permanently disabled under section 8(f) of the Act, but that he ha suffered a "loss of trade" due to the accidental injuries herein. Therefore, the Arbitrator finds that Petitioner is permanently disabled to the extent of 50% under section 8(d)2 of the [*11] Act.

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 & SSDICompensabilityInjuriesAccidental Injuries

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HUMBERTO HERNANDEZ, PETITIONER, v. TYSON FOODS, INC. / THE BRUSS CO., RESPONDENT,

NO. 07WC 51046

ILLINOIS WORKERS' COMPENSATION COMMISSION

STATE OF ILLINOIS, COUNTY OF COOK

13 IWCC 182; 2013 Ill. Wrk. Comp. LEXIS 144

February 20, 2013

JUDGES: Charles J. DeVriendt; Yolaine Dauphin; Ruth W. White

OPINION: [*1]

DECISION AND OPINION ON REVIEW

Timely Petition for Review haying been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, temporary total disability, nature and extent and 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.

Initially, we correct a few clerical errors on page three of the Decision. The first paragraph states that Petitioner sought medical attention with Dr. Jader Reis on March 27, 2011 but the year was actually 2007. Similarly, in the third paragraph, the references to April 10, 2010 and May 29, 2010 should be 2007. We hereby correct these dates to reflect that the correct year is 2007.

Although we agree with the Arbitrator that Dr. Lorenz was Petitioner's third choice of physician, we do find his opinion credible regarding the date that Petitioner had reached maximum medical improvement. Therefore, we modify the ending date of temporary total disability benefits from April 8, 2010, which is [*2] the date Petitioner underwent the functional capacity evaluation, to June 28, 2010, which is the date that Dr. Lorenz returned Petitioner to work with restrictions of occasional lifting up to 24 pounds. As such, we hereby award Petitioner 44 weeks of temporary total disability benefits for the periods from March 27, 2007 through April 4, 2007 and September 3, 2009 through June 28, 2010.

On the issue of permanency, we modify the Decision to find that Petitioner has sustained the 12% loss of use of the person-as-a-whole under Section 8(d)2.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $ 378.10 per week for a period of 44 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 $ 340.29 per week for a period of 60 weeks, as provided in § 8(d)2 of the Act, for the reason that the injuries sustained caused the 12% loss of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $ 15,285.93 for medical expenses under § 8(a) of the Act subject to [*3] the medical fee schedule in § 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit in the amount of $ 1,838.70 under § 8(j) of the Act; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $ 50,700.00. 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:

CORRECTED ARBITRATION DECISION

Humberto Hernandez
Employee/Petitioner

v.

Tyson Foods, Inc./The Bruss Co.
Employer/Respondent

Case # **07WC 51046**

An [*4] *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 Black, Arbitrator of the Commission, in the city of Chicago, on May 25, 2011, May 31, 2011, and June 22, 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 document.

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

FINDINGS

On **March 26, 2007**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** sustain an accident that arose out of and in [*5] the course of employment.

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

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

In the year preceding the injury, Petitioner earned **$ 29,492.19**; the average weekly wage was **$ 567.15**.

On the date of accident, Petitioner was **33** years of age, ***married*** with **2** children under 18.

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

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

Respondent is entitled to a credit of **$ 1,838.70** under Section 8(j) of the Act.

ORDER
Respondent shall pay Petitioner temporary total disability benefits of $ **378.10**/week for **32 3/7ths** weeks, commencing **March 27, 2007** through **April 4, 2007** and commencing **September 3, 2009** through **April 8, 2010**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **March 27, 2007** through **April 8, 2010**, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay reasonable [*6] and necessary medical services, pursuant to the medical fee schedule, of $ **85.00** to **Dr. Jader Reis (Fullerton and Artesian Medical)**, $ **1,838.70** to **St. Mary of Nazareth Hospital, $ 10,738.01** to **Neck and Back Clinic, $ 1,081.44** to **Dr. Steven Sclamberg**, and $ **1,542.78** to **Lake Shore Open MRI and CT**, as provided in Sections 8(a) and 8.2 of the Act. All other medical benefits are denied for the reasons stated in the findings.

Respondent shall be given a credit of $ **1,838.70** for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $ **340.29** /week for **50** weeks, because the injuries sustained caused the **10%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Petitioner's claim for penalties and attorneys' fees is denied for the reasons stated in the findings.

Respondent shall receive a credit for all amounts paid to or on behalf of Petitioner on account of said accidental injuries.

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

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

October 16, 2012

Date

Statement of Facts

Petitioner testified that on March 26, 2007 he sustained an injury to his low back after lifting a 65 pound box. Petitioner testified that his normal work shift is 5:00 a.m. to 2:00 p.m. and that this accident occurred around 9:00 a.m. or 10:00 a.m. Petitioner testified that he continued working but that he did not finish his work day. He testified that he felt pain in his low back and that his left foot felt weak. On March 27, 2011, he sought medical attention with his family physician, Dr. Jader Reis. Dr. Reis assessed back pain, he prescribed [*8] an MRI of the lumbar spine, and he prescribed medications (PX1, p2).

Petitioner testified that when he returned to work he met with Bob, in Human Resources, who referred him to Physicians Immediate Care. Petitioner was seen at Physicians Immediate Care on March 28, 2007. The assessment was lumbar spine strain. The medical plan included an MRI (PX2, p2). The MRI was done on March 31, 2007, and it indicated a small disc herniation along with early degeneration at L4-L5 (PX3).

Petitioner testified that he returned to work with restrictions on April 5, 2007 per Dr. Reis and Physicians Immediate Care. Petitioner chose to continue treating with Physicians Immediate Care. Petitioner was sent for physical therapy, was prescribed sit down work only, was kept on medications, and was continued on a back brace (PX2, p3). Petitioner testified that he began physical therapy on April 10, 2010. Petitioner testified that he returned to work light duty pulling plastic off the line where meat was wrapped and which was going to be disposed of as garbage. Petitioner testified he worked this light duty job for approximately three months. As of May 29, 2010, Petitioner had concluded physical therapy, was [*9] released from medical treatment, and returned to full duty work.

Petitioner testified that he continued to have back complaints. Petitioner testified that a co-worker referred him to the Neck and Back Clinic, where he saw Dr. Ramirez on September 27, 2007. Treatment included physical therapy. Petitioner testified that he was discharged on March 17, 2008. Petitioner testified that during this time he worked light duty he had worked previously and that he also cut meat. Petitioner testified that he was referred for an EMG which he underwent on October 12, 2007. The EMG indicated denervation of the left SI nerve root (PX4, p52).

Petitioner testified that Dr. Ramirez referred him to Dr. Steven Sclamberg, an orthopedic physician, who he saw on October 19, 2007. Dr. Sclamberg diagnosed a lumbar strain with radiculitis, left-sided, EMG proven. Dr. Sclamberg recommended that petitioner continue with physical therapy, chiropractic evaluation, light duty, and medication (PX6, p6). Dr. Sclamberg recommended injections. Petitioner testified that he did not want the injections, because he has diabetes and high cholesterol. On January 25, 2008, Dr. Sclamberg ordered another MRI (PX6, p14). That [*10] MRI was done on February 9, 2008. That MRI indicated that at the L4-L5 level, there is a 3 to 4 millimeter subligamentous posterior disc herniation indenting the ventral surface of the thecal sac without significant spinal stenosis. That MRI also indicated there is a mild bilateral neuroforaminal narrowing, greater on the left (PX7). On March 20, 2008, Dr. Sclamberg examined Petitioner, diagnosed a lumbosacral strain, discharged Petitioner from treatment, and released him to work with permanent restrictions (PX6, p20).

Petitioner testified that he returned to regular work. Petitioner testified that he was terminated from his employment by respondent on September 10, 2008 for excessive absenteeism.

Dr. Lorena Ramirez testified at the hearing. She testified that she is a chiropractic physician employed by Neck and Back Clinic, which is now known as Marque Medicos. She testified that her diagnosis was low back pain. She testified that she referred petitioner for physical therapy and to Dr. Sclamberg. She testified that she also ordered chiropractic manipulation, which she administered. She testified that she initially saw petitioner three times per week and then reduced his visits to [*11] once every two months. She testified that she was not aware that petitioner had refused the injections due to other health issues.

Petitioner testified he sought treatment with Dr. Mark Lorenz on September 3, 2009 due to waist pain and an inability to work. Dr. Lorenz examined petitioner, ordered another MRI, and prescribed that petitioner be off of work. Dr. Lorenz's assessment was radicular irritation, left side, probably SI and mechanical low back pain, which is now chronic and not responsive to conservative care (PX8, pp 1, 2, 19). That MRI indicated that at L4-L5, petitioner had a diffuse disk bulge and bony spondylotic changes causing mild to moderate central canal or foraminal stenosis. That MRI further indicated mild facet disease at L5-S1 causing mild left foraminal narrowing (PX8, p4). Petitioner underwent an FCE April 8, 2010; the testing was read as conditionally valid with inconsistent effort (PX9, p1).Dr. Lorenz cleared petitioner to return to work June 28, 2010 with a permanent restriction of no lifting over 24 pounds (PX8, pp6,21). Petitioner testified that he continues to have ongoing symptoms.

Petitioner testified that he looked for work, and he submitted work search [*12] forms (PX11). Petitioner testified that he found two jobs. Petitioner testified that the first job was in July of 2010 as a forklift driver earning minimum wage as a temporary worker for Labor Solutions. Petitioner testified that the job lasted two weeks. Petitioner testified that the second job was working as a packer for Long Grove Confectionary for two months in September and October of 2010 earning minimum wage. Petitioner testified he has not worked since October of 2010.

On March 15, 2011, Petitioner he was examined by Dr. Frank Phillips pursuant to Section 12, as requested by respondent. Dr. Phillips opined that petitioner has suffered a lumbar strain/sprain. Dr. Phillips opined that any treatment after the May 29, 2007 discharge from the Physicians Immediate Care is not related and that the ongoing symptoms or complaints are not related (PX2, p6).

Respondent submitted a Coventry utilization review regarding the medical necessity of Dr. Ramirez's treatment. Chiropractic treatment and physical therapy from September 27, 2007 through November 8, 2007 was not certified. Dr.

Ramirez filed a three page appeal of the non certification. Coventry responded with another non certification [*13] (RX1).

Conclusions of Law

Regarding (F) Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator concludes:

The Petitioner offered evidence, without rebuttal, that he never had any low back pain until the accidental injury at work. The Arbitrator notes that Dr. Sclamberg diagnosed a lumbar strain with radiculitis, left-sided, EMG proven. The Arbitrator further notes that Dr. Lorenz's assessment was radicular irritation, left side, probably S1 and mechanical low back pain, which is now chronic and not responsive to conservative care. There is no evidence that these spinal symptoms ever manifested until the accident. The Arbitrator is persuaded by the medical opinions of Dr. Sclamberg and Dr. Lorenz. Based upon the foregoing, the Arbitrator finds that Petitioner's current condition of ill-being causally related to the accidental injury March 26, 2007.

Regarding (J) Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services? The Arbitrator concludes:

Petitioner has provided a fee schedule analysis (PX10), which [*14] has been admitted into evidence.

Petitioner first sought medical treatment with his primary care physician, Dr. Jader Reis. That treatment was reasonable and necessary. The Dr. Reis (Fullerton and Artesian Medical) bill of $ 85.00 is less than the medical fee schedule amount. This bill is awarded.

Petitioner underwent an MRI at St. Mary of Nazareth Hospital that was ordered by Dr. Reis. This initial MRI was a reasonable and necessary to help determine the cause of the physical complaints. The bill is for. $ 2006.00. Blue Cross paid $ 1,838.70, and the parties agree that respondent is entitled to a credit pursuant to Section 8(j) of the Act. The negotiated amount of $ 1,838.70 is awarded. Respondent is entitled to a credit of $ 1,838.70 pursuant to Section 8(j) of the Act.

Petitioner went for chiropractic and physical therapy treatment at Neck and Back Clinic. Although he was injured at work, and although his current condition of ill-being is causally related to the accidental injury, he received excessive unnecessary medical treatment at Neck and Back Clinic. Petitioner's testimony regarding that treatment was unconvincing. Dr. Ramirez's testimony was unpersuasive. Respondent has [*15] previously authorized payments of $ 10,738.01 of $ 34,583.00 in billings. Based upon the foregoing, $ 10,738.01 of Neck and Back Clinic billing is awarded, but no more.

Petitioner went to Dr. Sclamberg for orthopedic treatments a total of four times. The bills amount to $ 1,144.00. These bills are reasonable and necessary. Based upon the foregoing, the fee schedule amount of $ 1,081.44 is awarded.

Petitioner underwent an MRI at Lake Shore Open MRI and CT that was ordered by Dr. Sclamberg. The repeat MRI was a reasonable and necessary diagnostic tool that Dr. Sclamberg deemed necessary to assess his patient's current condition. The bill is for $ 1,839.18. Based upon the foregoing, the fee schedule amount of $ 1,542.78 is awarded.

Petitioner went to Dr. Lorenz after first choosing Dr. Reis and subsequently choosing Neck and Back Clinic. Therefore, Dr. Lorenz is Petitioner's third choice of physicians, as defined in Section 8(a) (3) of the Act. Based upon the foregoing, Dr. Lorenz's bills are denied.

Petitioner underwent an FCE at ATI Physical Therapy at the recommendation of Dr. Lorenz, to whom the FCE report is addressed. Because Dr. Lorenz is Petitioner's third choice of physicians, [*16] and because the FCE is in that chain of medical referrals, the ATI Physical Therapy bill cannot be awarded. Based upon the foregoing, the ATI Physical Therapy bill is denied.

Regarding (K) What amount of temporary total disability is due? The Arbitrator concludes:

The parties are in agreement that Petitioner was temporarily and totally disabled for the first claimed period from March 27, 2007 through April 4, 2007. What is in dispute is the second claimed period from September 3, 2009 through June 28, 2010. It is during this second period that Dr. Lorenz assessed radicular irritation, left side, probably SI and

mechanical low back pain, which is now chronic and not responsive to conservative care. Dr. Lorenz wrote disability notes on September 3, 2009 (PX9, p19) and November 14, 2009 (PX9, p20) stating that petitioner was unable to return to work. The FCE of April 8, 2010, was only conditionally valid due to petitioner's inconsistent effort, and therefore temporary total disability should not be payable thereafter. Based upon the foregoing, the Arbitrator finds that Petitioner is entitled to a second period of temporary total disability from September 3, 2009 through April [*17] 8, 2010.

Regarding (L) What is the nature and extent of the injury?The Arbitrator concludes:

Petitioner sustained a moderately substantial lumbar injury resulting in permanent work restrictions. Based upon the foregoing, the Arbitrator finds that Petitioner has sustained a 10% loss of the person as a whole.

Regarding (M) Should penalties or fees be imposed upon Respondent?The Arbitrator concludes:

Respondent has relied upon medical opinions from Physicians Immediate Care, thereafter from utilization review, and thereafter from Dr. Phillips in its denial of benefits. Petitioner has not met his burden of proof on this issue. Based upon the foregoing, the Arbitrator finds that Petitioner's claim for penalties and attorneys' fees is denied.

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 & SSDICompensabilityInjuriesGeneral Overview

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ANA ESCOTO LOPEZ, PETITIONER, v. HILTON OAK LAWN, RESPONDENT.

NO. 11WC 37480

ILLINOIS WORKERS' COMPENSATION COMMISSION

STATE OF ILLINOIS, COUNTY OF COOK

13 IWCC 152; 2013 Ill. Wrk. Comp. LEXIS 200

February 15, 2013

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

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 5, 2012 is hereby affirmed and adopted.

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

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

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

The probable cost of the record to be filed as return to Summons is the sum of $ 35.00, payable to the Illinois Workers' Compensation Commission in the form of cash, check or money order therefor and deposited with the Office of the Secretary of the Commission.

ATTACHMENT:

19(b) ARBITRATION DECISION

ANA ESCOTO LOPEZ
Employee/Petitioner

v.

HILTON OAK LAWN
Employer/Respondent

Case # 11 WC 37480

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on June 22, 2012. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:
J. [X] Were the medical [*3] services that were provided to petitioner reasonable and necessary?
N. [X] Prospective medical care?

FINDINGS

. On August 15, 2011, the respondent was operating under and subject to the provisions of the Act.

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

. On this date, the petitioner sustained injuries that arose out of and in the course of employment.

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

. In the year preceding the injury, the petitioner earned $ 18,259.28; the average weekly wage was $ 351.14.

. At the time of injury, the petitioner was 43 years of age, *married* with no children under 18.

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

ORDER:

. The medical care rendered the petitioner was reasonable and necessary.

. The petitioner failed to prove that the lumbar epidural steroid injections recommended by Dr. Gireesan are reasonable medical care necessary to relieve the effects of the work injury.

. 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 [*4] for a permanent disability, if any.

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

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

Robert Williams

7/3/12

Date

FINDINGS OF FACTS:

On August 15, 2011, the petitioner, a 43-year-old laborer, was bending down, changing a bed and felt back pain. She received care at Concentra Medical Center the next day for complaints of low back pain. X-rays were negative. She was treated with medication, physical therapy and restricted work for a lumbosacral strain and sacroiliac strain. On September 9th, she was released with no restrictions. She followed up at Concentra through October 5th.

Pursuant to her attorney's direction, the petitioner saw Dr. Giri [*5] Gireesan on September 30th, whose assessment was discogenic back pain. The petitioner received chiropractic treatment with Dr. Benjamin Narcissi from October 17th through the 25th. She returned to Dr. Gireesan on November 1st and on the 7th, at which time he opined that an MRI of her lumbar spine revealed a mild diffuse disc bulge with a superimposed small, shallow central disc protrusion with annular fissure at L4-5 and mild bilateral facet degenerative changes. Dr. Gireesan recommended lumbar epidural steroid injections. Utilization reviews by Dr. Lisa Gill on November 16th and December 23rd was a denial of certification of the epidural injections because of the negative radicular findings and studies.

The petitioner followed up with Dr. Gireesan on December 19th and reported 8/10 back pain. Pursuant to Section 12, the petitioner was evaluated by Dr. Michael Kornblatt on January 30, 2012, who opined that the petitioner sustained a lumbar strain, had reached maximum medical improvement and could return to full-duty work. The petitioner returned to full-duty work.

The petitioner followed up with Dr. Gireesan on March 20th, April 17th and May 14th with essentially the same level of [*6] back pain. She reported worsening symptom on June 11th and reported that she wanted the injections.

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

The medical care rendered the petitioner was reasonable and necessary. The respondent shall pay the medical bills in accordance with the Act and the medical fee schedule. The respondent shall be given credit for any amount it paid toward the medical bills, including any amount paid within the provisions of Section 8(j) of the Act, and any adjustments, and shall hold the petitioner harmless for all the medical bills paid by its group health insurance carrier.

FINDING REGARDING PROSPECTIVE MEDICAL:

The petitioner failed to prove that the lumbar epidural steroid injections recommended by Dr. Gireesan are reasonable medical care necessary to relieve the effects of the work injury.

Legal Topics:

For related research and practice materials, see the following legal topics:
Workers' Compensation & SSDIBenefit DeterminationsMedical BenefitsGeneral OverviewWorkers' Compensation & SSDICompensabilityCourse of EmploymentGeneral OverviewWorkers' Compensation & SSDICompensabilityInjuriesAccidental Injuries

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PATRICIA SANTOYO, PETITIONER, v. SCELEBRATIONS, INC., RESPONDENT.

NO. 11WC 17542

ILLINOIS WORKERS' COMPENSATION COMMISSION

STATE OF ILLINOIS, COUNTY OF COOK

13 IWCC 129; 2013 Ill. Wrk. Comp. LEXIS 177

February 7, 2013

JUDGES: Yolaine Dauphin; Charles J. DeVriendt

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 causal connection, temporary total disability, medical expenses, and penalties and fees, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).*

Findings of Fact and Conclusions of Law

TESTIMONY OF PETITIONER

1. Petitioner testified through an interpreter that on May 3, 2011 she had been employed by Respondent for two days as a seamstress. Prior to her employment with Respondent, her health was "very good." She did not have any complaints regarding either knee or her lower back and never had diagnostic tests for any of these body parts.

2. As a seamstress, Petitioner [*2] took measurements, cut material, used glue, and used an industrial sewing machine. Using the sewing machine she would sit and use a foot pedal. She had to kneel to take measurements, and generally had to do a lot of bending. The merchandise is on the first floor and the workshop is on the second floor. She estimated she went up the stairway 15 to 20 times a day.

3. Petitioner testified that on May 3, 2011 she began her shift at 10:00a.m. and was scheduled to work to 7:00p.m. At about 6:00p.m. she and a co-worker were taking measurements of a customer. The co-worker asked Petitioner for pins. As Petitioner turned around her right foot touched the platform and she fell forward on her knees onto the platform. She eventually fell on her chest and stomach. Petitioner immediately felt "more or less 9-10/10" pain in both her knees and her back. She was unable to move. Co-workers helped her up. They wanted Petitioner to continue working, but she "couldn't do it." Her right knee swelled up immediately and she was unable to operate the pedal. A co-worker took her home.

4. Petitioner further testified that the next day she sought medical treatment at Marque Medicos. Dr. James ordered x-rays, [*3] prescribed physical therapy, and asked Petitioner to stay off work. She was

referred to Dr. Engel for her back and Dr. Nam for knee x-rays. Dr. Engel prescribed MRIs of both Petitioner's knees and back, which was performed on May 6, 2011 and May 9, 2011, respectively. Both Dr. Engel and Dr. Nam kept Petitioner off work. Dr. Nam prescribed physical therapy and medications.

5. Petitioner also testified she had physical therapy for about a month. The physical therapy was helpful, but she still had pain complaints. Dr. Engel administered an injection on June 16, 2011 and Petitioner was eventually released to work with restrictions on August 15, 2011. Respondent did not accommodate her restrictions. The injection to her back helped but she still had pain complaints. Dr. Engel also administered a cortisone injection to her right knee, but that did not help.

6. Dr. Nam then ordered an MRI arthrogram on Petitioner's right knee. The pain in Petitioner's left knee had resolved. After the MRI, Dr. Nam recommended surgery, which was performed on September 20, 2011. She had post-operative physical therapy from September 29, 2011 to December 26, 2011. As of the later date Petitioner was released [*4] to work without restrictions regarding her knee. Petitioner had no pain in her knee after the surgery but she still had some impairment and was not 100%.

7. Petitioner further testified that the back injection in June of 2011 helped her low back for about two months. After her pain increased another injection was administered on October 13, 2011. The physical therapy Petitioner had for her knee caused increased pain in her back.

8. Petitioner also testified Dr. Engel referred her to Dr. Erickson who ordered a discogram which was taken on January 25, 2012. After the test, Dr. Erickson recommended surgery, which was performed on March 9, 2012. Petitioner stated she currently feels better after the surgery and could walk. She started physical therapy. While Petitioner is better after the surgeries, she is not back to the health she had prior to the accident. She still had pain in her back.

9. On cross examination, Petitioner testified she was sure that she "turned around and hit the platform." Her knees landed on the platform. Nobody at work asked her if she were okay, whether she wanted to see a doctor, or whether she wanted to go home. When asked if she filled out an accident report, [*5] Petitioner answered that she "didn't see that." Petitioner was taken home in an SUV. Petitioner sat in the back seat. Petitioner is 4'10" and had difficulty getting into the back seat. She tried to return to work with restrictions on August 15th or 16th, but her restrictions could not be accommodated. Petitioner did not remember if she received a letter from Respondent's insurer after she had a medical examination pursuant to section 12. Respondent paid medical bills prior to that medical examination.

TESTIMONY OF MARLENE ESPINOSA

10. Marlene Espinosa testified on behalf of Respondent. She has been a sales representative for Respondent for a year and four months. She and Petitioner were both working on May 3, 2011. On that date Petitioner was fitting a customer. Petitioner was going downstairs to get scissors, when she tripped over "the stand what [they] have on the chairs." The witness observed Petitioner fall forward. She filled out an accident report with Petitioner. Petitioner complained of hurting her leg. Petitioner did not complain about her back and only pointed to one leg as being hurt. At first, Petitioner indicated that she would wait for her son to pick her up.

[*6] 11. However, by 7:00 Petitioner stated she was going to take the bus so the witness and her sister drove Petitioner home. The witness did not remember Petitioner having difficulty getting into the back seat, but she did use the little handles on top of the vehicle to get in.

12. A few days after the accident, Petitioner came to the work place to deliver some paperwork from a doctor. She came alone without somebody to help her. About a month or two months prior to the hearing, Petitioner came to the workplace with a letter indicating that she could work. Petitioner did not appear to be having problems walking or getting around. The witness first met Petitioner on the day of the accident.

13. On cross examination, Marlene Espinosa testified Petitioner did not fill out the accident report. It was filled out by the witness and her sister, Paolo Espinosa. The witness told her sister what had happened. Marlene Espinosa testified that through the day previous to the accident, Petitioner did not complain of pain in her back or her knees.

14. The undated accident report was prepared by "Paola Espinosa (manager)" indicating Petitioner missed the raised dais and fell to her knee at 5:30pm [*7] on May 3, 201. Petitioner was asked if she wanted to see a doctor or go home early and she refused.

MEDICAL EVIDENCE

15. The medical records indicate that on May 4, 2011, Petitioner presented to Marque Medicos after falling the previous day at work. Petitioner reported "she hit the platform at the corner's edge, hitting both of her knees, the right greater than the left. She ended-up falling face first on her stomach onto the platform." She experienced immediate pain in both her knees. She reported 9/10 pain in the right knee and less intense pain in her left knee. She also reported increased low back pain after the accident, 8/10 intensity. Petitioner reported no previous accidents or injuries.

16. Dr. James, a chiropractor, noted that Petitioner limped while ambulating and needed help walking. She also noted extreme swelling and bruising of the right knee as well as intolerance standing suggesting internal damage. While the left knee showed less swelling and bruising, the palpable lateral pain suggested possible ligamentous damage. She also noted that the accident could have resulted in a pelvic jolt that could "involve some facet joints." Dr. James diagnosed bilateral [*8] knee contusion with lumbar spine sprain/strain, ordered MRIs, and prescribed physical therapy and chiropractic treatment. She also referred Petitioner for pain management and orthopedic consultation pending the MRIs. In her "chiropractic and medical opinion" Dr. James opined that Petitioner's current symptomology was caused by her work accident.

17. On May 5, 2011, Petitioner presented to Dr. Engel for a pain management consultation upon referral from Dr. James. Petitioner related the accident and that her pain was getting worse and interfered with her work, sleep, and daily routine. Dr. Engel diagnosed low back pain syndrome and knee pain and prescribed Ultram. He opined that Petitioner's conditions were related to her accident. He would refer Petitioner to Dr. Nam an orthopedic surgeon when the MRIs were completed.

18. An MRI taken May 6, 2011 showed fluid within the prepatellar bursa of the right knee indicative of bursitis, hypointense structures within the prepatellar bursa which were likely calcified bodies, discoid lateral meniscus, and joint effusion.

19. An MRI of the left knee taken May, 9, 2011 showed a 6 mm intrameniscal or parameniscal cyst intimately associated with [*9] the anterior root of the lateral meniscus, intrasubstance signal irregularity involving much of the body and posterior horns of the menisci, suggestive of mucoid degeneration, mild tri-compartment changes of osteoarthritis and small effusion.

20. Also on May 9, 2011 an MRI of the lumbar spine showed a 9 mm broad based protrusion at L5-S1 resulting in mild central canal and bilateral neural foraminal stenosis, mild disc bulging from L1-2 through L4-5 without stenosis, minimal anteriolisthesis of L4 on L5, presumably secondary to chronic facet arthropathy, and mild levocurvature of the lumbar spine.

21. On May 12, 2011, Petitioner was initially evaluated by physical therapy. She complained of 5/10 low back pain, 8/10 right knee pain, and 2/10 left knee pain. The therapist noted imaging studies of the knees were normal, but showed a right lumbar tilt with an anterior translation in lumbar weight bearing with anterolisthesis, L4 on L5 with degenerative changes at L4-5 and L5-S1 apophyseal articulations.

22. On May 19, 2011, Petitioner presented to Dr. Engel complaining of 5/10 back pain and 9/10 right knee pain. The back pain was substantially better so Dr. Engel released her to full [*10] work for her

back condition. He prescribed medication and noted that Petitioner must adhere to physical therapy and work restrictions as established by Dr. Nam.

23. On June 1, 2011, Petitioner returned to Dr. James, who noted her gait was much improved and the bruising and discoloration had also improved. Petitioner still reported 7-8/10 right knee pain and minimal discomfort in her left knee. Dr. James recommended Petitioner follow the recommendations of Dr. Nam whom she was to see on June 6th.

24. Petitioner returned to Dr. James the next day complaining of 4-5/10 low back pain. Dr. James diagnosed intervetebral derangement. Dr. James noted that although Petitioner complained of persistent pain, her "movements during her physical therapy program demonstrate that she has more full movement with less restriction and apprehension."

25. On June 6, 2011, Petitioner presented to Dr. Nam, who noted her bruising had improved but she still had pain especially in the right knee. Dr. Nam kept her off work and continued physical therapy.

26. On June 16, 2011, Dr. Engel performed L5-S1 provocative discography with fluoroscopy in multiple planes for lumbar disc herniation and knee pain.

[*11] 27. On June 30, 2011, Petitioner returned to Dr. Engel with only 1/10 back pain and 6/10 knee pain. Dr. Engels administered a right knee injection.

28. On July 11, 2011, Petitioner presented to Dr. Nam, who noted her swelling had improved significantly but she still had considerable pain in the right knee. Petitioner stated she had too much pain to work. Dr. Nam continued physical therapy.

29. On July 14, 2011, Petitioner reported to Dr. Engel she had no back pain but 7/10 right knee pain and 3/10 left knee pain. Dr. Engels prescribed Ultram.

30. On August 15, 2011, Petitioner returned to Dr. Nam and reported the physical therapy was not helping. Physical therapy was put on hold.

31. On August 17, 2011, Petitioner reported to Dr. Engel 2/10 bilateral low back pain. Her knees still hurt, right more than left, but the pain had decreased slightly. Dr. Engel noted that Petitioner would "continue full duty for her back" but should abide by Dr. Nam's restrictions for her knee pain.

32. On September 12, 2011, Petitioner returned to Dr. Nam still complaining of severe pain in the right knee. Dr. Nam wanted an MRI arthrogram to rule out chondral injury.

33. On September 14, 2011, an MRI [*12] of Petitioner's right knee showed an abnormal signal within Hoffa's fat pad, most prominently below the patella, suggestive of prominent scar tissue/fibrous tissue, mild prepatellar bursitis, discoid lateral meniscus without obvious meniscal tears, and a small Baker's cyst.

34. On September 19, 2011, Petitioner returned to Dr. Nam, who noted that the MRI significant hypertrophy of her fat pad posterior to the patellar tendon, without obvious meniscal tear and the cruciate and collateral ligaments appeared to be intact. However, "she did have some wearing and perhaps some chondral fragments in the patellofemoral joint." Petitioner was not interested in additional injections, which were of limited benefit. Dr. Nam indicated he was going to proceed with "arthroscopy, possible chondroplasty of the patellofemoral joint, and debridement."

35. The next day, Dr. Nam performed arthroscopic saucerization of discoid lateral meniscus (partial lateral meniscectomy), arthroscopic chrondoplasty of trochlea, and arthroscopic synovectomy.

36. On September 26, 2011, Petitioner reported to Dr. Nam that she felt improvement after surgery. She would begin physical therapy and would stay off work until [*13] reevaluation in a month.

37. On October 12, 2011, Petitioner returned to Dr. Engel complaining of 3/10 low back pain which radiated into her buttocks and 4/10 right knee pain. Her knee pain was better after pain medication, surgery, and injections. Dr. Engel noted that Dr. West's reports, after his medical examination pursuant to section 12, were inconsistent because he first stated that Petitioner showed no symptoms, but then stated that there appeared to be a significant amount of malingering. Dr. Engel would proceed with L5 and S1transforaminal epidural injections.

38. The next day, Dr. Engel performed L5-S1 provocative discography with fluoroscopy in multiple planes for lumbar disc herniation and knee pain.

39. On October 24, 2011, Petitioner presented to Dr. Nam reporting her right knee felt markedly improved since surgery, but she still had some discomfort and pain. Dr. Nam noted Petitioner was making good progress, but he thought she should continue physical therapy for another month. Dr. Nam released Petitioner to sedentary work.

40. On October 27, 2011, Petitioner returned to Dr. Engel reporting essentially no pain, unless she was lifting something heavy which caused [*14] pain in her right knee and both sides of her low back. Dr. Engel noted Petitioner would continue to see Dr. Nam and would be a candidate for a functional capacity evaluation for both her knee and herniated disc after she completes physical therapy.

41. On November 28, 2011, Petitioner presented to Dr. Nam and reported minimal or no pain in her right knee. Dr. Nam was happy that she was doing so well. He prescribed a trial return to work without restrictions.

42. On December 13, 2011, Petitioner returned to Dr. Engel reporting a significant increase in her low back pain to 8/10. "Her pain increased on approximately December 19th, when she was in" physical therapy. Dr. Engel recommended that Petitioner try to continue her restricted work activities and referred her to "Dr. Erickson, the neurosurgeon."

43. On December 26, 2011, Petitioner returned to Dr. Nam reporting no more right knee pain. Dr. Nam indicated he disagreed with the assessment of Dr. West that Petitioner showed little or no degeneration of her right knee. Dr. Nam noted that in his surgery he noted a torn discoid lateral meniscus which was repaired. The surgery relieved her pain so he opined that that condition was the [*15] cause of her pain. Dr. Nam released Petitioner from care for her right knee.

44. On January 6, 2012, the record indicates that "dematomal evoked responses were elicited from peripheral stimulation of the L3, L4, L5, and S1 distributions," and "significant evidence of S1 bilaterally .09 *** dematomal conduction delay was replicated."

45. On January 20, 2012, Petitioner presented to Dr. Erickson on referral from Dr. Engel. Dr. Ericson noted that the MRI of May 9, 2011 showed a moderate sized left paracentral herniation at L5-S1 and a grade I listhesis at L4-5 without foraminal narrowing. Dr. Erickson ordered a discogram. He opined that the treatment was necessitated by Petitioner's work accident.

46. On January 24, 2012, Petitioner returned to Dr. Engel reporting increased low back pain to 10/10. The pain radiated into her buttocks left greater than right. She discontinued Mobic because of side effects and Ibuprofen was not decreasing her pain. They would proceed with the discogram recommended by Dr. Erickson. Dr. Engel continued Petitioner's work restrictions and prescribed omeprezole.

47. On January 25, 2012, Dr. Engel performed L3-4, L4-5, and L5-S1 provocative discography with [*16] fluoroscopy in multiple planes for lumbar disc herniation and knee pain. It showed grade 4 tears

at 2 levels, severe disc space narrowing at L5-S1, mild neural foraminal compromise at L4-5 and moderate at L5-S1, and no evidence of stenosis.

48. On January 31, 2012, Petitioner returned to Dr. Engel reporting an improved 8/10 pain because she was taking post discogram medication. Dr. Engel noted that Petitioner had a positive discography at L5-S1. He believed her L3-4 positive result was secondary to discography technique and not a true positive disc. He noted that Petitioner would remain off work per Dr. Erickson.

49. On February 10, 2012, Dr. Ericson informed Dr. Engel that Petitioner was an excellent surgical candidate.

50. On February 28, 2012, Petitioner returned to Dr. Engel reporting 9/10 pain. Dr. Engel hoped that the surgery recommended by Dr. Erickson would be approved as soon as possible.

51. On March 9, 2012, Dr. Erickson performed total facetectomy and osteotomy at L5-S1, foraminotomies over the L5-S1 nerve roots on the left, placement of anterior interbody devise, anterior arthrosis, transverse lateral arthrosis at L5-S1, and placement of pedicle screw fixation.

52. [*17] On March 16, 2012, Petitioner returned to Dr. Erickson with acute pain, consistent with spasms, with some radiation. X-rays showed that the cage had not migrated. Dr. Ericson prescribed Soma and Valium and increased the dosage of Norco.

53. On April 5, 2012, Petitioner returned to Dr. Engel reporting 7/10 pain, which was substantially better than the 9/10 she reported at the last visit. Dr. Engel noted that Petitioner would begin physical therapy per Dr. Erickson and advised her to discontinue the Hydrocodone.

54. The medical bills submitted at arbitration purported to total $ 618,533.65, including $ 265,281.66 from Ambulatory Surgical Care Facility LLC, $ 109,456.50 from Marque Medicos and Medicos Pain and Surgical Specialists, and $ 80,605.00 from Dr. Ericsson.

DR. WEST'S REPORTS

55. On July 27, 2011, Dr. West performed an examination of Petitioner at the request of Respondent and issued a report. He noted that Petitioner complained of some pain in her right knee and lesser pain in her left knee and back. Dr. West reviewed medical records and MRI reports. The examination revealed only mild tenderness along the paraspinal muscles of the lumbar spine, but her "reaction [*18] were inconsistent and inappropriate to exam maneuvers." He found no significant physical abnormalities in Petitioner's knees.

56. In the report, Dr. West also indicated he could not "accurately determine the age of the 9 mm broad-based protrusion at L5-S1. This could be pre-existing or could have resulted from or made worse by the injury. In either case she appears to have made a good response to her treatment, which included oral anti-inflammatory medications, epidural steroid injections, and intraarticular injections [of the] right knee. At this point acute findings are minimal. The physical examination today is for the most part unremarkable. The mild residual discomfort emanates from her back *i.e.* sciatica. There appears to be a significant amount of malingering."

57. Finally, Dr. West also opined that the treatment to date had been reasonable and necessary, but no additional treatment was necessary as she appeared to have completely recovered from the acute injuries to her lower back and knees, and could return to work without restriction. He found it hard to believe Petitioner had not had previous problems with her back. The accident resulted in a simple aggravation of [*19] her preexisting conditions and did not result in permanent disability.

58. On September 12, 2011, Dr. West issued an addendum report at the request of Respondent. He concluded that "the traumatic work incident did not cause the condition/disability. At most she had a temporary aggravation of pre-existing degenerative conditions." Any such aggravation had completely resolved

at the time of his examination. "The work injury did not precipitate, aggravate, nor accelerate her pre-existing conditions beyond normal progression."

DR. WEST'S TESTIMONY

59. On March 14, 2012, Dr. West testified by deposition that he is a board-certified orthopedic surgeon who practices general orthopedics. At the request of Respondent's insurer, on July 27, 2011, he reviewed medical records and examined Petitioner pursuant to section 12. Petitioner reported pain in her knees and low back which she attributed to her fall on May 3, 2011 when she tripped over an object and fell on her knees and abdomen. She denied any previous problems with her knees or her back.

60. In his examination Dr. West found some mild tenderness along the paraspinous muscles of the lower back, but Petitioner "overreacted to [*20] any of [his] maneuvers as far as pressing the muscles or even when [he] wasn't touching her." Her reactions were not consistent with what he was able to elicit objectively.

61. Dr. West further testified Petitioner's reflexes were completely normal and the examination of her knees was completely normal. He did not have MRI films to review but he did have the MRI reports. The MRI of the left knee showed small effusion and mild tri-compartmental arthritis with no acute derangement. The MRI of the right knee also showed some fluid, a discoid lateral meniscus, with no acute internal derangement. The MRI of the lumbar spine showed a 9 mm broad-based protrusion at L5-S1 resulting in mild central bilateral foraminal stenosis, a spondylolisthesis at L4-5 and a mild lateral curvature of the spine. He took lumbar x-rays in the office which showed advanced degenerative disc disease at L5-S1 with almost complete collapse of the disc space and moderate degenerative changes at L4-5 with grade 1 spondylolisthesis. Dr. West opined that such a degree of degeneration would take a minimum of 20 years to develop. Petitioner's back was that of a person older than her 51 years of age. He diagnosed bilateral [*21] acute knee contusions superimposed on old arthritic degenerative disease, and acute strain LS spine superimposed on old degenerative disc disease.

62. Dr. West opined that she had completely resolved from the acute injuries and no further treatment was necessary. He saw no indication for knee surgery and no need for back surgery at this particular time. He thought she could return to work without restrictions. If she had surgery after he examined her, it would have been definitely inappropriate.

63. In an addendum report the witness replied to specific questions. He opined that Petitioner suffered "simply a very temporary aggravation" of her preexisting conditions. He did not think the injuries were major, and were "blown out of proportion." She had completely and totally returned to her base line condition when he examined her.

64. On cross examination, the witness testified he no longer performs surgery on knees, but he did for over 30 years. He last performed arthroscopic knee surgery about two years ago. He stopped performing spine surgery about 20 years ago. If he has patients who need these surgeries he refers them out. He had not reviewed any medical records generated after [*22] his initial report and did not reexamine Petitioner. When he examined Petitioner it was about 1 1/2 months after she had an epidural steroid injection and one month after a Kenalog injection in her right knee. Kenalog is a steroidal anti-inflammatory to reverse inflammations and arthritis is an inflammatory condition. Pain can be temporarily alleviated by an injection but can return.

65. Dr. West further testified he did not know whether Petitioner's condition deteriorated after he examined her and had no opinion about her current condition. He "absolutely" did not believe review of an MRI arthrogram was necessary for him to make a diagnosis. He disagreed that the fluid on the knees meant swelling. He explained swelling is of soft tissue and Petitioner had fluid on the knee which is common with arthritic conditions. MRIs are the standard method to diagnose internal derangement of knees, but MRI arthograms are not.

66. Dr. West further explained that a discoid lateral meniscus is an "abnormality of the cartilages within the knee; and, in most instances, it's a congenital problem." That condition, as well as meniscal tears and chondral flaps, can be asymptomatic. A meniscal tear can [*23] be caused by torquing or blunt trauma. In a broad sense a blunt trauma could cause a meniscal tear and cause these conditions to become symptomatic. Similarly asymptomatic stenosis can become symptomatic after blunt trauma.

67. The witness also testified that facet hypertrophy is a buildup of bone in the joints in the synovial joints in the back of the spine, as a natural reaction to arthritis. This condition can also become symptomatic with blunt trauma. Dr. West also opined that epidural steroid injections should be used only to treat "spinal stenosis, foraminal stenosis with significant symptoms." Pain can be temporarily alleviated by an injection but can return.

68. Dr. West further opined that the pathology reported in the MRI reports and in his x-rays were present for a long time and he noted no recent changes. Degenerative arthritis does not change that fast. He agreed that Dr. Nam's post operative diagnosis was torn discoid lateral meniscus, chondral flap lesion of trochlear, and synovitis of the Hoffman's anterior fat pad. The witness was not present at the operation, did not view any videos or photographs of the surgery, and had no reason to doubt Dr. Nam's diagnosis. [*24] He agreed that the accident could have aggravated Petitioner's underlying symptoms, but only very temporarily.

69. On redirect examination, Dr. West testified his addendum was requested by Respondent for clarification. Between the time of his initial report and the addendum, his opinion had absolutely not changed. Petitioner's description of her accident did not convince him that the accident permanently affected her conditions, and his examination findings supported his conclusions. If she developed problems after his examination that would be the result of her underlying condition or a subsequent accident and not the May 3, 2010 accident. He did not believe a discogram was indicated because it is only really useful when patient's have "confusing back problems." The post operative knee diagnosis provided by Dr. Nam noted degenerative conditions.

70. On re-cross examination the witness testified that a knee arthroscopy is the ultimate method to determine what is actually going on in a knee. It is the gold standard.

The Arbitrator found that Petitioner sustained a contusion to her right knee in the undisputed accident, since resolved, and was entitled to 12 1/7 weeks temporary total [*25] disability. However, the Arbitrator also awarded Respondent credit of $ 45,147.39 for overpayment of TTD, prepayment of PPD, "and for other benefits."

The Arbitrator also found that Petitioner failed to prove her current lumbar spine and left knee conditions of ill being were caused by her work accident and denied benefits for those conditions. The Arbitrator found no causation based on his perception of Petitioner's lack of credibility and the causation opinion of Dr. West. The Arbitrator noted that Petitioner's testimony was contrary to the incident report and the testimony of Marlene Espinosa. Specifically, the Arbitrator noted that Petitioner testified that she hurt both knees and her back and that she was not asked about her condition after the accident, but Ms. Espinosa and the incident report indicated she injured only one knee, and indicated she was okay after being asked her condition. The Arbitrator also noted that Petitioner's failure to seek immediate treatment was inconsistent with her testimony that she had immediate 9/10 pain after the accident.

Petitioner argues that Arbitrator erred in not finding causation. Although she did not preserve the issue, Petitioner asserts [*26] the Arbitrator erred in admitting the accident report and reports of Dr. West because they were hearsay. Petitioner also argues the causation opinions of Petitioner's treaters were more persuasive than the inconstant causation opinion of Dr. West.

The Commission concludes that the inconsistencies to which the Arbitrator refers are minor. The fact that Petitioner may not have immediately complained of back and left knee pain is understandable because Petitioner asserted throughout that her right knee was the most troublesome part of her body immediately after the accident. The fact that she did not seek treatment until the next day is not abnormal because people often wait to see how the pain progresses prior to seeking treatment. In addition, her testimony was only directly contradicted regarding whether she fell on one or both knees, whether she was asked if she were okay, and whether she wanted to see a doctor or leave early. In the opinion of the Commission, those contradictions are too minor to defeat Petitioner's claim on their own.

The Commission does not find the causation opinion of Dr. West persuasive. Dr. West eventually opined that Petitioner's current conditions were completely [*27] chronic and congenital in nature and that she suffered only a minor temporary aggravation of those conditions. However, his reports were inconsistent in that he initially stated that he could not be certain that the accident did not cause or worsen Petitioner's lumbar disc protrusion, but later opined that she certainly did not sustain any permanent aggravation of her underlying condition. In addition, he did admit in his deposition that blunt trauma could hypothetically aggravate the underlying conditions Petitioner had and could cause them to become symptomatic. In addition, Petitioner's treaters all consistently opined that her condition and need for treatment was the result of the accident.

The Commission accepts the opinion of Dr. West that Petitioner had preexisting conditions in both her right knee and her lumbar spine. Nevertheless, there is no indication that Petitioner ever received any treatment or even diagnostic tests for either her knee or lower back. While she had the preexisting conditions the Commission concludes that the accident of May 3, 2010 caused her conditions to become symptomatic necessitating treatment. Therefore, the Commission reverses the Arbitrator and [*28] finds that Petitioner did sustain her burden of proving a causal connection between her May 3, 2010 accident and the conditions of ill being in her lumbar spine and right knee.

The Commission also awards Petitioner temporary total disability from the date Dr. James first took Petitioner off work on May 4, 2011, through the date of arbitration April 26, 2011, a total of 51 2/7 weeks. The Commission notes that throughout that period Petitioner's treaters either kept Petitioner off work or imposed work restrictions which Respondent did not or could not accommodate.

While the Commission finds that Petitioner's lumbar and knee conditions were related to her work accident, the Commission is not prepared to award medical expenses. The Commission notes that because the Arbitrator found no causation, he did not address the issue of the reasonableness or necessity of the medical charges, which at least on first glance appear to be unusually high. This case was tried under Section 19(b). Therefore, the case has to be remanded in any event for a determination of any additional temporary total disability benefits and/or permanent partial disability benefits, perhaps with the benefit of a utilization [*29] review analysis. Therefore, the Commission remands the case to the Arbitrator to consider the appropriate award of medical expenses.

Although the Commission finds that Petitioner proved her case, the Commission does not believe Respondent acted in an unreasonable and vexatious manner. Respondent paid Petitioner benefits up to the date of Dr. West's report after his examination pursuant to section 12. The Commission notes that Dr. West's opinion was sufficiently persuasive to convince the Arbitrator that Petitioner's claim was not compensable. Therefore, the Commission finds that Respondent was not unreasonable to rely on it to deny benefits. Petitioner's request of penalties and fee is denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $ 220.11 per week for a period of 51 2/7 weeks, that being the period of temporary total incapacity for work under § 8(b), and that as provided in § 19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the [*30] case be remanded to the Arbitrator for determination of the appropriate award of reasonable and necessary medical expenses under § 8(a).

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $ 70,000.00. 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 [*31] the Commission.

ATTACHMENT:

ARBITRATION DECISION

19(b)

PATRICIA SANTOYO,
Employee/Petitioner

v.

SCELEBRATIONS, INC.,
Employer/Respondent

Case # **11** WC **17542**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **4/26/2011**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this 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?
[X] TTD
M. [X] Should penalties or fees be imposed upon Respondent?
N. [X] Is Respondent due any credit?

FINDINGS

On the date of accident, **5/3/2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship [*32] ***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 $ **132.00;** the average weekly wage was $ **330.00**.

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

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

Respondent shall be given a credit of $ **4,588.58** for TTD, $ **1,320.00** for *PPD advance*, $ 0 for maintenance, and $ **39,238.81** for other benefits, for a total credit of $ **45,147.39.**

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

ORDER

Petitioner's right knee contusion was causally connected to her work injury on May 3, 2011. Her right knee contusion resolved by July 27, 2011. Respondent paid all medical bills and TTD related to this condition. Petitioner's request for surgery on her [*33] right knee is denied.

Petitioner has failed to prove that her left knee or lumbar spine conditions are causally related to her work accident.

Petitioner is not entitled to any medical benefits or TTD after July 27, 2011. Respondent is entitled to a credit in the amount of $ 1,516.44 for an overpayment of TTD and $ 1,320.00 for an advance against PPD.

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

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

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

May 16, 2012

Date

BEFORE THE ILLINOIS WORKERS' COMPENSATION [*34] **COMMISSION**

PATRICIA SANTOYO,

Petitioner,

v.

SCELEBRATIONS, INC.,

Respondent.

NO. 11 WC 17542

Rider

Findings of Fact

Respondent is a dress boutique. Respondent hired Petitioner as a seamstress in May 2011. Petitioner does not speak English, and testified through a translator. According to Petitioner, her job as a seamstress involved taking measurements of customers and using an industrial sewing machine operated with a foot pedal to sew garments. Petitioner took measurements on the ground floor of the building where the customers shopped, and performed sewing upstairs on the second floor.

On May 3, 2011, her second day of employment, Petitioner was injured when she tripped over one of three platforms used for taking measurements. Petitioner offered a photo of the platforms, which are square boxes at the rear of Respondent's boutique. *RX26.* Customers stand on the platforms, which are raised and carpeted like the rest of the floor. According to Petitioner, she was taking a customer's measurements with a coworker named "Cocoa" when Cocoa asked her to get some pins. Petitioner turned and caught her right foot on the platform. She fell onto [*35] her knees and the rest of her body went forward. Her knees struck the platform and she landed on the floor with her arms extended in front of her.

Petitioner was in "a lot of pain" immediately after she fell. She rated her pain at that time as being at a level of 9 out of 10, and she testified that she was unable to move. She identified Cocoa and unnamed customers as witnesses to the accident. Respondent does not dispute that she fell. One of the store assistants came to her aid and helped her stand up. She did not remember the name of the store assistant but identified her as the sister of the store manager, Paolo. When asked on cross exam, she recalled her name was "Marlene."

Petitioner testified that her right knee immediately became swollen, and she did not finish her shift. No one asked her if she wanted to see a doctor, and no one asked her if she wanted to leave. After the store closed that evening, Paolo and her sister drove Petitioner home in their SUV. Petitioner denied that anyone made an incident report.

Marlene Espinoza has been a sales representative for Respondent for a year. Her sister is Paolo, the store manager. Espinoza, who speaks Spanish, was working on the accident [*36] date and observed Petitioner fall. According to Espinoza, Petitioner was inside a fitting room helping fit a customer. She tripped over one of the platforms after she walked out of the fitting room. Espinoza came to Petitioner's aid. Petitioner told her she injured a knee, not both knees. Espinoza did not remember which knee it was. Petitioner did not mention anything about her low back. Espinoza asked Petitioner if she was okay, and Petitioner said she was fine and that her pain was going away. Petitioner did not want to leave early. Espinoza and Paolo drove Petitioner home that evening in their Ford Edge SUV.

Espinoza related to Paola what happened, and Paola completed a form titled "Incident Report." *RX1*. The form indicates that on May 3, 2011, Petitioner missed a "dais," or platform, and fell onto her knee. The form further indicates that Petitioner refused medical attention. Petitioner did not work for Respondent again after the accident date.

Petitioner sought medical attention at Marque Medicos the following day. She testified that she complained of bilateral knee and low back pain. Dr. Sofia James, a chiropractor, took x-rays, ordered physical therapy, and authorized Petitioner [*37] off work. Petitioner testified that Dr. James referred her to two specialists, Dr. Ellis Nam for her knees and Dr. Andrew Engle for her back. Dr. Nam's medical records confirm that he examined her for the first time on May 6, 2011. *PX5*.

MRIs taken at Archer Open MRI on May 9, 2011, showed fluid and a small effusion in Petitioner's right knee; a cyst, mild effusion, and mild degeneration in her left knee; and mild disc bulging from L1-L2 through L4-5 and a disc protrusion at L5-S1 in her low back. Dr. Nam ordered physical therapy for Petitioner's knees and restricted her from working. Petitioner underwent physical therapy for about a month. She testified that it resolved the pain in her left knee but not her right. Petitioner testified that Dr. Engle kept her off work during the same time that Dr. Nam did. Dr. Engle administered an injection into her back, which was helpful. He released Petitioner to return to work with restrictions in June 2011.

Dr. Carlton West performed a Section 12 examination of Petitioner at Respondent's request on July 27, 2011. Dr. West testified by deposition on March 14, 2012. *RX2*. Dr. West has been licensed since 1975 and has been board-certified [*38] in orthopedic surgery since 1977. *RX2, page 5-6*. He estimated that only one or two percent of his practice consists of performing section 12 exams. *RX2, page 5*.

Dr. West took a history from Petitioner and reviewed medical records. He also reviewed the MRI reports. *RX2, page 16*. He did not see the films, but he took x-rays at his office. *RX2, page 17-18*. His impression was bilateral acute knee contusions and an acute lumbosacral strain superimposed upon old degenerative arthritic and degenerative disc disease. His acute findings were minimal, and Petitioner exhibited a number of exaggerated pain responses that were inconsistent with his exam. *RX2, page 13-14*. He felt Petitioner sustained "a minor injury" that was "blown out of proportion." *RX2, page 22-23*. He opined that she could work without restriction. In his addendum report, he opined that petitioner sustained at most a temporary aggravation of pre-existing degenerative conditions that resolved by the time of his exam.

On August 15, Dr. Nam released Petitioner to return to work with restrictions. According to Petitioner, she called Respondent's boutique on the same day as the exam and spoke with Paolo at [*39] approximately noon. Respondent did not have any work for her. Petitioner did not return to Respondent again after this. Espinoza recalled Petitioner bringing papers into the boutique and asking for light duty work. Espinoza observed Petitioner at that time, and Petitioner did not exhibit any difficulties getting around. Espinoza did not see Petitioner again.

After a cortisone injection that did not help, Petitioner underwent an MRI arthrogram of her right knee on September 11, 2011. Dr. Nam recommended surgery, which she underwent on September 20, 2011. Dr. Nam's operative report indicates a torn "discoid," or abnormally shaped, meniscus; a chondral flap lesion; and synovitis of the fat pad. The operative report indicates that Dr. Nam performed a partial lateral meniscectomy, chondroplasty, and synovectomy of the right knee. Postoperatively, Petitioner underwent physical therapy and used a machine for cold treatment on her knee. The last time she saw Dr. Nam was on December 26, 2011. He discharged her from care without any restrictions on that date. Petitioner testified that surgery resolved her symptoms.

As for her low back, Petitioner testified that she had increased back pain when [*40] she saw Dr. Engle on August 17, 2011. Dr. Engle prescribed another epidural injection, which she underwent on October 13, 2011. Dr. Engle referred her to Dr. Robert Erikson, who examined her for the first time on January 20, 2012. *PX5*. Dr. Erikson performed a lumbar fusion at L5-S1 on March 9, 2012. His operative report contains a diagnosis of "lumbar disc disease."

Conclusions of Law

1. Petitioner sustained an undisputed accidental injury when she tripped over a measurement platform on May 3, 2011. The real question is the extent of her injury. The Arbitrator has carefully considered the testimony of the witnesses, carefully reviewed the medical records and Respondent's Incident Report, and carefully weighed the credibility of Petitioner, Espinoza, and the physicians in this case. The Arbitrator finds a causal connection between the accident and a contusion to Petitioner's right knee.

The Arbitrator does not find Petitioner credible. First, her testimony about the events immediately following her accident are refuted by both Espinoza and the Incident Report that was completed after the accident occurred. Petitioner testified that she injured both knees and her back, [*41] and claimed this was what she told "Paola's sister." Espinoza, on the other hand, testified that Petitioner told her only that she injured one of her knees. According to Espinoza, Petitioner said she was okay. This is wholly corroborated by the Incident Report that Espinoza related to Paola. Indeed, Petitioner admitted that she did not seek treatment that night, but went to Marquee Medicos the next day. This is inconsistent with pain complaints at a level of 9 out of 10. Second, Petitioner testified that no one took any kind of report from her, offered to take her for medical attention, or asked her if she wanted to go home. Again, Espinoza and the completed Incident Report refute all three points. The Arbitrator acknowledges that the Incident report was not completed on the same day as the accident. However, the Arbitrator accepts Espinoza's testimony that it was completed within days, and finds that this was still well before Petitioner's testimony.

While it is plausible that the injury could have caused left knee and low back conditions--which Dr. West conceded--the Arbitrator finds insufficient proof in the Record to support that Petitioner actually did sustain work-related injuries [*42] to her back or left knee. The MRI reports of all three body parts show longstanding degenerative conditions. Petitioner admitted that her left knee symptoms resolved shortly after her accident, and Dr. Engle's records show her back improved by June. This corroborates Dr. West's opinion that Petitioner's injuries, if any, were minor and temporary. Even when she had surgery, Dr. Nam's diagnoses are all congenital or degenerative conditions. The Arbitrator adopts the opinion of Dr. West that Petitioner sustained a minor injury that at most resulted in a very temporary aggravation of an underlying degenerative condition. The Arbitrator places more credibility on the opinion of Dr. West, whose CV indicates he has practiced as an orthopedic surgeon for almost 40 years, over the opinions of Petitioner's treating physicians. Neither Dr. Nam's, Dr. Engle's, nor Dr. Erikson's credentials are contained anywhere in the Record.

2. The Arbitrator finds that Petitioner is entitled to 12-1/7 weeks of TTD from May 4, 2011 through July 27, 2011. Petitioner is entitled to the statewide minimum TTD rate ($ 253.00), or $ 3,072.14.

As for the rest of the time period Petitioner claims entitlement to TTD, [*43] the Arbitrator again does not find Petitioner or her treating physicians credible. The Arbitrator notes that Dr. Engle released her to return to work based on her alleged back injury in June, and Dr. Nam released her to return to work for her right knee in August. It was after Dr. West's exam that Petitioner began complaining of increased pain.

Based on the Parties' stipulation, the Arbitrator finds that Respondent paid a total of $ 3,588.58 in TTD. The Arbitrator finds that Respondent is entitled to a credit for an overpayment of $ 1,516.44. The Arbitrator further finds that Respondent is entitled to a credit for an advance against permanency in the amount of $ 1,320.00.

3. The Arbitrator finds that Respondent acted reasonably considering the totality of circumstances. Respondent never disputed that Petitioner fell. To the contrary, Respondent paid TTD and medical expenses. There is no evidence in the Record to show that payments were paid at a lower rate than they should have been, or that they were untimely. Respondent's belief that Petitioner injured only one knee was objectively reasonable based on Espinoza's personal observations and communication with Petitioner. The Incident [*44] Report completed after the accident corroborates Respondent's belief.

Respondent did not unilaterally suspend benefits. Rather, Respondent arranged a Section 12 examination with a licensed medical doctor and based its decision on Dr. West's opinions. The Arbitrator notes that Respondent actually paid TTD well after July 27, 2011, the date to which it stipulated that Petitioner was entitled to TTD. Moreover, Respondent complied with Section 19 of the Act and notified Petitioner and her attorney in writing that it would be suspending benefits. Respondent continued to pay medical bills even after it suspended TTD. The Arbitrator finds no basis for Petitioner's request for penalties and attorneys fees, and therefore denies her Petition for both.

DISSENTBY: RUTH W. WHITE

DISSENT: With respect, I dissent. Arbitrator Kane's decision is based on a thorough and accurate grasp of the evidence. His determination that Petitioner is not credible should not be disturbed. I would affirm and adopt the decision of Arbitrator Kane.

7 of 183 DOCUMENTS

MITCHELL ENGLISH, JR., PETITIONER, v. COOK COUNTY -- DEPARTMENT OF CORRECTIONS, RESPONDENT.

NO. 09WC 32920

ILLINOIS WORKERS' COMPENSATION COMMISSION

STATE OF ILLINOIS, COUNTY OF COOK

13 IWCC 109; 2013 Ill. Wrk. Comp. LEXIS 180

February 7, 2013

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

OPINION: [*1]

CORRECTED DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, reasonableness and necessity of 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.

1. Petitioner, through his attorney, filed an Application for Adjustment of Claim on August 7, 2009 which listed a date of accident of September 1, 2008 and alleged injuries to his right leg while working.

2. Petitioner filed a § 8(a) Petition/Motion on March 13, 2012. Hearing on the § 8(a) Petition/Motion was held before Arbitrator Williams on April 26, 2012 and he issued his Decision/Order on that date.

In his Decision/Order, Arbitrator Williams noted no Request for Hearing was submitted and that the parties stipulated to the following: Petitioner began treating with Advanced Physicians at the direction of Dr. Markarian, who was originally Respondent's examiner, but then became Petitioner's treating physician. Dr. [*2] Markarian referred Petitioner for treatment at Advanced Physicians. Petitioner began treating with Advanced Physicians on September 12, 2008. Treatment consisted of physical therapy for strength, pain reduction and biomechanics. On July 15, 2009, Dr. Markarian opined Petitioner's post-operative rehabilitation sessions are entirely appropriate and medically necessary and within the standard of care (Px2). Petitioner continued treating with Advanced Physicians through October 12, 2009. Respondent retained the services of GENEX to review the healthcare services for medical necessity and appropriateness. GENEX issued Outpatient Partial Recommendation Reports on February 26, 2009, April 27, 2009, July 24, 2009 and September 29, 2009 (Rx1). The Arbitrator noted that no Healthcare Services Review for Medical Necessity and Appropriateness was done after July 15, 2009.

The Arbitrator noted that the Advanced Physicians medical bill was $ 50,218.60, of which $ 27,793.54 remained unpaid. Of that unpaid amount, unpaid medical services prior to July 15, 2009 totaled $ 11,688.54. The charges for medical services after July 15, 2009 totaled $ 16,105.00.

Arbitrator Williams granted Petitioner's § [*3] 8(a) Petition. The Arbitrator ordered Respondent to pay $ 16,105.00 to Advanced Physicians for medical services performed after July 15, 2009. The Arbitrator found that no evidence had been presented by Respondent demonstrating that those charges were inappropriate, medically unnecessary and not within the standard of care. Regarding those charges incurred prior to July 15, 2009, the Arbitrator found

that $ 5,844.27 represented the sum that is appropriate, medically necessary and within the standard of care. Therefore, the Arbitrator ordered Respondent to pay to Advanced Physicians the total sum of $ 21,949.27 ($ 16,105.00 + $ 5,844.27) as provided in § 8(a) of the Act. The Arbitrator found Respondent's conduct did not warrant penalties.

3. The Commission notes the following was admitted into evidence at arbitration: Rx1 consisted of Utilization Review Reports by GENEX. In a February 26, 2009 Outpatient Partial Certification Recommendation, Physician Advisor Dr. Trotter, a board certified orthopedic surgeon, approved only the initial 24 post-operative physical therapy sessions. The requested treatment was 53 post-operative physical therapy sessions. Of those, 24 were approved and [*4] 29 were not approved. The start date October 17, 2008 was noted as was an end date of February 16, 2009. Dr. Trotter noted that Petitioner would appear to have had a reasonable combination of pain reduction and motion and strength established as early as approximately December 31, 2008. Dr. Trotter noted that as of December 29, 2008, the right knee motion was documented to have been up to 130 degrees and opined that at that point, Petitioner would not appear to have had any additional indication for active formal supervised therapy. Dr. Trotter noted that the ODG Guidelines regarding therapy allows for "fading of treatment frequency plus active self-directed home therapy program and allows for up to 24 visits after an arthroscopic type procedure involving the ACL", which this did not. Dr. Trotter opined, "However, the magnitude of the combination of preexisting comorbidity along with the arthroscopic procedure does appear to have warranted therapy through approximately 12/31/08 on a formal supervised basis, subsequent to that date, a prescribed self administered home program is what appeared to have been exclusively appropriate to allow for potential further consolidation of gains [*5] already well documented to have been achieved." Dr. Trotter noted that GENEX offers the opportunity for the requesting provider to discuss the non-certification decision and noted that an appeal of this decision could be filed by the provider. Dr. Trotter noted that this recommendation is for medical necessity and appropriateness. Petitioner was copied on this letter.

In an April 27, 2009 Outpatient Partial Certification Recommendation, Physician Advisor Dr. Trotter approved 10 work hardening sessions only and non-certified 10 visits. Dr. Trotter noted that ODG Guidelines support work hardening when an individual has had treatment with an adequate trial of physical or occupational therapy with improvement followed by plateau, but not likely to benefit from continued physical or occupational therapy or general conditioning. Dr. Trotter noted that the guidelines indicate that treatment is not supported for longer than 1-2 weeks without evidence of patient compliance and demonstrated significant gains as documented by subjective and objective gains and measurable improvement in functional abilities. Dr. Trotter noted that the maximal work conditioning indicated per the ODG Guidelines [*6] is to be "12 visits over an 8 weeks." Dr. Trotter noted that overall, there is no reasonable documentation of any recent severe deficit of motion or strength and that Petitioner has had an extensive amount of therapy over and above the ODG Guidelines previously. Dr. Trotter opined that Petitioner has the indication for a minimum amount of work hardening for one to two weeks, i.e. no more than 10 visits of work hardening. Dr. Trotter noted that this decision is based on the lack of documentation of any significant acuity, and/or severity of a combination of symptoms and/or exam findings that would warrant other than a prescribed self-administered home therapy program. Dr. Trotter opined that this would further consolidate gains already well documented to have currently been achieved. There was the same discussion and appeal language. Petitioner was copied on this letter.

In his To Whom It May Concern letter dated July 15, 2009, Px2, Dr. Markarian noted that Petitioner's physical therapy on February 26, 2009 was denied. Dr. Markarian noted that he had performed an arthroscopy partial lateral meniscectomy and synovectomy. Petitioner had continued pain which ultimately required a second [*7] arthroscopy for a re-torn lateral meniscus and a synovitis for which he performed a synovectomy. Dr. Markarian noted that he prescribed physical therapy for strengthening, pain reduction and to help Petitioner regain normal biomechanics. Dr. Markarian opined, "Therefore his post operative rehabilitation sessions are entirely appropriate and medically necessary and within the standard of care."

In a July 24, 2009 Outpatient Non-Certification Recommendation, Physician Advisor Dr. Kraft, American Board of Orthopedic Surgery, did not certify any additional physical therapy sessions after March 26, 2009. Dr. Kraft listed the medical records he had reviewed. Dr. Kraft noted that Petitioner completed 53 post-operative physical therapy sessions as of February 16, 2009. Dr. Kraft noted that Petitioner had an additional 38 physical therapy visits after February 16, 2009 to the present time. Dr. Kraft noted that evidence guidelines do not recommend prolonged passive intervention. Dr. Kraft noted that education to an effective home exercise program to address residual deficits should be established in the early course of care. Dr. Kraft opined that Petitioner already had more than 60 physical [*8] therapy visits prior to March 26, 2009 and that additional visits are not reasonable. Dr. Kraft noted that Petitioner is expected to be independent in an established home program to address remaining or recurrent deficits after the significant course to physical therapy through March 26, 2009. Dr. Kraft noted that regarding the documentation submitted, there is no evidence

that Petitioner has sustained significant functional and objective improvement as a result of the 91 visits attended. Dr. Kraft noted that the Progress Notes almost have the same contents with minimal changes and without evidence of home treatment program. Dr. Kraft opined, "Moreover, as claimant has not sustained significant improvement from the extensive 60 PT visits, continuing to provide more of the same treatment beyond 03/26/09 would not be reasonably expected to provide a different or better outcome." Dr. Kraft noted that furthermore, Petitioner has also attended work conditioning program. Dr. Kraft opined that medical necessity of additional physical therapy sessions after March 26, 2009 is not supported by documentation and is not recommended by evidence based medicine guidelines. Dr. Kraft recommended [*9] non-certification of physical therapy sessions after March 26, 2009. There was the same discussion and appeal language. Petitioner was copied on this letter.

In a September 29, 2009 Outpatient Non-Certification Recommendation, Physician Advisor Dr. Kraft did not certify the 9 physical therapy sessions from August 25, 2009 through September 13, 2009. Dr. Kraft listed the medical records he reviewed. Dr. Kraft noted that ODG-TWC Knee and Leg Procedure Summary last updated August 21, 2009 recommended 12 visits over 12 weeks following knee meniscectomy. Dr. Kraft indicated ODG-TWC notes that to justify ongoing treatment, even within these guidelines, patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction prior to continuing with the care. In addition to the six-visit clinical trial, every six visits thereafter the treating therapist should validate improvement in function in order for treatment to continue. Dr. Kraft noted that at about 3 months post-op, Petitioner had completed 39 physical therapy visits, far exceeding the recommended general course of therapy after meniscectomy. [*10] Dr. Kraft noted that in review of the treatment notes prior to August 25, 2009, pain reduction, increased range of motion and increased strength are noted. Dr. Kraft noted that however, based on the August 6, 2009 Progress Note, range of motion is noted to be within the functional range. Other than this, tenderness and pain are noted, but ongoing functional restrictions are not documented. Dr. Kraft noted that there is no physician evaluation noting significant ongoing deficits requiring further treatment. Dr. Kraft opined that considering minimal ongoing deficits and prior extensive treatment, the medical need for the performed physical therapy visits from August 25, 2009 through September 13, 2009 is not evident. Dr. Kraft opined that with the amount of treatment received to date, Petitioner is expected to be independent in a home exercise program and well-versed in a self-application of physical modalities to address any remaining deficit. Dr. Kraft recommended non-certification of the 9 physical therapy sessions from August 25, 2009 through September 13, 2009. There was the same discussion and appeal language. Petitioner was copied on this letter.

In a November 12, 2009 Outpatient [*11] Standard Appeal Decision, Dr. Kraft recommended Non-Certification. Dr. Kraft noted that the provider appealed the February 26, 2009 Outpatient Partial Certification Recommendation by Physician Advisor Dr. Trotter, who had recommended no additional physical therapy sessions beyond the initial 24 post-operative sessions. Dr. Kraft noted that the provider stated that Petitioner had a second arthroscopic knee surgery in June 2009. Dr. Kraft noted that although post-operative physical therapy is recommended by referenced medical guidelines, objective documentation of status, condition and knee deficits following surgery in June 2009 is absent. Dr. Kraft noted that more recent reports, especially following the second knee surgery, are not submitted for review. Dr. Kraft opined that absent such, medical necessity of the 24 additional physical therapy sessions beyond the initial 53 completed sessions (from February 16, 2009 up to the present) previously provided for the right knee is likewise not established. Dr. Kraft again recommended non-certification. Dr. Kraft noted that this recommendation is for medical necessity and appropriateness.

Px1 consists of medical bills from Advanced Physicians [*12] from September 21, 2008 through April 15, 2009 and from June 27, 2009 through October 12, 2009. The medical bills show that on September 12, 2008, there is a charge of $ 1,850.00. The next charge is on October 17, 2008 for physical therapy. The GENEX reports indicate these physical therapy sessions were post-operative. Therefore, the Commission infers that the first surgery was performed on September 12, 2008.

In 2008, Petitioner attended the following physical therapy sessions at Advanced Physicians: 10-17, 10-20, 10-22, 10-24, 10-27, 10-29, 10-31, 11-3, 11-5, 11-7, 11-10, 11-12, 11-14, 11-17, 11-19, 11-21, 11-24, 11-26, 11-28, 12-1, 12-3, 12-5, 12-8, 12-10, 12-12, 12-15, 12-17, 12-19, 12-22, 12-24, 12-26, 12-29, 12-31 (a total of 33 sessions; 24 sessions would be through 12-10-08).

In early 2009, Petitioner attended the following physical therapy sessions at Advanced Physicians: 1-2, 1-5, 1-7, 1-9, 1-12, 1-14, 1-17, 1-19, 1-21, 1-24, 1-26, 1-28, 1-30, 2-4, 2-5, 2-7, 2-9, 2-11, 2-13, 2-16, 2-18, 2-20, 2-23, 2-25, 2-27, 3-2, 3-4, 3-6, 3-9, 3-11, 3-13, 3-16, 3-18, 3-20 (34 sessions).

Petitioner then attended the following work conditioning sessions at Advanced Physicians: 3-23, 3-24, [*13] 3-25, 3-26, 3-27, 3-30, 3-31, 4-1, 4-2, 4-3, 4-6, 4-7, 4-8, 4-9, 4-10, 4-13, 4-14, 4-15 (18 sessions; 10 sessions would be through 4-3-09).

Petitioner had a second right knee surgery in June 2009. Petitioner then attended the following physical therapy sessions at Advanced Physicians: 6-27, 6-29, 7-1, 7-6, 7-8, 7-10, 7-14, 7-15, 7-17, 7-20, 7-22, 7-24, 7-27, 7-29, 7-31, 8-3, 8-5, 8-6, 8-10, 8-12, 8-13, 8-17, 8-19, 8-24, 8-25, 8-26, 8-27, 8-31, 9-2, 9-4, 9-9, 9-10, 9-11, 9-14 (34 sessions; 24 sessions would be through 8-24-09).

Petitioner then attended the following work conditioning sessions at Advanced Physicians: 9-15, 9-16, 9-17, 9-18, 9-21, 9-22, 9-23, 9-24, 9-25, 9-28, 9-29, 9-30, 10-1, 10-3, 10-5, 10-6, 10-7, 10-8, 10-9, 10-12 (20 sessions; 10 sessions would be through 9-28-09).

There are also additional charges on February 18, 2009 of $ 830.00 for metatarsal supports and on September 14, 2009 of $ 1,440.00 for a functional capacity evaluation.

The Commission affirms the Arbitrator's granting of the § 8(a) Petition, but modifies the amount awarded. Dr. Markarian made a blanket opinion that the post-operative treatment is entirely appropriate, medically necessary and within the [*14] standard of care, but he did not opine why. The GENEX Utilization Reviewers, Physician Advisors Dr. Trotter and Dr. Kraft, base their opinions on guidelines and reviewed medical records as noted in their reports. The Commission gives more weight to the opinions of Dr. Trotter and Dr. Kraft than those of Dr. Markarian regarding Petitioner's post-operative care. For those charges before June 2009, the Commission awards 24 physical therapy sessions from October 17, 2008 through December 10, 2008 and 10 work conditioning sessions from March 23, 2009 through April 3, 2009, as per the GENEX Utilization Review reports. According to the medical bill, this amounts to $ 14,810.00 and the Commission awards this amount, which includes the September 21, 2008 charge of $ 1,850.00 for surgery and the February 18, 2009 metatarsal supports charge of $ 830.00. For those charges after the June 2009 second surgery, the Commission awards 24 sessions of physical therapy from June 27, 2009 through August 24, 2009 and 10 work conditioning sessions from September 15, 2009 through September 28, 2009. According to the medical bill, this amounts to $ 13,265.00 and the Commission awards this amount, which includes [*15] the September 14, 2009 charge of $ 1,440.00 for the functional capacity evaluation. The Commission notes that the GENEX reports did not mention any reduction of the amount charged per session. The total award is $ 28,075.00 ($ 14,810.00 + $ 13,265.00) and is to be through the medical fee schedule. Respondent is given credit for $ 22,425.06 paid ($ 50,218.60 charges - $ 27,793.54 unpaid). The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $ 28,075.00 for medical expenses under § 8(a) of the Act, subject to the Medical Fee Schedule under § 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury. The Commission notes Respondent paid $ 22,425.06 in medical expenses.

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

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 therefore and deposited [*16] with the Office of the Secretary of the Commission.