2014 IL App (2d) 121283WC
No. 2-12-1283WC
Opinion filed March 28, 2014

IN THE

APPELLATE COURT OF ILLINOIS

SECOND DISTRICT

WORKERS' COMPENSATION COMMISSION DIVISION

COMPASS GROUP,	)	Appeal from the Circuit Court
	)	of Du Page County
Appellant and Cross-Appellee,	)	
	)	
v.	)	No. 12-MR-700
	)	
ILLINOIS WORKERS' COMPENSATION	)	
COMMISSION *et al.*,	)	
	)	Honorable
(Jeffrey Berman, Appellee and	)	Bonnie M. Wheaton,
Cross-Appellant).	)	Judge, Presiding.

JUSTICE HUDSON delivered the judgment of the court, with opinion.
Presiding Justice Holdridge and Justices Hoffman, Harris, and Stewart concurred in the judgment and opinion.

OPINION

¶ 1 I. INTRODUCTION

¶ 2 Respondent, Compass Group, appeals an order of the circuit court of Du Page County confirming a decision of the Illinois Workers' Compensation Commission (Commission) awarding benefits to claimant, Jeffrey Berman, under the Illinois Workers' Compensation Act (Act) (820 ILCS 305/1 *et seq.* (West 2008)). Claimant cross-appeals, arguing that the Commission erred in failing to impose penalties or award costs for purportedly medically necessary modifications that claimant made to his home. For the reasons that follow, we affirm in part, vacate in part, and remand.

¶ 3 II. BACKGROUND

¶ 4 The parties are aware of the facts, and the evidence presented below will not be set forth in great detail. Rather, we provide the following background to facilitate an understanding of this disposition. Additional detail will be provided, as necessary, as we encounter the issues raised by the parties.

¶ 5 Claimant was employed by respondent as a food-service manager. On March 19, 2009, he picked up a case of bottled soda weighing about 40 pounds. He immediately felt pain and heard a pop in his back, as well as a hissing sound. He worked the rest of his shift in pain. He saw Dr. Sofia Elterman the next morning and she diagnosed a sprain, prescribed Vicodin, and referred claimant to Dr. Lapp, a chiropractor. Following his appointment with Elterman, claimant worked the rest of the day in pain. He saw Lapp the next day, which was a Saturday. The following Monday, claimant went to work despite having difficulty walking. That evening, he was examined by Dr. Jonathan Erulkar at the Illinois Bone and Joint Institute and was diagnosed with stenosis. An MRI was ordered. Erulkar noted that claimant needed a cane to walk. Claimant did not have a cane, so he used his wife's walker.

¶ 6 Claimant worked on Tuesday (March 24, 2009). He was in excruciating pain and used the walker to ambulate. On Wednesday morning (March 25, 2009), claimant arose to go to work. He was descending the stairs in his house when his left foot gave way due to severe pain in his back and radiating down his leg. Claimant fell down the stairs, sustaining lacerations and bruises on his elbows, arms, and chest. Claimant was also bleeding from his nose as a result of the fall. Claimant's wife called paramedics, who arrived and helped claimant to his feet. Claimant declined to be taken to a hospital and instead went to work. At work, claimant did paperwork in an office. He could not get out of his desk chair due to pain. A coworker

eventually contacted claimant's wife. She came and took claimant to the hospital, where he was admitted.

¶ 7 At the hospital, claimant was noted to have abrasions on his head, knees, elbows, and fingers. X rays revealed olecranon bursitis in both elbows. On March 27, 2009, while still in the hospital, claimant began acting delusional. A blood test revealed a blood infection. Claimant was moved to the intensive care unit. Dr. Richard Sherman drained and packed claimant's olecranon bursae. Claimant's renal function began to deteriorate, and he began bleeding in his gastrointestinal system. An endoscopy was performed.

¶ 8 An exploratory laparotomy led to a colectomy. Claimant was intubated due to respiratory failure. Subsequently, a tracheotomy was performed, as claimant had difficulty weaning from the breathing machine.

¶ 9 On April 30, 2009, claimant was transferred to a long-term care facility. Dr. Istina Morariu observed olecranon bursitis and deep vein thrombosis. A CT scan revealed various back problems, and claimant was eventually diagnosed with a disc space infection. On May 21 and May 31, 2009, claimant underwent spinal surgeries. On June 26, 2009, claimant was transferred to a rehabilitation center, where he was noted to have a right foot drop and shingles on his face. On September 29, 2009, he was transferred to a hospital due to renal insufficiency. He was treated surgically for a left-elbow ulcer. He was sent back to the rehabilitation center, but returned to the hospital on December 1, 2009, for a four-day stay. He was again transferred to the rehabilitation center. Sherman examined claimant and noted ecchymosis and a hematoma in the left forearm. Claimant returned home, but remained under medical care. On May 20, 2010, claimant returned to the hospital and underwent an ileostomy reversal. Claimant was then transferred back and forth between the rehabilitation center and the hospital a number of times.

¶ 10 Sherman was of the opinion that the abrasions on claimant's elbows led to septic olecranon bursitis. This infection spread, via claimant's blood stream, to claimant's spine, intestinal tract, and kidneys. Dr. Scott Kale, who examined claimant on respondent's behalf, opined that claimant's condition was caused by either his olecranon bursitis or his spinal infection. Kale did not believe that claimant's condition was causally related to his fall down the stairs.

¶ 11 III. ANALYSIS

¶ 12 We will first address respondent's appeal. We will then turn to claimant's cross-appeal. Before proceeding further, we note that the party appealing an issue has the burden to convince this court that a reversible error has been committed in the proceedings below. *TSP-Hope, Inc. v. Home Innovators of Illinois, LLC*, 382 Ill. App. 3d 1171, 1173 (2008).

¶ 13 Both parties cite decisions of the Commission in support of their arguments. This is improper, as they have no precedential value. See *S&H Floor Covering, Inc. v. Illinois Workers' Compensation Comm'n*, 373 Ill. App. 3d 259, 266 (2007). Hence, we strike such citations from both parties' briefs.

¶ 14 A. RESPONDENT'S APPEAL

¶ 15 Respondent raises a number of issues in its appeal. First, it contests the Commission's finding regarding causation. Second, it asserts that "[n]o penalties or fees should be imposed," a puzzling assertion, as the Commission did not award penalties or fees in this case. Similarly odd is respondent's third claim, that it is entitled to a credit of $420,385.16 in accordance with section 8(j) of the Act (820 ILCS 305/8(j) (West 2008)), since respondent was given a credit in this amount (discounting the possibility, of course, that respondent was entitled to two awards of exactly that amount and received only one). Fourth, respondent contends that the award of

medical expenses should have been based upon a negotiated rate rather than the scheduled rate. Fifth, respondent complains of the arbitrator's denial of its request to conduct an evidence deposition of its own expert witness, Dr. Kale. Sixth and finally, respondent asserts that the Commission erred in failing to address a number of objections that it purportedly raised to medical bills.

¶ 16 1. Causation

¶ 17 We first turn to respondent's arguments regarding causation (respondent raises a general argument about causation and, in a separate section, an argument concerning medical expenses that is based on lack of causation; we will address these arguments jointly). It is axiomatic that to recover under the Act, an employee must show that his or her condition of ill-being is causally related to his or her employment. *Palos Electric Co. v. Industrial Comm'n*, 314 Ill. App. 3d 920, 926 (2000). When a " 'primary injury is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury likewise arises out of the employment.' " *Caterpillar, Inc. v. Industrial Comm'n*, 228 Ill. App. 3d 288, 293 (1992) (quoting 1 Arthur Larson, The Law of Workmen's Compensation § 13.00, at 3-502 (1990)). Moreover, we note that employment need be only a cause, not the sole or primary cause, of a claimant's condition, that an employer takes an employee as it finds him, and that the existence of a preexisting condition does not preclude recovery under the Act. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 205 (2003).

¶ 18 Causation presents a question of fact. *Id.* As such, we will disturb the decision of the Commission only if it is contrary to the manifest weight of the evidence. *University of Illinois v. Industrial Comm'n*, 365 Ill. App. 3d 906, 910 (2006). A decision is against the manifest weight of the evidence only where an opposite conclusion is clearly apparent. *Mobil Oil Corp. v.*

Industrial Comm'n, 327 Ill. App. 3d 778, 789 (2002). It is primarily the role of the Commission to weigh and resolve conflicts in the evidence and to evaluate witnesses. *O'Dette v. Industrial Comm'n*, 79 Ill. 2d 249, 253 (1980). Finally, we owe substantial deference to the Commission's findings regarding medical issues, as its expertise in this area is well recognized. *Long v. Industrial Comm'n*, 76 Ill. 2d 561, 566 (1979).

¶ 19 The crux of this issue involves the divergent opinions of claimant's treating physician, Dr. Sherman, and respondent's section 12 examiner (820 ILCS 305/12 (West 2008)), Dr. Kale. Respondent blatantly requests this court to "find the opinion of Dr. Kale to be the most qualified and persuasive opinion" and to "adopt the opinion of Dr. Kale." Of course, this is not our role. We will not merely reevaluate the credibility of these witnesses and substitute our judgment for that of the Commission. See *Setzekorn v. Industrial Comm'n*, 353 Ill. App. 3d 1049, 1055 (2004).

¶ 20 Indeed, resolving the conflict in the testimony of these two doctors was primarily for the Commission. *O'Dette*, 79 Ill. 2d at 253. In support of its argument that the Commission's finding was erroneous, respondent points to the relative qualifications of the two doctors. Kale is board certified in internal medicine; Sherman is an orthopedic surgeon with no special expertise in internal medicine. While this consideration favors respondent's position, it is also true that Sherman is a treating physician and Kale is a hired expert. This factor favors the Commission's finding. *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill. 2d 1, 4 (1979); see also *Sears v. Rutishauser*, 102 Ill. 2d 402, 407 (1984). We cannot say Kale's heightened expertise is so compelling that it renders a conclusion opposite to the Commission's clearly apparent.

¶ 21 Respondent also attempts to reinforce Kale's testimony by pointing to the purportedly similar testimony of other physicians, specifically, Drs. Patel, Khan, Beasdale, Woloson, and

Sikka. Claimant disputes respondent's characterizations of the opinions of these doctors; however, we note that, even accepting respondent's characterizations, the mere fact that one party can line up more experts on its side of a dispute does not mean that a decision by the Commission in favor of the other party is against the manifest weight of the evidence. See *Monark Battery Co. v. Industrial Comm'n*, 354 Ill. 494, 500 (1933) ("It cannot be said that, where three expert witnesses testify in contradiction of two other expert witnesses, that fact alone shows that a finding in accordance with the opinion of the lesser number is manifestly against the weight of the evidence."). Moreover, Sherman was not alone in his opinion, as respondent intimates, for, as the arbitrator noted, Dr. Neil Freedman "clarified in his medical note that [claimant's] staph aureus sepsis *** was now linked to bilateral elbow olecranon bursitis, along with diagnoses of acute renal failure and lower gastro intestinal bleed." In any event, this argument fails to persuade us that a conclusion opposite to the Commission's is clearly apparent.

¶ 22 Furthermore, it is well established that prior good health followed by a change immediately following an accident allows an inference that a subsequent condition of ill-being is the result of the accident. *Navistar International Transportation Co. v. Industrial Comm'n*, 315 Ill. App. 3d 1197, 1205 (2000). Here, the Commission recognized that claimant "had a history of treatment for a wide range of ailments." However, it noted that there was no indication that claimant was "under active medical treatment, particularly with respect to his lower back, during the period leading up to the accident." It further noted that there was no indication suggesting that claimant was suffering from an ongoing infection. Finally, it observed that claimant's problems began after his fall at home, which could be traced to his accident at work. These findings support an inference of causation and bolster the Commission's reliance on Sherman's opinion of causation.

¶ 23 In sum, respondent has not demonstrated that a conclusion opposite to the Commission's is clearly apparent. As such, we cannot find the Commission's finding to be against the manifest weight of the evidence. Also, in a one-sentence argument, respondent asserts that, based on its causation argument, claimant is not entitled to temporary total disability benefits. Having rejected respondent's causation argument, we reject this contention as well.

¶ 24 2. Penalties, Fees, and Credits

¶ 25 Respondent next argues that no penalties and fees should be imposed and that it is entitled to a credit in the amount of $420,385.16 for medical expenses paid by claimant's group health insurance. However, the Commission's decision grants respondent a credit in that amount and does not impose penalties or fees. Thus, it appears that respondent has already received the relief it now seeks. As these arguments present no real controversy, they are moot. *Rivera v. City of Chicago Electoral Board*, 2011 IL App (1st) 110283, ¶ 15.

¶ 26 3. Negotiated Rate

¶ 27 Respondent next contends that the Commission erred in awarding medical expenses based on the fee schedule rather than on a negotiated rate. Section 8(a) of the Act (820 ILCS 305/8(a) (West 2008)) provides, in pertinent part, that "[t]he employer shall provide and pay the negotiated rate, if applicable, or the lesser of the health care provider's actual charges or according to a fee schedule, subject to Section 8.2, in effect at the time the service was rendered for all the necessary first aid, medical and surgical services, and all necessary medical, surgical and hospital services thereafter incurred ***." The parties entered into a stipulation regarding fees, and stipulations are construed like contracts. *People v. Nelson*, 2013 IL App (3d) 110581, ¶ 13. Hence, a question of law is presented, so our review is *de novo*. *Myoda Computer Center, Inc. v. American Family Mutual Insurance Co.*, 389 Ill. App. 3d 419, 422 (2009).

¶ 28 The parties' stipulation provided as follows:

> "The parties hereby agree and stipulate that the following medical expenses would be due and owing pursuant to § 8(a) and the fee schedule provisions of § 8.2 of the Act in the event the matter is found to be compensable. However, by so stipulating, Employer does not waive any objection it may have as to liability (or the reasonableness and necessity) of said expenses."

The stipulation then set forth the exact amount to be awarded regarding various bills. For example, with regard to services rendered by North Shore Cardiologists, it stated the dates of services followed by the charge ($1,878), the scheduled amount ($1,692.72), and finally the award ($1,692.72). Clearly, the stipulation contemplated that the award for North Shore Cardiologists would be based on the schedule. Indeed, it set forth the exact amount to be awarded. The same is true of the other charges set forth in the stipulation. Having expressly agreed that these amounts were proper, respondent will not now be heard to complain of them. See *People v. Calvert*, 326 Ill. App. 3d 414, 419 (2001) ("Parties who agree to the admission of evidence through a stipulation are estopped from later complaining about that evidence being stipulated into the record."); see also *People v. Anderson*, 239 Ill. 168, 186 (1909) ("Where parties enter into an agreement in reference to the course to be pursued in any particular litigation, they will not afterwards be heard to complain that the court acted on the stipulation.").

¶ 29 4. Respondent's Motion to Depose Dr. Kale

¶ 30 Respondent next complains of the Commission's denial of its motion seeking leave to conduct an evidence deposition of Kale. Kale was originally scheduled to testify during the arbitration hearing; however, claimant's counsel could not be present on the day Kale was scheduled to testify. Kale could not make himself available to testify on another day.

Respondent moved to depose Kale, but the arbitrator concluded that it would be sufficient for respondent to submit Kale's report into evidence. Whether to grant such a motion is a matter within the arbitrator's discretion. See *Janda v. United States Cellular Corp.*, 2011 IL App (1st) 103552, ¶ 96. Therefore, we will reverse only if that discretion was abused (*i.e.*, where no reasonable person could agree with the decision below). *Certified Testing v. Industrial Comm'n*, 367 Ill. App. 3d 938, 947 (2006). Moreover, an error will result in reversal only where it caused prejudice to the appealing party. *Ming Auto Body/Ming of Decatur, Inc. v. Industrial Comm'n*, 387 Ill. App. 3d 244, 257-58 (2008); *Presson v. Industrial Comm'n*, 200 Ill. App. 3d 876, 879-80 (1990).

¶ 31 Here, respondent has failed to demonstrate how this ruling prejudiced it. Respondent states, "While [respondent] maintains that Dr. Kale's opinion is persuasive and in concordance with the other qualified physicians in this matter, [respondent] was severely prejudiced because the deposition of Dr. Kale was not allowed to proceed." According to respondent, this decision "scarcely addressed [its] concern that Dr. Kale's professional background in internal medicine and infectious disease be recognized[] and ignored the importance of a more detailed explanation by Dr. Kale of the foundation and supporting evidence for his causal opinion." Respondent further states that Kale would have been able to "clarify" his opinions in a deposition. However, respondent never states what additional information would have been provided in a deposition. It never identifies any opinions in need of clarification, much less how they would have been clarified. It does not explain why Kale's *curriculum vitae* is insufficient to establish his credentials. The decision of the Commission cannot be disturbed based on such speculation as to prejudice. See *Conley v. Industrial Comm'n*, 229 Ill. App. 3d 925, 932 (1992); *Service Adhesive Co. v. Industrial Comm'n*, 226 Ill. App. 3d 356, 370 (1992). Absent a showing of prejudice, any

error that occurred does not warrant reversal. *Ming Auto Body/Ming of Decatur, Inc.*, 387 Ill. App. 3d at 257-58.

¶ 32 5. Unaddressed Objections

¶ 33 Respondent's final complaint is that the Commission failed to address four of its objections to "unsubstantiated medical bills." Respondent "asks this Honorable court to address these objections." It states that the arbitrator did not address its "objections regarding duplicate and unsubstantiated bills that included inconsistent charges for the same medical tests as well as unsubstantiated billing charges." Respondent provides no citation to the record indicating to which objections it is referring. Moreover, respondent does not discuss its objections in any detail (indeed, beyond the general statement set forth above, it does not even identify its objections) and cites no case law whatsoever in support of this argument. It has oft been repeated that a court of review "is not a repository into which an appellant may foist the burden of argument and research." *Ramos v. Kewanee Hospital*, 2013 IL App (3d) 120001, ¶ 37 (citing *Velocity Investments, LLC v. Alston*, 397 Ill. App. 3d 296, 297 (2010)). Pursuant to Illinois Supreme Court Rule 341(h)(7) (eff. July 1, 2008), points not argued are forfeited. The "failure to properly develop an argument and support it with citation to relevant authority results in forfeiture of that argument." *Ramos*, 2013 IL App (3d) 120001, ¶ 37. As such, we deem this argument forfeited.

¶ 34 B. CLAIMANT'S CROSS-APPEAL

¶ 35 We now turn to claimant's cross-appeal. In it, he raises two main arguments. First, claimant contends that the Commission erred in not imposing penalties and fees against respondent. Second, claimant alleges error in the Commission's failure to award him certain costs he incurred in making modifications to his home to accommodate his condition.

¶ 36 1. Penalties and Fees

¶ 37 Claimant asserts that he is entitled to penalties and attorney fees in accordance with sections 16, 19(k), and 19(l) of the Act. See 820 ILCS 305/16, 19(k), 19(l) (West 2008). We review such claims using the manifest-weight-of-the-evidence standard of review (*Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 763 (2003)), so we will reverse only if an opposite conclusion is clearly apparent (*Mobil Oil Corp.*, 327 Ill. App. 3d at 789).

¶ 38 A section 19(l) fee is similar to a late fee. *Dye v. Illinois Workers' Compensation Comm'n*, 2012 IL App (3d) 110907WC, ¶ 15. An award under this section is mandatory if payment is late and an employer does not show an adequate justification for the delay. *McMahan v. Industrial Comm'n*, 183 Ill. 2d 499, 515 (1998). The burden is on the employer to justify the delay. *Jacobo v. Illinois Workers' Compensation Comm'n*, 2011 IL App (3d) 100807WC, ¶ 19. Sections 16 and 19(k) require a finding that an employer's denial of benefits was unreasonable or vexatious. *Vulcan Materials Co. v. Industrial Comm'n*, 362 Ill. App. 3d 1147, 1150 (2005). That is, the refusal to pay must result from bad faith or improper purpose. *McMahan*, 183 Ill. 2d at 515.

¶ 39 Claimant contends that he is entitled to penalties and fees under all three subsections. He points out that it was not until a year after his accident that Kale produced his report questioning causation. Moreover, claimant asserts that certain aspects of his claim—namely those pertaining to his back injury and fall down the stairs, as opposed to the subsequent infection—were undisputed. Respondent agrees that it stipulated that the at-work incident involving lifting the case of soda was work related, but it contends that the stipulation did not encompass claimant's fall down the stairs. We note that Kale testified that claimant's septic discitis was most likely responsible for claimant's fall. The Commission found that respondent's failure to immediately

pay benefits was not unreasonable in light of the record. We, in turn, cannot say that an opposite conclusion is clearly apparent given that respondent could rely on Kale's testimony, even if the Commission ultimately did not find it persuasive. *Matlock v. Industrial Comm'n*, 321 Ill. App. 3d 167, 173 (2001) ("[W]hen the employer acts in reliance upon responsible medical opinion or when there are conflicting medical opinions, penalties ordinarily are not imposed.").

¶ 40 Claimant further complains that respondent did not have Kale's report available to rely on until approximately a year after the accident and that prior to this time respondent had no basis to withhold payment. Keeping in mind that reasonableness is a key consideration underlying all claims for penalties and fees (*Vulcan Materials Co.*, 362 Ill. App. 3d at 1150; *Consolidated Freightways, Inc. v. Industrial Comm'n*, 136 Ill. App. 3d 630, 633 (1985)), we could not expect an employer to be able to obtain a report from a medical expert immediately following an accident—generating such a report would take some time. That is, an employer's conduct is not unreasonable simply because following an accident it waited while it was seeking an opinion from a medical expert, so long as the time period is reasonable in light of the facts of the case. Claimant cites nothing that holds to the contrary. We cannot say that waiting one year—under the circumstances presented here—for such an opinion is so clearly unreasonable that a conclusion opposite to the Commission's is clearly apparent. Nor can we conclude that it is clearly apparent that respondent's conduct was vexatious under these circumstances. As such, we perceive no basis to disturb the Commission's decision to decline claimant's request for penalties and fees.

¶ 41 2. Home Modifications

¶ 42 Claimant's final argument is that the Commission erred when it did not award him the costs of certain modifications he made to his house (*e.g.*, installing a chair lift and modifying his

bathroom and stairs) that were recommended by his physical therapists. The modifications cost $10,230. The Commission, adopting the decision of the arbitrator, declined to award these costs, explaining:

> "[T]here is no evidence that these recommendations were made or even seconded by a treating physician. Without such a prescription by a physician and said physician's inherent representation that such recommendations were reasonable and necessary and related to the accident in question, the Arbitrator is unwilling to make such an award based solely on the recommendation of a physical therapist."

Thus, it appears that under no circumstances would the Commission accept the recommendation of a physical therapist regarding a home modification. Respondent contends that the prescription of a physician is required. Whether the law requires the prescription of a physician presents a question of law. Thus, *de novo* review is appropriate.

¶ 43 Respondent cites *Beelman Trucking v. Illinois Workers' Compensation Comm'n*, 233 Ill. 2d 364, 380-84 (2009), in support of its position. That case does involve the testimony of a physician, regarding the necessity of purchasing a computer; however, it nowhere says that such testimony was a necessary prerequisite to awarding such a cost. *Id.* As such, *Beelman Trucking* provides little guidance here.

¶ 44 Indeed, our research indicates that there is no requirement that the opinion of a physician is necessary to support such an award. In *Zephyr, Inc. v. Industrial Comm'n*, 215 Ill. App. 3d 669, 675 (1991), we found no error in the Commission's relying on the opinion of an architect who "admittedly did not rely on a doctor's recommendations in formulating his remodeling plan for claimant's home." Moreover, our review of the Act reveals no such requirement. See 820 ILCS 305/8 (West 2008).

¶ 45 Finally, we note that this question has arisen outside the context of workers' compensation law. In *Compton v. Ubilluz*, 353 Ill. App. 3d 863 (2004), the trial court permitted an expert witness to opine on the future medical care of the victim of a tort. *Id.* at 865. The witness's qualifications were that he was the executive director of an organization that provided assistance to people with disabilities, and his duties involved, in addition to his administrative tasks, making recommendations regarding "life care plans." *Id.* This included helping "families modify their homes or construct new ones to accommodate disabled family members." *Id.* The witness recommended, *inter alia*, that the victim have a power wheelchair, a voice-activated computer, and a van with a wheelchair lift. *Id.* at 866. The reviewing court found the admission of this testimony to be within the trial court's discretion. *Id.* at 867. Thus, *Compton* provides additional support for our holding.

¶ 46 As the Commission applied the incorrect legal standard, we vacate that portion of its decision and remand for further proceedings on this issue. There is no absolute requirement that an award of the type sought here be supported by the testimony of a physician, *so long as competent evidence establishes the reasonableness and necessity of the award.* On remand, the Commission should evaluate the opinions of the physical therapists as it would any other such witness in light of all appropriate facts and circumstances.

¶ 47 IV. CONCLUSION

¶ 48 In light of the foregoing, we vacate the Commission's decision regarding expenses for modifications to claimant's home, and we affirm in all other respects. We remand this cause for further proceedings in accordance with this opinion and also as appropriate pursuant to *Thomas v. Industrial Comm'n*, 78 Ill. 2d 327 (1980).

¶ 49 Affirmed in part and vacated in part; cause remanded.

JEFFREY BERMAN, PETITIONER, v. COMPASS GROUP, RESPONDENT.

NO: 09WC 24821

ILLINOIS WORKERS' COMPENSATION COMMISSION

STATE OF ILLINOIS, COUNTY OF DUPAGE

12 IWCC 387; 2012 Ill. Wrk. Comp. LEXIS 382

April 16, 2012

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

OPINION: [*1]

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 22, 2010 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing [*2] 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 $ 75,000.00. The probable cost of the record to be filed as return to Summons is the sum of $ 35.00, payable to the Illinois Workers' Compensation Commission in the form of cash, check or money order therefor and deposited with the Office of the Secretary of the Commission.

ATTACHMENT:

ARBITRATION DECISION

19(b)/8(a)

Jeffrey Berman,
Employee/Petitioner

v.

Compass Group,
Employer/Respondent

Case # **09** WC **24821**

Consolidated cases: **none**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to [*3] each party. The matter was heard by the Honorable **Peter M. O'Malley,** Arbitrator of the Commission, in the city of **Wheaton,** on **October 6, 2010**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

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

FINDINGS

On the date of accident, **March 19, 2009**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice [*4] 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 $ **28,000.00**; the average weekly wage was $ **538.46.**

On the date of accident, Petitioner was **63** years of age, ***married*** with **no** dependent children.

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

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

Respondent is entitled to a credit of $ **420,385.16** under Section 8(j) of the Act. (See Arb.Ex.# 2).

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $ 358.97 per week for 80-1/7 weeks, commencing March 25, 2009 through October 6, 2010, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from March 25, 2009 through October 6, 2010, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay [*5] reasonable and necessary medical services of $ 1,244,528.02, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $ 420,385.16 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. (See Arb.Ex.# 2).

Respondent shall pay to Petitioner penalties of $ **0.00**, as provided in Section 16 of the Act; $ **0.00**, as provided in Section 19(k) of the Act; and $ **0.00**, as provided in Section 19(l) of the Act.

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

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* [*6] 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.

12/20/10

Date

STATEMENT OF FACTS:

Petitioner testified that on March 19, 2009 he was employed by Respondent as a food service manager. He indicated that he did not have any physical complaints and was not under any active medical care during the year preceding the accident in question. Petitioner testified that for the few months prior to March of 2009 he had been taking care of his wife on account of the fact that she had ankle fusion surgery and could not perform activities of daily living without Petitioner's assistance. Petitioner testified that he worked in a large commercial office setting, and that one of his job duties included keeping track of inventory. Petitioner testified that on March 19, 2009 while working in his capacity as food service manager for Respondent, he lifted a case of Coca-Cola containing approximately twenty-four 20-ounce bottles, weighing a total of approximately 40 pounds. When he lifted the case, Petitioner heard a popping in his back along [*7] with a hissing sound. Petitioner testified that immediately after feeling the pain and discomfort in his back, he contacted his manager, John Castro, and called the company's workers' compensation contact person. Petitioner then continued working for the remainder of the day in pain. Petitioner testified that for the rest of the day, he walked and moved very slowly with his legs spread apart in an attempt to alleviate the debilitating pain he was experiencing.

The following day, March 20, 2009, Petitioner sought treatement at Buffalo Grove Medical Center where he was seen by an associate, Dr. Sofia Elterman. (PX3). Dr. Elterman diagnosed a back sprain, prescribed Vicodin and referred Petitioner to a chiropractor due to the pain. (PX3). Petitioner testified he then went to work that day, Friday March 20, 2009 and worked a full day in terrible pain. The next day, Saturday March 21, 2009, Petitioner visited Dr. Jeanne Lapp of Lapp Chiropractic per the referral from Dr. Elterman. (PX11). Dr. Lapp's records state the patient was not treating for any other medical reasons and this was his first onset of low back pain. (PX11). Dr. Lapp stated the patient was barely ambulatory and in severe [*8] pain. (PX11).

Petitioner testified that on Saturday and Sunday he was not scheduled to work. While at home, Petitioner struggled to ambulate. Petitioner moved slowly around the house taking a long time to complete daily tasks and stayed mostly in bed due to the severe pain. Petitioner testified he lives in a two story, townhome with the master bedroom located upstairs and the main living area located on the ground level.

On Monday, March 23, 2009 Petitioner went to work, as scheduled, despite difficulty with walking. Petitioner testified that while walking down stairs from his bedroom to the main level, he took one stair at a time, turning his body sideways holding on to the railing and using his walker to stabilize himself. After a full day of work, Petitioner was exam-

ined at Illinois Bone and Joint Institute by Dr. Jonathan Erulkar, who noted that Petitioner required a cane to walk, due to pain. (PX8). Dr. Erulkar diagnosed Petitioner with lumbar stenosis, and ordered an MRI and Medrol Dosepak. (PX8). Petitioner testified he did not have a cane accessible for him to use so he used his wife's walker that he had at home to ambulate.

On Tuesday, March 24, 2009 Petitioner went to [*9] work, using his walker to ambulate and in excruciating pain. Petitioner returned home from work and went up the stairs to bed, using the walker to assist in his movements.

Petitioner testified that on Wednesday, March 25, 2009 he arose with the intention of going to work. Petitioner testified he was in terrible pain. While descending the stairs sideways, with his walker in his right hand, and his left hand braced on the railing to accommodate his pain, his left foot buckled due to severe pain in his low back shooting down his leg. When Petitioner's foot buckled, his body and his walker tumbled down the remaining eight stairs. Petitioner testified that he did not trip on the carpet; rather the severe pain in his low back and pain down his leg caused his foot to buckle. Petitioner landed at the bottom of the stairway. Due to this fall, he sustained bruises and lacerations on his arms, elbows, and chest and bleeding from his nose. Joyce Berman, Petitioner's wife, testified that she heard the noise and instantly came to her husband's aid. Petitioner attempted to get up from the floor, and his wife attempted to assist him in moving, but neither was able due to pain. Petitioner's wife [*10] then called the paramedics. Petitioner testified that when the paramedics arrived they helped him get to his feet. With the paramedics present and ready to take him to the hospital, Petitioner received a phone call from his manager, John Castro. Petitioner testified that Mr. Castro inquired as to why Petitioner was late to work, and when he would be in. Petitioner then refused transport to the hospital from the ambulance, and attempted to go to work.

Petitioner testified that after the paramedics left he needed assistance getting into his vehicle. He then had his friend help him get into his car, and Petitioner drove to work in a great deal of pain. Petitioner testified once he arrived at his work he used his walker and very slowly walked into the building. Petitioner then notified his co-worker that he would "take care of the back of the house", meaning he would do paperwork in the back office. Petitioner testified that he sat at his desk and worked for a few hours doing paperwork. He noted that he attempted to get out of the chair several times but was unable to due to the pain. Petitioner testified his co-worker finally contacted his wife, Joyce Berman, and told her of his inability [*11] to stand. Mrs. Berman testified that she arrived at her husband's place of employment, ready to take him to the hospital. Petitioner again attempted to move from his chair, but was unable to do so. Petitioner testified that in order to move him from his desk to his car, several people were needed, including a security guard, his manager, Mr. Castro, and another man. The process took over an hour from desk to vehicle. Finally, Petitioner's wife took him to Highland Park Hospital where he came under the care of Dr. Richard Sherman. Petitioner was admitted to Highland Park Hospital at that time. (PX28). Petitioner testified that the next thing he remembered after being admitted into Highland Park Hospital on March 25, 2009 was waking up several months later in a different hospital.

Upon initial admission into Highland Park Hospital, Petitioner was examined by several doctors, each time giving a consistent history of an injury at work the week prior which caused back pain followed by a fall down stairs at home due to weakness and manipulation of his walker. (PX28). Petitioner was noted to have abrasions on his face, head, bilateral knees, elbows, and finger. X-rays of Petitioner's elbows [*12] revealed the presence of olecranon bursitis in both the right and the left elbows. (PX28). Additionally, Petitioner was examined for generalized pain, and localized pain in his lumbar spine. (PX28).

On March 27, 2009 during his inpatient stay at Highland Park Hospital, Petitioner began acting delusional, calling out for his wife, stating he was feeling dizzy. The next day, Evanston Lab contacted Highland Park Hospital to notify them that Petitioner's blood cultures results tested positive for gram cocci, an infection in Petitioner's blood. (PX28). Petitioner was quickly transferred to the Intensive Care Unit for this life threatening infection. Petitioner was treated at Highland Park Hospital rigorously over the next several weeks for infection. (PX28). This infection caused Petitioner's organs to start shutting down. Dr. Richard Sherman performed incision, drainage and packing of Petitioner's bilateral olecranon bursae. (PX28). Petitioner's renal function began to worsen. Due to gastrointestinal bleeding, an upper endoscopy was performed on April 4, 2009, along with additional wound care, focusing on Petitioner's bilateral elbows. (PX28). On April 5, 2009, Dr. Todd Nega at Highland [*13] Park Hospital diagnosed Petitoner with staph aureus growing from the left elbow, and noted renal insufficiency as well as gastro intestinal bleed. (PX28).

On April 6, 2009 Dr. Neil Freedman clarified in his medical note that Petitioner's staph aureus sepsis, with an original unclear source of infection, was now linked to bilateral elbow olecranon bursitis, along with diagnoses of acute renal failure and lower gastrointestinal bleed. (PX28).

Dr. Sherman, at his evidence deposition, testified that Petitioner's fall on March 25, 2009 caused abrasions which lead to septic olecranon bursitis. (PX41). Dr. Sherman explained that Petitioner's septic olecranon bursitis which developed as a consequence of a fall on March 25, 2009, caused an infection which spread throughout Mr. Berman's body. (PX41). Dr. Sherman noted that due to this infection in his blood stream, Petitioner developed an infection in his spine, intestinal tract, and renal complications. (PX41). The infection in Petitioner's intestinal tract, due to the sepsis, required exploratory laparotomy and eventual colectomy of ileum cecum and ascending colon performed on April 4, 2009 by Dr. Haggerty. Due to respiratory failure, Petitioner [*14] was intubated. He subsequently had difficulty weaning from the machine. Due to this failed weaning, a tracheostomy was performed on April 24, 2009. (PX28).

Petitioner was transferred to Holy Family Medical Center on April 30, 2009 for long term care. In his admitting notes, Dr. Istina Morariu noted the patient had developed olecranon bursitis and staph infection, along with upper extremity clots, and bilaterally below the knee deep vein thromboses. (PX21). Additionally, Dr. Morariu noted Petitioner's gastrointestinal complications, ischemic bowel, and respiratory complications which were treated at Highland Park Hospital. (PX21). On May 14, 2009 Petitioner had a CT scan of his lumbar spine and was found to have spinal canal stenosis at T12-L1 with exit foraminal narrowing on the right; degenerative disc disease at L3-4 with disc space narrowing, spinal canal stenosis, and facetal degenerative changes, right greater than left, destructive lesions at L4-5 with minimal reversed listhesis and widening of the facet joints, findings favoring infection with the following noted to be markedly advanced since the previous study of March 28, 2009. (PX21).

On May 21, 2009 Petitioner was transferred [*15] to Advocate Lutheran General Hospital. (PX23). Petitioner was evaluated and found to have disc space infection at L4-5 with diskitis, osteomyelitis, destruction and instability, canal compromise and paraparesis. (PX23). Petitioner was treated operatively by Dr. Thomas Gleason on May 21, 2009 with decompressive laminectony at L4-5 with posterior smith-peterson, osteomy at L4-5, posterior lateral fusion L2-S1 to the area with extraarticular lumbosacral iliac fusion, anterior corpoectomy from behind, anterior interbody fusion L4-5 and three harm's cages. (PX23).

On May 31, 2009 Petitioner was again seen by Dr. Gleason at which time he was diagnosed with osteomyelitis L4-5 with spondylodiscitis C3-C4, osteomyelitis with spinal instability L4-5 and was again treated operatively. On May 31, 2009 Dr. Gleason performed another spinal surgery: spinal laminectomy, posterior osteotomies, applied complex posterior spinal instrumentation, inserted bilateral iliac screws, spinal fusion at L2-3, L3-4, L4-5 and L5-S1, applied bone morphogenic protein implants, performed partial hemicorpoectomy L3 and hemicorpectomy L5 with posterior lumbar interbody fusion technique L4-5 utilizing titanium mesh [*16] cages, posterior lumbar interbody fusion L4-5 and somatosensory evoked potentials monitoring. (PX23). Additionally, Dr. Gleason noted Petitioner's vertebral osteomyelitis L4-5 was progressing due to the methicillin-sensitive staphylococcus aureus. (PX23). Petitioner was then transferred back to Holy Family Hospital for recovery on June 6, 2009. (PX21).

On June 26, 2009 Petitioner was transferred from Holy Family Hospital to Manor Care Rehabilitation for continued recovery and monitoring. (PX26). While at Manor Care Rehabilitation, Petitioner was seen by a psychologist to monitor his behavior and mood. During his stay at Manor Care, Petitioner was seen by several doctors, with Dr. Bino Oommen being his main physician. Dr. Oommen noted on August 13, 2009 that Petitioner was suffering from a right foot drop, and shingles on his face. (PX26).

On September 19, 2009 Petitioner was transferred to Northwest Community Hospital for renal insufficiency. (PX29). Petitioner was admitted with acute kidney failure, acute osteomyelitis, acute kidney failure with lesion of tubular necrosis, pressure ulcer, intestinal infection due to clostridium difficile, primary hypercoaglable state, acute venous [*17] embolism and thrombosis of deep vessels of proximal and distal lower extremities, hydronephrosis, acidosiss, calculus of kidney, hypertensive chronic kidney disease Stage 1 through 4, colostomy status, chronic kidney disease, pressure ulcer, elbow. Petitioner was treated surgically for a left elbow ulcer by Dr. David Mahon who debribed the skin, subcutaneous tissue, muscle and bone of the left elbow. (PX29). Additionally, Dr. Mahon saucerized the left elbow (radius) for osteomyelitis. (PX29). Petitioner then returned to Manor Care Rehabilitation for recovery.

Petitioner was again transferred to Northwest Community Hospital on November 10, 2009 where he was seen for acute venous embolism and thrombosis of deep vessels of his proximal lower extremity. (PX29). Petitioner was also seen for his bilateral elbow ulcers. (PX29). After evaluation and treatment at Northwest Community Hospital, Petitioner was again transferred back to Manor Care Rehabilitation on November 21, 2009. Petitioner was again monitored and treated with physical therapy. (PX26).

On December 1, 2009 Petitioner was transferred to Northwest Community Hospital with an admitting diagnosis of pain in limb, phlebitis and [*18] thrombophebitis of deep veins. (PX29). Petitioner had ultrasounds of his limbs done to rule out deep vein thromboses. He was continued on medicine. (PX29). On December 5, 2009, Petitioner again returned to Manor Care Rehabilitation. (PX26). Petitioner was seen by Dr. Sherman due to swollen left forearm. He was found to have ecchymosis in the left forearm and hand, and a hematoma in the left forearm. (PX8). Petitioner continued therapy and evaluation at Manor Care until April 24, 2010. At that time, Petitioner returned to his home to live, with continued physical therapy and evaluation 5 days a week for 3 hours each day. (PX26).

On May 20, 2010 Petitioner was admitted to Northwest Community Hospital for pain in limb. (PX29). A CT scan revealed an intramuscular hematoma involving the vastus lateralis muscle. The hematoma in Petitioner's thigh caused a fever. (PX29). Additionally, Petitioner underwent ultrasound for renal insufficiency. (PX29). Petitioner was treated at Northwest Community Hospital until May 28, 2010 at which point he returned to Manor Care. (PX29). Petitioner was treated at Manor Care Rehabilitation from May 28, 2010 until June 1, 2010 at which point Petitioner was [*19] transferred to Northwest Community Hospital with an admitting diagnosis of attention to ileostomy. (PX29). Petitioner underwent an illeostomy reversal at Northwest Community Hospital by Dr. David Mahon on June 3, 2010. (PX29). Petitioner then returned to Manor Care Rehabilitation on June 16, 2010 where he continued with therapy and rehabilitative care until July 17, 2010 at which point he returned to his home. (PX26).

During the course of his deposition, Dr. Sherman testified that the treatment of Petitioner's septic olecranon bursa was caused by his fall on March 25, 2009. Additionally, Dr. Sherman testified that Petitioner's fall on March 25, 2009 was due to complications of a work injury on March 19, 2009 which weakened the Petitioner's body causing his leg to buckle due to pain while he was descending the stairway in his home. (PX41). Dr. Sherman further clarified that the septic infection in Petitioner's body could have reasonably developed within the hours between his falling and injuring his elbows to him being admitted into Highland Park Hospital in the same day. (PX41). Dr. Sherman testified that the infection due to Petitioner's septic olecranon bursitis caused the subsequent [*20] infections and ailments which have been described herein. Dr. Sherman testified that he was knowledgeable of Petitioner's treatment to date and that it was all reasonable and necessary to alleviate his pain and or cure his symptoms. (PX41).

At the request of Respondent, Dr. Scott Kale authored a report dated March 2, 2010 based upon a medical records review. Dr. Kale opined that Petitioner's septic condition was caused either by olecranon bursitis or smoldering diskitis. (RX1). Dr. Kale felt that Petitioner likely suffered from septic diskitis which more probably than not was responsible for his fall down the stairs. (RX1).

Petitioner is still currently treating, receiving physical therapy several times per week and under regular medical care. Petitioner has never been released to any form of work status at this time.

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Respondent does not dispute that Petitioner suffered a work related injury involving his lower back on March 19, 2009 when attempting to lift a case of soda. The question is whether the myriad of conditions and related [*21] treatment following Petitioner's subsequent fall down the stairs at home on March 25, 2009 can be said to be causally related to the work injury in question.

The record shows that Petitioner sought treatment with Dr. Elterman the day after the accident, on Friday March 20, 2009. Petitioner testified that he had worked that day, but was in terrible pain. Dr. Elterman prescribed Vicodin and referred Petitioner to Dr. Lapp for chiropractic treatment. Petitioner visited Dr. Lapp on Saturday March 21, 2009. Petitioner testified that he was not scheduled to work on Saturday or Sunday.

Petitioner indicated that he returned to work on Monday March 23, 2009 despite pain and difficulty with stairs. On that date he visited Dr. Jonathan Erulkar who noted Petitioner's "... complaint of low back pain radiating into his left leg, particularly at his left groin and down his thigh and into his knee. It does not radiate past his knee. However, he does have significant low back pain as well. It is particularly painful, to the point that he requires a cane for walking." (PX8). X-rays of the lumbar spine revealed significant loss of disc height and loss of normal lumbar lordosis at multiple levels of [*22] the lumbar spine, with no clear evidence of fracture and anterior and posterior osteophyte formations. (PX8). X-rays of the left hip revealed no significant change from previous films. (PX8). Dr. Erulkar started Petitioner on a Medrol Dosepak and recommended an MRI of the lumbar spine. (PX8). Petitioner testified that he had difficulty getting upstairs that night to go to bed.

Petitioner testified that despite still being in terrible pain he went to work on Tuesday March 24, 2009. He noted that he performed his work activities very slow that day.

The following day, Wednesday March 25, 2009, Petitioner testified that he awoke with the intention of going to work, despite pain that he described as no better and, if anything, worse. He noted that as he was walking down the stairs in his home his left side and foot buckled due to the pain and he went head over heels down the stairs. He noted that he did not trip down the stairs and that as a result of the fall his elbow, arms and nose were bleeding and his chest was bruised. When neither Petitioner nor his wife could move him, paramedics were called to the scene. Petitioner testified that he then got a call from his manager, John Castro, [*23] asking what was going on. Petitioner indicated that he informed Mr. Castro that he would be in shortly, and a friend got him in the car and drove him to work. Petitioner testified that he felt pain and discomfort following the incident, and used a walker to walk from the car to work. He noted that he then sat at his desk for a couple of hours and did paperwork after which he was unable to get out of his seat. Around noon he called his wife and he was rolled out of the building on a computer chair by Mr. Castro, a security guard and another man. He was then taken to Highland Park Hospital where he saw Dr. Sherman. Petitioner testified that the next thing he remembers is waking up in either Holy Family or Lutheran General Hospital several months later.

While at Highland Park Hospital, Petitioner was diagnosed with bilateral septic olecranon bursitis, due to his fall down the stairs. (PX28). The septic infection spread throughout his body and attacked his renal function, intestinal tract and spine. (PX28, PX41). Petitioner was immediately seen by Dr. Sherman for his bilateral septic olecranon bursitis. (PX28, PX41). Dr. Sherman testified that Petitioner had been seen in his office after [*24] the work injury of March 19, 2009 for severe lumbar spine pain. Dr. Sherman further testified that due to the Petitioner's severe lumbar pain his leg buckled on March 25, 2009 while he was descending the stairway in his home, and he fell down sustaining lacerations to his face, knees, and elbows which resulted in bilateral septic olecranon bursitis. (PX41). Dr. Sherman testified that the bilateral septic olecranon bursitis caused a nearly deadly infection to spread throughout his body, ultimately causing: renal failure, intestinal failure, respiratory failure, spinal fusion surgery, foot drop syndrome, and numerous other ailments. (PX41).

Respondent submitted into evidence the report of Dr. Scott Kale dated March 2, 2010. (RX1). Following his review of the records, Dr. Kale opined that "[t]he most probable cause of [Petitioner's] medical condition, which included chiefly MRSA sepsis, was a preexisting condition either a result of olecranon bursitis or smoldering discitis. Although he had a bilateral hip replacements and undergone knee surgery prior to this injury, there is no evidence that the area of the pelvis or knee were the source of his infection. There is also no evidence [*25] that the injury that he sustained on March 19, 2009, altered his conditions or was a prodrome of his ultimate MRSA infection, as he was able to return to work following his accident... In my opinion, the diagnosis that best fits his condition was septic discitis, which is not causally related to his work and more probably than not is responsible for him falling down the stairs at home for which he later received care and treatment." (RX1).

After having reviewed Dr. Kale's report, Dr. Sherman noted, in a letter dated March 27, 2010, that he did not agree with Dr. Kale's opinion regarding "the relation of a work injury to [Petitioner's] ultimate medical impairment", stating that "[i]t is very clear from a review of the records, both from Dr. Jeanne Lapp as well as from the records of Dr. Erulkar, that the onset of his back pain began after lifting a case of soda at his place of work. The injury to his lower back led to an evaluation by Dr. Kale, and a continuation of low back and leg pain ultimately resulted in a fall that resulted in multiple injuries including abrasions to the elbow. This led to subsequent infection and septicemia. I do feel that all of his medical disability traces [*26] back to the initial injury of a lower back strain that continually worsened to the point of his fall." (PX8).

While Petitioner had a history of prior treatment for a wide range of ailments, there is no evidence to suggest that he was under active medical treatment, particularly with respect to his lower back, during the period leading up to the accident. More importantly, there is likewise no evidence to suggest that Petitioner was suffering from any type of infection, sepsis or otherwise, or that he was experiencing any symptoms such as a fever and the like that might suggest that an infectious process was at work much less that it was the overriding reason for his fall on March 25, 2009. Instead, Petitioner credibly testified that he had been in terrible pain since the accident on March 19, 2009 -- a fact that Dr. Erulkar made reference to, in a note dated March 23, 2009, when he related that it was "... particularly painful, to the point that he requires a cane for walking" (PX8) -- and that as result of this significant and ongoing pain his leg buckled and he fell down the stairs in his home. It was not until this incident at home, which itself was due to the pain he was experiencing [*27] as a result of the original accident, that his course of treatment took a decidedly more serious and life threatening turn as a result of the ensuing sepsis.

Therefore, based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner's current conditions of ill-being, including the initial low back injury as well as the subsequent sepsis infection and the related complications that ensued, were causally related to the accident on March 19, 2009. Along these lines, the Arbitrator chooses to place greater weight on the opinion and findings of treating physician Dr. Sherman over those of Respondent's § 12 record reviewer, Dr. Kale.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

The parties submitted into evidence an agreed stipulation as to the amount of medical expenses that would be due and owing in this case in the event the matter was held to be compensable. (Arb.Ex.# 2).

The parties also agreed, in this stipulation, that Respondent would be entitled [*28] to credits for amounts paid by the group health carrier in the amount of $ 420,385.16 "... up until the time Petitioner began paying for his own insurance through Cobra. Respondent further agrees to hold Petitioner harmless for claims of reimbursement for Group Health Benefits paid." (Arb.Ex.# 2).

In light of the Arbitrator's holding as to causation (issue "F", supra), and based on the record taken as a whole, including the parties' stipulation contained in Arb.Ex.# 2, the Arbitrator finds that Petitioner is entitled to reasonable and necessary medical expenses pursuant to § 8(a) and the fee schedule provisions of § 8.2 of the Act in the amount of $ 1,244,528.02. Furthermore, as noted above, the parties agree that Respondent is entitled to a credit for amounts paid by the group carrier in the amount of $ 420,385.16 and Petitioner is to be held harmless for any and all claims for reimbursement for any amounts paid by the group health insurance carrier on account of this injury.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner's doctors have indicated that Petitioner will benefit from continued physical [*29] therapy and continued evaluation. (PX26). Petitioner has not been released for work. Without continued physical therapy and evaluation Petitioner will not be able to get any better and will not be able to sustain gainful employment.

Based on the above, and the record taken as a whole, including the Arbitrator's determination as to causation (issue "F", supra), the Arbitrator finds that entitled to prospective medical care in the form of ongoing physical and occupational therapy for his work related conditions.

WITH RESPECT TO ISSUES (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, AND (O), WHETHER PETITIONER IS ENTITLED TO HOUSING MODIFICATION EXPENSES, THE ARBITRATOR FINDS AS FOLLOWS:

It is undisputed that Petitioner suffered a work injury on March 19, 2009. Petitioner reported to work as scheduled up until March 24, 2009. Dr. Richard Sherman testified that at no time from March 25, 2009 to the present has Petitioner been able to work. (PX41). Petitioner was under constant medical care, and hospitalized from March 25, 2009 to April 24, 2010, and then again from May 20, 2010 to July 17, 2010. (PX21, PX23, PX26, PX28, PX29) When he wasn't hospitalized [*30] during this time, Petitioner was still under intensive medical care and unable to return to his work duties. (PX41).

Therefore, based on the above and the record taken as a whole, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits from March 25, 2009 through the hearing on October 6, 2010, for a period of 80-1/7 weeks.

WITH RESPECT TO ISSUE (M), SHOULD PENALTIES BE IMPOSED UPON THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that significant questions of law and fact existed in this matter, and that Respondent's conduct in the defense of this claim was neither unreasonable nor vexatious so as to warrant the imposition of penalties.

Therefore, based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner's claim for additional compensation pursuant to § 19(k) and § 19(l) as well as attorneys' fees pursuant to § 16 of the Act is hereby denied.

WITH RESPECT TO ISSUE (O), WHETHER PETITIONER IS ENTITLED TO HOUSING MODIFICATION EXPENSES, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner requests reimbursement for the cost of housing modifications totaling $ 10,230.00. In support of this [*31] request, Petitioner argues that therapists Christina Navilio and Eileen Duffy-Cribbin had recommended housing modifications to Mr. Berman's house, including the need for a chair lift, lowered steps in Petitioner's home and certain bathroom modifications. (PX31). Unfortunately, there is no evidence to show that these recommendations were made or even seconded by a treating physician. Without such a prescription by a physician, and said physician's inherent representation that such recommendations were reasonable and necessary and related to the accident in question, the Arbitrator is unwilling to make such an award based solely on the recommendation of a therapist.

Accordingly, Petitioner's claim for reimbursement of housing modification expenses is hereby denied.

Legal Topics:

For related research and practice materials, see the following legal topics:
Labor & Employment LawDisability & Unemployment InsuranceDisability BenefitsGeneral OverviewWorkers' Compensation & SSDIAdministrative ProceedingsClaimsTime LimitationsNotice PeriodsWorkers' Compensation & SSDICompensabilityInjuriesGeneral Overview

2014 IL App (1st) 130621
No. 1-13-0621
Opinion filed March 26, 2014

Third Division

IN THE

APPELLATE COURT OF ILLINOIS

FIRST DISTRICT

JAMES PALUCH, Plaintiff-Appellee, v. UNITED PARCEL SERVICE, INC., Defendant-Appellant.	)	Appeal from the Circuit Court of Cook County. No. 12 L 50237 The Honorable Daniel Gillespie, Judge, presiding.

PRESIDING JUSTICE HYMAN delivered the judgment of the court, with opinion.
Justices Pucinski and Mason concurred in the judgment and opinion.

OPINION

¶ 1 Sloppy, imprecise drafting can lead to legal wrangling. A single word in reciting the terms of a settlement, for example, can bring about intense litigation over interpretation. In drafting settlement agreements, lawyers should, quoting novelist Vladimir Nabokov's advice to writers, "have the precision of a poet," leaving out the poet's creativity, originality or artistic flourishes. Had the lawyers here been more studious and careful in choosing a single word ("plus"), this case undoubtedly would not have been necessary.

¶ 2 Under the terms of a workers' compensation settlement agreement between defendant United Parcel Service, Inc. (UPS), and its employee, James Paluch, UPS was required to pay Paluch an amount that UPS sets at $400,000 and Paluch sets at $400,000 *in addition* to a Medicare set-aside (MSA) annuity. After UPS refused to read the agreement in the manner that Paluch contended it should be read, he filed this action, arguing that UPS had not fully satisfied the agreement. The trial court agreed with Paluch. UPS now appeals, arguing that $400,000 included the MSA.

¶ 3 We find the agreement ambiguous as to the total amount UPS owed to Paluch and reverse the trial court and remand for an evidentiary hearing because the settlement agreement is ambiguous and open to more than one interpretation.

¶ 4 BACKGROUND

¶ 5 Plaintiff James Paluch settled his worker's compensation claim against defendant UPS. The agreement documenting the settlement received approval as an Illinois Workers' Compensation Commission (the Commission) settlement contract lump sum petition and order. The agreement states:

> "Respondent agrees to pay and Petitioner agrees to accept $400,000.00 in a lump sum plus payment of a Medicare Set-Aside (MSA), in annuity form, in full and final settlement of all claims for benefits past, present and future based on injuries arising out of an accident on or about July 11, 2006. This settlement represents as a compromise of wage-differential benefits in the amount of $218,419.04 under Section 8(d)(1) of the Workers' Compensation Act, plus funding of an MSA in the amount of $148,790.00, direct reimbursement of BCBS lien in the amount of $31,135.82 and direct reimbursement of AETNA lien in the amount of $1,655.14. Respondent will

pay all necessary and related medical expenses pursuant to the fee schedule or negotiated rate, whichever is less, that have been submitted to Respondent prior to contract approval and that contain all the required data elements necessary to adjudicate the bills pursuant to Section 8.2(d). Petitioner is responsible for payment of any and all medical expenses not submitted prior to contract approval. Petitioner hereby foregoes any right to review or reopen the settlement and agrees that all rights under Section 8(a) and 19(h) are expressly waived unless otherwise retained under the terms of this contract. The parties have taken Medicare's interests into consideration and included with this settlement is a proposed MSA with initial funding of $106,650.00 and an annuity providing $3,329.87 per year continuing for life for a total proposed MSA of $148,790.00. The MSA shall be submitted to CMS for approval. Should CMS determine the MSA to be insufficient, the Respondent reserves the right to appeal the decision, and Respondent agrees to either modify the MSA consistent with CMS recommendations or elect to allow Petitioner to retain his medical rights under Section 8(a). If the MSA is approved, then petitioner's rights under section 8(a) will cease upon funding of the MSA and the matter will be finalized with no futher [*sic*] activity necessary at the Commission."

The next paragraph states:

"Total Amount of Settlement $400,000.00

Deduction: Attorney's Fees $43,600.00 reduced from $80,000.00

Deduction: Medical reports, X-rays $2,611.84

Deduction: Other (explain) $[blank]

Amount employee will receive $353,788.16"

¶ 6 A social security rider to the settlement divided the award by Paluch's life expectancy, stating "$353,788.16 divided by Petitioner's life expectancy expressed in weeks is $282.31 per week."

¶ 7 UPS paid $218,419.04 in wage-differential benefits, $31,135.82 reimbursing a Blue Cross Blue Shield lien, and $1,655.14 reimbursing an Aetna lien. UPS also submitted $148,790 for the MSA in annuity form to the Centers for Medicare and Medicaid Services (CMS). (The parties agree that the MSA is not due until the amount is approved by CMS.) Paluch filed a petition for judgment on award, alleging that UPS owed Paluch another $181,580.96 under the settlement. UPS moved to dismiss, claiming full satisfaction because the specific list of items to be paid by UPS, including the MSA, equaled exactly $400,000, and the settlement did not identify any other specific payments. Paluch countered that the $400,000 was exclusive of the MSA, citing the language obligating UPS to pay "$400,000.00 in a lump sum *plus* payment of a Medicare Set-Aside" (emphasis added).

¶ 8 The trial court initially granted UPS's motion, finding that the parties intended the settlement to total $400,000, inclusive of the MSA. But the trial court reversed itself following Paluch's motion to reconsider and entered judgment for Paluch.

¶ 9 The trial court determined that the social security rider constituted conclusive evidence of the parties' intent to exclude the MSA from the $400,000 award. The trial court reasoned that had the parties intended the MSA to be part of the award, they would have listed and deducted the MSA in calculating the rider. UPS appeals, arguing the settlement agreement unambiguously includes the MSA in the $400,000 award and, alternatively, if the agreement is ambiguous, the trial court should have held an evidentiary hearing rather than entering judgment in Paluch's favor.

¶ 10 ANALYSIS

¶ 11 As a preliminary matter, Paluch argues that judgment in his favor was mandated under section 19(g) of the of the Illinois Workers' Compensation Act (820 ILCS 305/19(g) (West 2010)), which limits enforcement of Commission orders. Section 19(g) provides that "either party may present *** a certified copy of the decision of the Commission when the same has become final, *** whereupon the court shall enter a judgment in accordance therewith." 820 ILCS 305/19(g) (West 2010). Accordingly, judgment on the award must be entered without the court questioning the Commission's decision, even if the court disagrees with the Commission's construction of the law. *Ahlers v. Sears, Roebuck Co.*, 73 Ill. 2d 259, 268 (1978). Paluch argues that the court should enforce the judgment without determining the amount of the judgment or deciding whether it had been satisfied. Further, Paluch contends that section 19(f) of the Illinois Workers' Compensation Act (820 ILCS 305/19(f) (West 2010)), which does not permit a review of a Commission order after "20 days of the receipt of notice of the decision of the Commission," prohibits court review of the agreement itself. UPS responds that it does not challenge the validity of the agreement approved by the Commission, so section 19(f) is irrelevant. Rather, UPS contends it made full payment, which is a viable defense to a section 19(g) petition. *Dallas v. Ameren CIPS*, 402 Ill. App. 3d 307, 312 (2010); *Aurora East School District v. Dover*, 363 Ill. App. 3d 1048, 1055 (2006).

¶ 12 We agree with UPS that payment can be raised as a defense to a section 19(g) petition. This has meaning only if the court can determine the amount of the settlement to verify whether the award has been fully paid. Hence, we turn to the settlement agreement.

¶ 13 A settlement agreement is a release governed by contract law. *Gassner v. Raynor Manufacturing Co.*, 409 Ill. App. 3d 995, 1006 (2011). When interpreting a contract, the court attempts to give effect to the parties' intentions, which are best indicated by the plain meaning of the words of the contract. *Gallagher v. Lenart*, 226 Ill. 2d 208 (2007). If the words in the contract are clear and unambiguous, we must give them their plain, ordinary and popular meaning. *Thompson v. Gordon*, 241 Ill. 2d 428, 441 (2011). But if the language of the contract is ambiguous, we may look to extrinsic evidence to determine the parties' intent. *Id.* at 441. Language in a contract is ambiguous if it is "susceptible to more than one meaning." *Id.* The mere fact that the parties disagree over the contract's interpretation does not establish ambiguity. *Intersport, Inc. v. National Collegiate Athletic Ass'n*, 381 Ill. App. 3d 312, 319-20 (2008). Rather, instead of focusing on one clause or provision in isolation we must read the entire contract in context and construe it as a whole, viewing each provision in light of the other ones. *Gallagher,* 226 Ill. 2d at 233. We review a contract's interpretation *de novo*. *Carr v. Gateway, Inc.*, 241 Ill. 2d 15, 20 (2011); *Dowling v. Chicago Options Associates, Inc.*, 226 Ill. 2d 277, 285 (2007).

¶ 14 UPS contends that in the context of a workers' compensation settlement agreement, an MSA is deemed to be a portion of the net proceeds of a workers' compensation settlement unless the agreement specifically states otherwise. For support, UPS cites *In re Marriage of Washkowiak*, 2012 IL App (3d) 110174. In *Washkowiak*, the parties' divorce settlement agreement granted the plaintiff ex-wife 17.5% of "net proceeds" from her ex-husband's workers' compensation settlement. The workers compensation agreement stated that the husband would be awarded " '$365,000 ([which] does not include $70,000 MSA).' " *Id.* ¶ 5. When the trial court awarded the plaintiff $12,250, or 17.5% of the MSA, the husband

appealed, arguing that the MSA was not part of the workers' compensation settlement agreement. *Id.* ¶ 6. The appellate court affirmed, finding that "net proceeds" of the husband's workers' compensation settlement included the $70,000 MSA. *Id.* ¶ 10. Relying on *Washkowiak*, UPS asserts that since there is no language specifically excluding the MSA, it should be deemed to be a portion of the next proceeds. We disagree. The court in *Washkowiak* made no holdings as to meaning of the language stating that the $365,000 award " 'does not include the $70,000 MSA.' " *Id.* ¶ 5. The court was interpreting the parties' divorce settlement, not the workers' compensation settlement, when it held that the "net proceeds" of the husband's settlement included the MSA. UPS cites no other cases to support its assertion that an MSA must be deemed a part of the net proceeds absent language excluding it.

¶ 15 Turning to the language of the settlement, both UPS and Paluch contend it is unambiguous. Of course, they assert different theories about what "unambiguous" means.

¶ 16 Paluch argues that the sentence providing that UPS must pay him "$400,000.00 in a lump sum plus payment of a Medicare Set-Aside (MSA), in annuity form" shows that UPS owed him $400,000 in a lump sum exclusive of UPS's obligation to fund the MSA. Paluch argues that the key word is "plus," and that the MSA was in addition to the lump-sum payment. Paluch further argues that the MSA cannot be part of the $400,000 because when the settlement lists $353,788.16 as the "amount employee will receive," the contract means that UPS must pay $353,788.16 directly to Paluch, not through an MSA. But the $400,000 includes amounts paid to other parties on Paluch's behalf, such as the Blue Cross and Aetna liens. Therefore, the "amount employee will receive" includes amounts that UPS pays to third parties which inure to Paluch's benefit like the MSA.

¶ 17 Conversely, UPS argues that the settlement agreement unambiguously requires UPS to pay Paluch $400,000, which includes the MSA, as evidenced by the fact that when the amounts it must pay for wage differential benefits, the MSA, and direct reimbursement to Blue Cross Blue Shield and Aetna are added up, the total amount is $400,000. UPS asserts that since it has satisfied all of its obligations under the agreement, the trial court erred in granting Paluch's motion to reconsider and in entering a judgment in Paluch's favor. But UPS's interpretation fails to acknowledge the ambiguity created by the use of the word "plus" in the first sentence of the agreement. Had the agreement stated that "Petitioner agrees to accept $400,000.00 in a lump sum, which includes payment of a Medicare Set-Aside (MSA)," it would be evident that the parties intended for the MSA to be included in the $400,000 settlement amount.

¶ 18 The agreement has conflicting clauses. The first sentence of the agreement suggests the MSA is not included in the $400,000 award. But the list of specific items the agreement requires UPS to pay Paluch totals $400,000 suggests the MSA is included in the settlement amount. Further, if UPS owes more than what it has paid, the agreement does not state what other obligations UPS might have in addition to the MSA, wage-differential, and liens. Thus, because the four corners of the agreement are ambiguous, we may look to extrinsic evidence to try to determine the parties' intent. *Thompson*, 241 Ill. 2d at 441-42.

¶ 19 Paluch argues the social security rider provides further evidence that the parties intended to exclude the MSA from the net settlement proceeds. The Social Security Administration reduces workers' social security disability benefits if the worker's disability benefits, including workers' compensation settlements, exceed 80% of the employee's predisability earnings. See 42 U.S.C. 424a(a)(5) (2000). Paluch's workers' compensation settlement

award was a lump sum. The social security rider prorated the award across Paluch's life expectancy to use a weekly amount to reduce his social security disability benefits. The amount of the settlement that is dedicated to future medical expenses does not reduce social security benefits and this amount would not be used to calculate the prorated lump sum. 20 C.F.R. § 404.408(d) (2012).

¶ 20 A MSA allocates a certain amount of a settlement toward future medical expenses because Medicare will not pay for medical services that a party was already compensated for by a workers' compensation settlement. See 42 C.F.R. § 411.26 (2006). If a party appears to be shifting his or her obligation to pay for a worker's future medical expenses onto Medicare by dedicating an insufficient amount for future medical expenses, the settlement will not be recognized. *Id.*

¶ 21 Paluch argues that the fact that the parties used the full $400,000 (less attorney fees and other expenses) to calculate the social security rider shows that this amount does not include the MSA. Accordingly, if the $400,000 included the MSA, the parties would have deducted the MSA before calculating the social security rider because the MSA represents future medical expenses. Otherwise, the parties unnecessarily reduced Paluch's social security benefits by using the MSA amount representing future medical expenses.

¶ 22 The Commission does not have the authority to rule on social security matters and the IWCC approved the settlement agreement alone, not the social security rider. But the rider suggests Paluch understood his lump-sum payment would be $353,788.16. Weighing against that interpretation is the fact that, as previously noted, the $353,788.15 sum includes amounts paid to other parties on Paluch's behalf, such as the Blue Cross and Aetna liens, money that

would not be going directly to Paluch. Thus, the social security rider does not eliminate the ambiguity in the settlement agreement language.

¶ 23 Lastly, Paluch asserts an argument alleging that CMS has denied the MSA as insufficient, and therefore, this should change the interpretation of the agreement. UPS denies this assertion. Paluch relies on facts outside of the record, and, thus, the argument will not be considered. *Silvestros v. Silvestros*, 206 Ill. App. 3d 84, 90 (1990).

¶ 24 Precision is important in writing. Otherwise, as here, the ambiguous wording requires an evidentiary hearing. We reverse the trial court's holding and remand for further proceedings consistent with this order.

¶ 25 Reversed and remanded.

Illinois Official Reports

Appellate Court

***City of Chicago v. Illinois Workers' Compensation Comm'n*, 2014 IL App (1st) 121507WC**

Appellate Court Caption	THE CITY OF CHICAGO, Appellant, v. THE ILLINOIS WORKERS' COMPENSATION COMMISSION *et al.* (Joseph Locasto, Appellee).
District & No.	First District, Workers' Compensation Commission Division Docket No. 1-12-1507WC
Filed Rehearing denied	January 6, 2014 February 13, 2014
Held (*Note: This syllabus constitutes no part of the opinion of the court but has been prepared by the Reporter of Decisions for the convenience of the reader.*)	In an action arising from an application for benefits based on the injuries claimant suffered while employed by a city to train for a position as a paramedic, the trial court's judgment confirming the Workers' Compensation Commission's award of temporary partial disability benefits and temporary total disability benefits for the period after August 3, 2009, the date on which claimant was found by the retirement board to have made a full recovery from his injuries, was reversed, but the portion of the trial court's judgment awarding temporary total disability benefits for time periods prior to that date was affirmed.
Decision Under Review	Appeal from the Circuit Court of Cook County, No. 11-L5-1071; the Hon. Margaret Brennan, Judge, presiding.
Judgment	Affirmed in part and reversed in part; cause remanded.

Counsel on Appeal	Joseph A. Zwick, of Hennessy & Roach P.C., of Chicago, for appellant. Jeffrey C. Hart, of Segal, McCambridge, Singer & Mahoney, Ltd., of Novi, Michigan, for appellee.
Panel	PRESIDING JUSTICE HOLDRIDGE delivered the judgment of the court, with opinion. Justices Hoffman, Hudson, Harris, and Stewart concurred in the judgment and opinion.

OPINION

¶ 1 The claimant, Joseph Locasto, filed an application for adjustment of claim under the Workers' Compensation Act (the Act) (820 ILCS 305/1 *et seq.* (West 2008)) seeking benefits for injuries which he sustained while working for the employer, the City of Chicago (the City). After conducting a hearing, the arbitrator found that the claimant had proven a work-related injury and awarded him $75^{5}/_{7}$ weeks of temporary total disability (TTD) benefits plus medical expenses. However, the arbitrator denied the claimant's claim for temporary partial disability (TPD) benefits and/or maintenance benefits.

¶ 2 Both parties appealed the arbitrator's decision to the Illinois Workers' Compensation Commission (the Commission). The claimant appealed the arbitrator's denial of TPD and/or maintenance benefits. The City appealed the Commission's award of TTD benefits and medical expenses, arguing that: (1) the claimant's claims are barred by section 1(b)(1) of the Act (820 ILCS 305/1(b)(1) (West 2008)), which excludes "duly appointed member(s)" of the City's fire department from the Act's definition of a covered "employee" for purposes of the claims at issue in this case; (2) the claimant's claims are barred under the doctrines of *res judicata* and/or collateral estoppel because the Retirement Board of the Firemen's Annuity and Benefit Fund of Chicago (the Board) denied the claimant's claim for duty disability benefits arising out of the same accident and injuries at issue in this case. The Commission unanimously rejected the City's arguments, modified the arbitrator's decision by awarding TPD benefits and reducing the award of medical expenses, and affirmed and adopted the arbitrator's decision in all other respects.

¶ 3 The City sought judicial review of the Commission's decision in the circuit court of Cook County, which confirmed the Commission's ruling. This appeal followed.

¶ 4 FACTS

¶ 5 In May 2008, the claimant was employed by the City as a candidate in training at the Chicago Fire and Paramedic Academy (the Academy).[1] The claimant was training to become a paramedic with the Chicago fire department. At that time, the claimant had been licensed as a paramedic by the State of Illinois for eight years. Prior to his employment with the City, the claimant worked as a paramedic with Children's Memorial Hospital (Children's). Before he was admitted to the Academy, the claimant was examined and declared fit for duty by the City's physician and by his own doctor, and he passed a physical fitness and agility test.

¶ 6 On May 6, 2008, the claimant reported to the Academy for training at 6 a.m. The claimant testified that the candidates underwent rigorous physical training (including intense, continuous physical exercises) for several hours in an extremely hot environment with very minimal water breaks. He stated that the training included military-style hazing with yelling, verbal abuse, and the assignment of additional exercises as punishment for the entire group if a single candidate did not complete a task in a timely manner. He testified that, following a 45-minute lunch break at noon, the candidates were required to exercise vigorously straight through until 4:30 p.m. with only a single, one-minute water break. The claimant did not request special permission to get a drink of water out of fear of punishment for the entire group.

¶ 7 After completing his first day of training, the claimant experienced cramps in his right quadriceps. That evening, he drank Gatorade and water, took Advil, and iced his leg.

¶ 8 The following morning, the claimant reported to the Academy for training at 7 a.m. He testified that the candidates were required to work out straight through until lunchtime with no water breaks. According to the claimant, the instructors yelled at individual candidates, telling them to "quit or go to the hospital" if they could not take it. He testified that, following a 45-minute lunch break, the workouts became more intense and lasted for longer periods of time. During the late afternoon, the claimant noticed severe cramping in his right leg. He testified that, by the end of the training session, his leg was so sore he had difficulty climbing into his sport utility vehicle to drive home.

¶ 9 Although the claimant took Advil later that evening, he continued to experience severe cramping in his right leg. He hydrated and applied ice and heat to his leg. At 5:30 a.m., the claimant noticed his urine was tea colored and looked like blood. When he phoned his instructor to report his condition, the instructor told him to go to the emergency room.

¶ 10 The claimant sought treatment at Illinois Masonic Hospital, where he was diagnosed with rhabdomyolysis, acute kidney failure, and compartment syndrome. Rhabdomyolysis is a condition of the kidneys that occurs when muscle tissue rapidly breaks down (due to overexertion and dehydration, crush injury or toxins) and releases the protein myoglobin into the bloodstream, causing the kidneys to lose function. Compartment syndrome is a condition caused by the compression of nerves, blood vessels and muscle inside a closed space within the body. The compression can lead to tissue death due to lack of oxygenation as the blood vessels are compressed by the raised pressure within the compartment. This can cause subsequent loss

[1]The City requires its firemen and paramedics to undergo the same training.

of function, including paralysis. Amputation of the affected area might be required in some cases.

¶ 11 The medical records of the emergency room reflect that orthopedic surgeons were consulted regarding the swelling of the claimant's legs. Dr. David Hoffman, an orthopedic surgeon, diagnosed compartment syndrome and performed immediate surgery. The claimant underwent a fasciotomy wherein his right leg was cut open and left open for several weeks to relieve the pressure and swelling in the leg and to allow the muscles to expand. He remained in the intensive care unit for approximately 15 days. The claimant required over 100 staples to close the fasciotomy. Moreover, the claimant was placed on dialysis due to his rhabdomyolysis from dehydration. He was discharged from the hospital on June 13, 2008, and he continued to undergo dialysis for several months thereafter.

¶ 12 Following his discharge from the hospital, the claimant saw Dr. Steven Fox, his primary care physician, Dr. Eduardo Cremer, a nephrologist, and Dr. Hoffman. All three doctors opined that the claimant's conditions of ill-being were causally related to the intense workouts and subsequent dehydration he suffered at the Academy. The claimant also saw physicians at the Chicago fire department. The City's physicians continued the claimant off work through at least February 25, 2009.

¶ 13 On August 26, 2008, Dr. Hoffman opined that the claimant's compartment syndrome had resolved and he released the claimant to return to work from an orthopedic point of view. However, Dr. Hoffman advised that claimant continue to follow up with his nephrologist.

¶ 14 After examining the claimant and evaluating the condition of his kidneys, Dr. Cremer released the claimant to return to work at a regular job on September 17, 2008, provided that he stayed well hydrated and did not overexert himself. On November 11, 2008, Dr. Cremer released the claimant to return to "regular activities." However, during his December 3, 2009, evidence deposition, Dr. Cremer testified that the claimant should "absolutely not" return to the strenuous and intense rigors of the Academy training. Dr. Cremer opined that the claimant's kidneys will never be normal. He stated that the claimant should avoid nonsteroidal anti-inflammatory medications, antibiotics, and anything that causes extreme exhaustion or severe muscle soreness. He noted that the claimant requires annual metabolic testing. However, Dr. Cremer acknowledged that claimant could possibly run a marathon if he used extreme caution, conditioned properly, and hydrated appropriately.

¶ 15 The claimant continued to follow up with Chicago fire department physicians. The claimant testified that one of the City's nurses told him that he needed a written release from his doctor to allow him to enter the next Academy class in November 2008. Accordingly, the claimant returned to Dr. Fox and asked him for a work release. On November 5, 2008, Dr. Fox wrote a note stating that the claimant was in excellent health and that he had been cleared for "unrestricted physical activity." One week later, the claimant met with Commander Edenburgh, a doctor who heads the Chicago fire department's medical division, and gave him Dr. Fox's note. Although Commander Edenburgh read the note, he told the claimant that it was his opinion that the claimant was not ready to return to the Academy.

¶ 16 Following this meeting, the claimant continued to follow up with Dr. Fox and the Chicago fire department's doctors. The records of the Chicago fire department's medical division

reflect that, on December 9, 2008, the claimant was noted to have an elevated "Ca+ level" and was instructed to see both his renal and orthopedic physicians. On January 20, 2009, it was noted that claimant was complaining of continued right leg cramping. He was instructed to follow up with his treating orthopedic surgeon and undergo repeat lab work. On February 25, 2009 (the last recorded visit contained in the record), the claimant continued to complain of leg cramping. According to the claimant, the City asked him to undergo a functional capacity examination (FCE) but refused to pay for the test after the claimant's insurance denied coverage. The City's doctors never released the claimant to return to the Academy.

¶ 17 In his report dated February 9, 2009, Dr. Fox opined that: (1) it is highly likely that the claimant has some permanent kidney damage; (2) the claimant will be forever prone to recurrent bouts of acute renal failure; and (3) the claimant has been irreversibly compromised by the events occurring due to the Academy training. Dr. Fox stated that the claimant should not subject himself to the same rigors that he was put through at the Academy. On July 23, 2009, Dr. Fox wrote a letter clarifying his November 5, 2008, physical activity release. In the letter, Dr. Fox stressed that, although his November 5, 2008, release had allowed for unrestricted physical activity, "at no time did [he] intend for this to mean that [the claimant] could or should return to the Fire Academy." The doctor noted that the claimant was "well aware of the harm caused by the undue severity of [the Academy's] training," and that "[h]e knew my [November 5, 2008] note cleared him to seek other employment and to engage in physical activity on his own in a way that did not subject him to the extremes of exercise, as expected at the Academy." The doctor also prescribed additional physical therapy for the claimant's ongoing complaints of right thigh pain and cramping.

¶ 18 On May 7, 2009, Dr. Isaac Marcos, an occupational health physician with the Chicago fire department, issued a letter in which he opined that the claimant had completely recovered and had been returned to full duty without restrictions by Drs. Fox, Cremer, and Hoffman. He further opined that the claimant was currently in stable condition and he noted that the claimant remained off duty and had exhausted all his injury and sick leave.

¶ 19 On August 17, 2009, the claimant was examined by Dr. Kathleen Weber, the City's independent medical examiner (IME). Dr. Weber is an internist who specializes in sports medicine. Dr. Weber opined that the claimant's acute compartment syndrome, exercise-induced rhabdomyolysis, and subsequent acute renal failure were causally related to his May 2008 training at the Academy. She also opined that claimant had no residual right leg disability as a result of his compartment syndrome other than some muscle tightness which she thought would be relieved with a short two- to three-week course of physical therapy and home strengthening/stretching exercises. Dr. Weber concluded that, following this treatment, the claimant would be at maximum medical improvement (MMI). The doctor opined that the claimant could return to work for the Chicago fire department, and she assumed that he would return to the Academy. However, she acknowledged that the claimant is now at a higher risk for rhabdomyolysis and noted that, if the claimant returned to the same rigorous training conditions at the Academy, he would have to be in great condition and would need to be monitored throughout the training.

¶ 20 On December 8, 2009, the claimant was examined by Dr. Sheldon Hirsch, a nephrologist who served as the City's second IME. Dr. Hirsch opined that the claimant seemed to have no residual deficits and had been cleared to perform any work from a renal viewpoint. However, Dr. Hirsch noted that:

> "given the injury that the claimant suffered, I advised him against any form of particularly strenuous exercise, which conceivably could lead to a recurrent injury. Presumably this would preclude him from returning to the fire department, assuming that strenuous training sessions would be necessary."

Moreover, Dr. Hirsch noted that he would defer to an internist or neurologist regarding whether there was "any lingering injury or restrictions derived from his muscle injury." Dr. Hirsch noted that the claimant was not to return to work that included extensive exercise.

¶ 21 Although the City paid the claimant salary continuation from May 8, 2008, through May 8, 2009, it did not pay him TTD benefits. The City did not allow the claimant to return to the Academy and did not offer him any alternative employment.

¶ 22 In October, 2009, after he was terminated by the City, the claimant sought employment with his previous employer (Children's) as an emergency room paramedic. However, there were no such positions available. Beginning on October 6, 2009, the claimant obtained part-time employment with Children's working on an "IV Access Team." The claimant and his team start IVs for patients throughout the hospital when the nurses are unable to do so. The claimant testified that he works two 12-hour shifts per week and earns a net weekly salary of $900 to $1,000 per week. He eventually obtained group insurance coverage again through Children's and subsequently resumed his treatment with Dr. Fox.

¶ 23 The claimant testified that, at the time of the arbitration hearing, he continued to have cramping and pain in his right leg which is increased by prolonged sitting. He stated that he had gained approximately 20 pounds since his accident due to his reduced activity level. Pursuant to his physicians' instructions (and due to his fear of re-injury), he no longer plays sports or exercises vigorously.

¶ 24 Relying on the claimant's testimony and the testimony of Drs. Cremer, Hoffman, Fox, Hirsch, and Weber, the arbitrator found that the claimant sustained an accident arising out of and in the course of his employment on May 6, 2008, and May 7, 2008, and that the claimant's present condition of ill-being is causally related to those work accidents. The arbitrator found that the claimant was eligible for benefits under the Act because he was not a "duly appointed member" of the Chicago fire department at the time of his work accidents. In support of that conclusion, the arbitrator cited *Dodaro v. Illinois Workers' Compensation Comm'n*, 403 Ill. App. 3d 538, 539 (2010), in which we held that a Chicago police recruit in training was not a "duly appointed member" of the Chicago police department because a recruit does not have full police powers until he or she completes training at the police academy and is sworn in as a police officer. The arbitrator "applie[d] the same logic" to the claimant, who was a paramedic candidate.

¶ 25 The arbitrator found that the claimant had incurred $152,788.84 in reasonable and related medical expenses for treatment provided to him to cure or relieve his condition. The arbitrator

ordered the City to pay these expenses pursuant to the fee schedule. Moreover, the arbitrator concluded that the claimant was entitled to TTD and/or maintenance benefits from May 8, 2008 through October 5, 2009 (the day before the claimant began part-time employment as an IV technician with Children's).

¶ 26 However, the arbitrator found that the claimant did not prove that he was entitled to receive TPD or maintenance benefits after his return to work on October 6, 2009, and denied the claimant's claim for such benefits. In support of this decision, the arbitrator noted that: (1) although several physicians restricted the claimant from returning to the vigorous strenuous activity of Academy training, no physician restricted him from returning to work as a paramedic; (2) no physician restricted the claimant to part-time work; (3) the claimant did not testify to a job search other than attempting to return to his old position at Children's and his new position at Children's as an IV technician; (4) a full-time, 40-hour work week at the claimant's current hourly salary approximates his salary as a paramedic candidate with the City.

¶ 27 Both parties appealed the arbitrator's decision to the Commission. The claimant appealed the arbitrator's denial of TPD and/or maintenance benefits. The employer appealed the Commission's award of TTD benefits and medical expenses, arguing that the claimant's claims are barred by section 1(b)(1) of the Act (820 ILCS 305/1(b)(1) (West 2008)), which excludes "duly appointed member(s)" of the employer's fire department from the Act's definition of a covered "employee" for purposes of the claims at issue in this case; (2) the claimant's claims are barred under the doctrines of *res judicata* and/or collateral estoppel because the Board denied the claimant's claim for duty disability benefits arising out of the same accident and injuries at issue in this case.

¶ 28 The Commission modified the arbitrator's decision by awarding TPD benefits. The Commission found that the claimant was entitled to TPD benefits at a rate of $251.40 for the period from October 6, 2009, through May 5, 2010. The Commission concluded that the arbitrator had "erred in calculating [the] [c]laimant's current wages based on a 40 hour a week schedule because [the] [c]laimant is currently employed as a part time employee for Children's *** and not full time." Moreover, although the Commission acknowledged that no doctor has restricted the claimant from part time employment, it noted that "it is also true that [the City] refused to permit [the] [c]laimant to return." The Commission also observed that the City required the claimant to undergo a FCE but denied coverage for the FCE. Further, although the Commission acknowledged the limited nature of the claimant's job search, the Commission "[found] it significant that [the City] failed to offer any vocational assistance after refusing to let [the] [c]laimant return to the *** Academy." The Commission also found that the City failed to comply with section 7110.10 of title 50 of the Illinois Administrative Code (50 Ill. Adm. Code 7110.10 (2006)) which required the City to perform a vocational assessment even though the claimant did not request vocational assistance.

¶ 29 The Commission rejected the City's arguments. Specifically, the Commission concluded that the claimant was not a "duly appointed member" of the Chicago fire department and, thus, is not precluded from benefits under section 1(b)(1) of the Act. The Commission held that this issue was controlled by our decision in *Dodaro*, 403 Ill. App. 3d 538.

¶ 30 Further, the Commission rejected the City's argument that the Board's denial of the claimant's application for duty disability benefit's bars the claimant's claims before the Commission under principles of *res judicata* and/or collateral estoppel. In so holding, the Commission reasoned:

> "The issues presented before the Commission here are not the same issues that were presented before the *** Board. The issue before the *** [B]oard was whether [the] [c]laimant was entitled to receive duty disability benefits. The *** [Board] found that he was not disabled and therefore not entitled to benefits from the Firemen's Annuity and Benefit Fund of Chicago because he was capable of returning to work. The issues before the Commission are jurisdiction, accident, causal connection, medical expenses, temporary disability benefits, temporary partial disability benefits, and penalties and attorneys' fees. The *** [B]oard made no determinations that are relevant to the issues on review here. The Commission concludes that [the] [c]laimant's claim is not barred by collateral estoppel or *res judicata*."

¶ 31 The Commission further modified the arbitrator's decision by reducing the award of medical expenses, and affirmed and adopted the arbitrator's decision in all other respects.

¶ 32 The City sought judicial review of the Commission's decision in the circuit court of Cook County, which confirmed the Commission's ruling. This appeal followed.

¶ 33 ANALYSIS

¶ 34 1. Section 1(b)(1) of the Act

¶ 35 The City argues that the claimant's claim is barred by section 1(b)(1) of the Act (820 ILCS 305/1(b)(1) (West 2008)). At the time of the claimant's May 2008 work injury, that section provided that "[a] duly appointed member of a fire department in any city, the population of which exceeds 200,000 according to the last federal or State census,[2] is an employee under this Act only with respect to claims brought under paragraph (c) of Section 8." 820 ILCS 305/1(b)(1) (West 2008). The claimant's claims were not brought pursuant to section 8(c) of the Act. The City argues that the claimant was a "duly appointed member" of the Chicago fire department at the time of his May 2008 work injury and, therefore, his claims are barred under section 1(b)(1). The Commission rejected this argument. We interpret the meaning of the statutory exclusion in section 1(b)(1) *de novo*. *Dodaro*, 403 Ill. App. 3d at 544-45. However, because the Commission's determination that the claimant was not a "duly appointed member" of the Chicago fire department concerns the legal effect of a given set of facts, we review that decision for clear error. *Id.* We will reverse the Commission's decision "only when there is evidence supporting reversal and [we are] left with the definite and firm conviction that a mistake has been committed." *Id.* at 544.

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[2]Effective August 8, 2011, the legislature amended the statute by substituting the term "500,000" for "200,000." This amendment is immaterial. The parties do not dispute that the City of Chicago has more than 500,000 residents.

¶ 36 During the arbitration hearing, each party presented evidence regarding the claimant's employment status at the time he was injured. At that time, the claimant was a candidate fire paramedic in training at the Academy. The claimant testified that, as a candidate, he was not a sworn officer of the fire department, he was not given a badge or identification identifying him as a Chicago fire paramedic,[3] and he received a lower salary than a sworn paramedic. According to the claimant, candidates are not able to render medical assistance to citizens on behalf of the City. Candidates engage in physical training and take classes in a classroom environment, but they do not work as actual paramedics. The claimant testified that candidates are not considered paramedics until they graduate from the Academy and are sworn in at Navy Pier.

¶ 37 Kenneth Kaczmarz, the executive director of the Firemen's Annuity and Benefit Fund of Chicago, testified on behalf of the City. Kaczmarz testified that, according to the fire department's records, the claimant was hired as a "fireman/paramedic" beginning May 1, 2008. Kaczmarz stated that, once an employee is put on the Chicago fire department's payroll and begins his duties, he is a "full and contributing member[ ] of the pension fund," even if he is a candidate in training at the time. Kaczmarz considered the claimant an "active fireman" under section 6-109 of the Illinois Pension Code (40 ILCS 5/6-109 (West 2008)) who was entitled to apply for and receive disability benefits under the Code. The City also presented various fire department personnel records signed by the claimant shortly before he began his employment which identify him as a "paramedic" working for the fire department. The City argues that these documents, together with Kaczmarz's testimony, establish that the claimant was a "duly appointed member" of the Chicago fire department at the time of his May 2008 work injury and, therefore, his claims are barred under section 1(b)(1) of the Act.

¶ 38 We disagree. We addressed a similar issue in *Dodaro*. In that case, the City argued that a Chicago police recruit who was injured during a training exercise was a "duly appointed member" of the Chicago police department and therefore not eligible for benefits under section 1(b)(1) of the Act. Construing that section of the Act *de novo*, we interpreted the word "member" to mean "a person who has been admitted [usually formally] to the responsibilities and privileges of some association or joint enterprise." (Internal quotation marks omitted.) *Dodaro*, 403 Ill. App. 3d at 546. Thus, we found that "the legislature intended the statutory exclusion to apply to individuals who have been formally admitted to the responsibilities and privileges of the Chicago police department." *Id.* The claimant testified that police recruits were instructed that they were not police officers and had no authority to act as police officers. *Id.* at 540. They were not issued badges or any identification issued by the Chicago police department and they were not authorized to make arrests. *Id.* Recruits, unlike actual officers, were not "sworn in." *Id.* We held that the evidence showed that the claimant did not have full police powers and had not been "formally admitted to the responsibilities and privileges" of the Chicago police department at the time of her injury. *Id.* at 546. Accordingly, we held that the Commission's ruling that police recruits were not "duly appointed members" of the police

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[3]The claimant stated that his uniform consisted of basic blue pants and a blue shirt without a Chicago fire department emblem.

department for purposes of section 1(b)(1) was not clearly erroneous. *Id.* We reached this holding even though "[t]here was evidence that recruits were treated like sworn police officers with respect to their eligibility for benefits under the Police Pension Fund." *Id.*

¶ 39 The same reasoning applies here. As *Dodaro* makes clear, the dispositive question is whether the claimant had been "formally admitted to the responsibilities and privileges" of the Chicago fire department at the time of his injury. *Id.* As noted, at the time he was injured, the claimant was a candidate fire paramedic in training at the Academy, not a sworn member of the fire department. He did not work as a paramedic, was not given a badge or identification identifying him as a Chicago fire paramedic, and was not authorized to render medical assistance to citizens on behalf of the City. Like the claimant in *Dodaro*, he did not have the full powers and privileges of the job for which he was training. Thus, the Commission's ruling that the claimant was not a "duly appointed member" of the Chicago fire department was not clearly erroneous.

¶ 40 The City argues that the claimant was a "duly appointed member" of the fire department at the time of his injury because: (1) he was an "active fireman" under section 6-109 of the Pension Code (40 ILCS 5/6-109 (West 2008)) and was therefore entitled to apply for and receive disability benefits under the Code; and (2) fire department personnel records signed by the claimant identify him as a "paramedic." We rejected the same types of arguments in *Dodaro*. There, the City presented witnesses (including the executive director of the police pension fund) who testified that police recruits injured during training were eligible to receive duty disability benefits under the Pension Code. *Dodaro*, 403 Ill. App. 3d at 541-42. Moreover, the City presented documents that the claimant signed during her training at the police academy which referred to her as a "member" of the police department. *Id.* at 547. However, "looking beyond the label placed on recruits in [those] documents" (and beyond the claimant's employment classification under the Pension Code), we focused instead on the fact that the claimant lacked the full powers and privileges of a Chicago police officer.

¶ 41 We employ the same analysis here. The fact that the claimant was considered an "active fireman" under the Pension Code for purposes of duty disability benefits does not establish that he is a "duly appointed member" of the fire department under section 1(b)(1) of the Act. As we made clear in *Dodaro*, the claimant's status under section 1(b)(1) depends upon the powers and privileges he enjoyed at the time of his injury, not upon his eligibility for benefits under the Pension Code or any labels used in personnel documents.

¶ 42 2. *Res Judicata* and Collateral Estoppel

¶ 43 The City argues that the Board's denial of claimant's claim for duty disability benefits under the Pension Code bars the claimant's workers' compensation claims under principles of *res judicata* and/or collateral estoppel. We begin our analysis of this issue by providing a brief factual background of the proceedings before the Board. On April 9, 2009, the claimant filed an application for duty-related disability benefits with the Board pursuant to section 6-151 of the Pension Code (40 ILCS 5/6-151 (West 2008)). After conducting a hearing during which the claimant testified and presented testimony from some of his treating doctors, the Board issued a letter on August 3, 2009, denying the claimant's application.

¶ 44 The Board's written decision contained several express findings of fact, including that: (1) prior to May 8, 2008, the claimant was an "active fireman" as that term is defined under section 6-109 of the Pension Code (40 ILCS 5/6-109 (West 2008)); (2) on May 8, 2008, the claimant was engaged in training activities at the Academy when he experienced pain in his legs and dark-colored urine; (3) the claimant was subsequently diagnosed with "acute rhahdmyelesis [*sic*]" and with compartment syndrome of the right lower extremity; (4) the claimant received medical treatment and physical therapy to treat his kidney condition "until his conditions subsided"; (5) on May 7, 2009, a physician with the Chicago fire department found the claimant to be in stable condition; (6) the claimant was examined by the physician consultant to the Board, Dr. George S. Motto, who found the claimant to be in "good physical condition"; and (7) "[the claimant's] treating nephrologist, Sudesh K. Vohra, M.D. and the *** Board's physician-consultant, George S. Motto, M.D., have concluded that the [claimant] is able to perform his duties in the Chicago Fire Department and that his kidney condition has stabilized."

¶ 45 Based on these findings, the Board concluded that the claimant "has made a full recovery from the conditions that he experienced while in training with the Chicago Fire Department," he "is not currently experiencing any physical condition that would prevent him from performing his paramedic duties with the Chicago Fire Department," and the claimant "has not produced sufficient evidence to meet his burden of proving that he is entitled to receive a Duty Disability Benefit pursuant to 40 ILCS 5/6-151 of the Illinois Pension Code."

¶ 46 The claimant filed a complaint for administrative review of the Board's decision in the circuit court of Cook County, arguing that the Board's decision contained factual errors, was against the manifest weight of the evidence, and was contrary to law. The circuit court affirmed the Board's decision.[4]

¶ 47 In the case at bar, the City argues that the Board's denial of the claimant's claim for duty disability bars his workers' compensation claims under the doctrine of *res judicata* and/or collateral estoppel. We hold that *res judicata* does not apply here. However, we hold that some (but not all) of the claimant's claims are barred under principles of collateral estoppel.

¶ 48 Under the doctrine of *res judicata*, "a final judgment rendered by a court of competent jurisdiction on the merits is conclusive as to the rights of the parties and their privies, and, as to them, constitutes an absolute bar to a subsequent action involving the same claim, demand, or cause of action." *J&R Carrozza Plumbing Co. v. Industrial Comm'n*, 307 Ill. App. 3d 220, 223 (1999). Administrative agency decisions have *res judicata* effect when the agency's determination is made in proceedings which are adjudicatory, judicial, or quasi-judicial in nature. *McCulla v. Industrial Comm'n*, 232 Ill. App. 3d 517, 520 (1992). "To establish *res judicata*, a party must show: (1) that the former adjudication resulted in a final judgment on the merits; (2) that the former and current adjudications were between the same parties; (3) that the former adjudication involved the same cause of action and same subject matter of the later case; and (4) that a court or administrative agency of competent jurisdiction rendered the first judgment." *Hannigan v. Hoffmeister*, 240 Ill. App. 3d 1065, 1075-76 (1992).

[4]Apparently, the claimant chose not to appeal the circuit court's decision.

¶ 49 Several of these elements cannot be satisfied in this case. First, the litigation before the Board involved different parties than the case before the Commission. The defendant in the claimant's action for duty disability benefits was the Board, while the defendant in the instant case is the City. The Board and the City are separate entities. See, *e.g.*, *Hannigan*, 240 Ill. App. 3d at 1076 (concluding that two state agencies were not identical parties for *res judicata* purposes); *Rhoads v. Board of Trustees of the City of Calumet City Policemen's Pension Fund*, 293 Ill. App. 3d 1070, 1075 (1997) (holding that the City of Calumet City and the Calumet City Police Pension Board were different parties, precluding the application of collateral estoppel).

¶ 50 Moreover, the claimant's claim for duty disability benefits does not involve the "same cause of action and same subject matter" as his claims for workers' compensation benefits. The latter claims were brought under a different statute (the Act, as opposed to the Pension Code), and they seek benefits that are not available under the Pension Code, such as TTD benefits and medical expenses. See *Hannigan*, 240 Ill. App. 3d at 1076 (holding that claim under the Pension Code was not same cause of action as prior claim bought under the Act, precluding the application of *res judicata*).[5]

¶ 51 However, some, but not all, of the claimant's claims before the Commission are barred by principles of collateral estoppel. "Collateral estoppel prohibits the relitigation of an issue essential to and actually decided in an earlier proceeding by the same parties or their privies." *McCulla*, 232 Ill. App. 3d at 520. Administrative agency decisions made in adjudicatory, judicial, or quasi-judicial proceedings may have collateral estoppel effect. *Id.* Collateral estoppel may be asserted when: (1) the issue decided in the prior adjudication is identical to the issue in the current action; (2) the issue was "necessarily determined" in the prior adjudication; (3) the party against whom estoppel is asserted was a party or in privity with a party in the prior action; (4) the party had a full and fair opportunity to contest the issue in the prior adjudication; and (5) the prior adjudication must have resulted in a final judgment on the merits. *Mabie v. Village of Schaumburg*, 364 Ill. App. 3d 756, 758 (2006); *McCulla*, 232 Ill. App. 3d at 520.

¶ 52 The City argues that the Board's denial of duty disability benefits precludes all of the claimant's workers' compensation claims. In support of this argument, the Board relies on cases which hold that the standard for determining whether a fireman's injury was incurred in the line of duty under the Pension Code is equivalent to the standard for determining whether an accidental injury arose out of and in the course of his employment under the Act. See, *e.g.*, *McCulla*, 232 Ill. App. 3d at 521; *Mabie*, 364 Ill. App. 3d at 760-61; *O'Callaghan v. Retirement Board of Firemen's Annuity & Benefit Fund*, 302 Ill. App. 3d 579, 583 (1998);

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[5]Accordingly, while the Board had jurisdiction to decide the claimant's claims for duty disability benefits, it would not be a tribunal of competent jurisdiction to decide his claims for workers' compensation benefits. The award of workers' compensation benefits is controlled by the Act, and the Commission has exclusive original jurisdiction to decide claims for such benefits. See 820 ILCS 305/18 (West 2008) (providing that "[a]ll questions arising under th[e] Act, if not settled by agreement of the parties interested therein, shall, except as otherwise provided, be determined by the Commission"); see also *Hartlein v. Illinois Power Co.*, 151 Ill. 2d 142, 157-58 (1992); *Nestle USA, Inc. v. Dunlap*, 365 Ill. App. 3d 727, 732 (2006).

Wilfert v. Retirement Board of the Firemen's Annuity & Benefit Fund, 263 Ill. App. 3d 539, 544 (1994). Applying this principle, we have held that a determination by the Board that a fireman's injury was not incurred in the line of duty collaterally estops that fireman from relitigating the issue of causation before the Commission. *McCulla*, 232 Ill. App. 3d at 521-22.[6] However, these cases are inapposite. Here, the Board did not find that the injuries the claimant suffered during his training in May 2008 were not incurred in the line of duty. (In fact, to the extent the Board addressed causation at all, it implicitly found that the claimant's injuries were caused by his training.) The Board merely held that, however the claimant's injuries were caused, they were resolved by August 3, 2009 (the date of the Board's decision) and that the claimant was fully recovered and able to perform his duties as a paramedic with the City at that time. Accordingly, the Board's decision is fully consistent with the Commission's award of TTD benefits and medical expenses prior to August 3, 2009. The City's argument that the Board's decision collaterally estops *all* of the claimant's workers' compensation claims cannot succeed.

¶ 53 However, the Board's decision does collaterally estop the claimant from relitigating the issues of whether he was disabled after August 3, 2009, and whether his work-related injuries rendered him unable to work as a paramedic after that date. As noted, the Board decided that he was fully recovered and fully able to perform his job as a paramedic by that date. In order to award TTD and TPD benefits after that date, the Commission would have to reach a contrary conclusion. See, *e.g.*, *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 759 (2003) ("To establish entitlement to TTD benefits, a claimant must demonstrate not only that he or she did not work, but also that the claimant was unable to work."); 820 ILCS 305/8(a) (West 2008) (providing that an employee is entitled to TPD benefits only when he is "*working light duty* on a part-time basis or full-time basis and earns less than he or she would be earning if employed in the full capacity of the job or jobs" (emphasis added)). All of the requirements for collateral estoppel are met as to any claim for TTD or TPD benefits after August 3, 2009. We therefore reverse the Commission's award of such benefits.[7] However, we emphasize that,

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[6]*Mabie* stands for the converse proposition. In *Mabie*, our appellate court held that the Commission's decision that a fireman's injury arose out of and in the course of his employment barred the Village of Schaumburg from relitigating the issue of causation in a subsequent proceeding under the Public Employee Disability Act (5 ILCS 345/0.01 *et seq.* (West 2000)) by arguing that the claimant's injury did not occur in the line of duty.

[7]The claimant argues that there were "procedural irregularities" in the Board proceedings and that the Board's decision was based on blatantly incorrect factual findings. By raising these issues, the claimant appears to suggest that he did not have a "full and fair" opportunity to litigate his claims before the Board. However, the Board conducted a hearing during which the claimant had the opportunity to testify and to present evidence, including medical witness testimony. Moreover, the circuit court affirmed the Board's decision, and the claimant apparently chose not to appeal that decision. Thus, we are not in a position to pass on any alleged errors or "procedural irregularities" in the Board's decision, and we cannot deny the preclusive effect of the Board's judgment. See *McCulla*, 232 Ill. App. 3d at 521 (rejecting claimant's argument that board's decision should not collaterally estop his workers' compensation claim because the board misunderstood his claims and the applicable law, and stating

although TTD and TPD benefits after August 3, 2009, are barred by collateral estoppel, all benefits awarded for any time periods before that date are not barred.

¶ 54 Because the Commission's award of TPD benefits commenced on October 6, 2009, it is barred by collateral estoppel. Accordingly, we do not need to address the City's alternative argument that the Commission's award of TPD benefits was against the manifest weight of the evidence.

¶ 55 CONCLUSION

¶ 56 For the foregoing reasons, we reverse the judgment of the circuit court of Cook County to the extent that it confirmed the Commission's award of TPD and TTD benefits for any time period after August 3, 2009. We affirm the circuit court of Cook County's judgment in all other respects, including its confirmation of the Commission's award of TTD benefits for time periods prior to August 3, 2009.

¶ 57 Affirmed in part and reversed in part; cause remanded.

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that "whatever the pension board's understanding of the claimant's claim and any errors of law are not before this court" and that "[t]he claimant did not appeal the board's determination").

JOSEPH LOCASTO, PETITIONER, v. CITY OF CHICAGO, CHICAGO FIRE DEPARTMENT, RESPONDENT.

NO. 08WC 51606

ILLINOIS WORKERS' COMPENSATION COMMISSION

STATE OF ILLINOIS, COUNTY OF COOK

11 IWCC 841; 2011 Ill. Wrk. Comp. LEXIS 876

August 26, 2011

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

OPINION: [*1]

DECISION AND OPINION ON REVIEW

Timely Petition for Review under § 19(b) having been filed by both parties herein and notice having been given to all parties, the Commission, after having considered the issues of jurisdiction, medical bills, temporary total disability benefits, temporary partial disability benefits, penalties and attorneys' fees, and whether the doctrines of collateral estoppel and *res judicata* apply, and having been advised of the facts and law, hereby modifies the Arbitrator's decision as stated below and otherwise affirms and adopts the Arbitrator's decision, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).*

The Commission modifies the Arbitrator's decision with respect to medical expenses and temporary partial disability benefits and otherwise affirms and adopts the Arbitrator's decision. The [*2] Arbitrator awarded medical expenses in the amount of $ 152,788.84. The Commission reduces the amount of medical expenses and finds that Petitioner is entitled to medical expenses in the sum of $ 138,303.00. In the Request for Hearing form, Petitioner indicated that the bills from Advocate Illinois Masonic Medical Center totaled $ 138,588.00. The Commission finds that the bills from Advocate Illinois Masonic Medical Center, presented under Petitioner's Exhibit 4, total $ 127,288.00. In the Request for Hearing form, Petitioner indicated that the bills from Dr. Fox totaled $ 6,243.00. The Commission finds that Dr. Fox's bills, submitted as Petitioner's Exhibit 5, total $ 3,023.00. In the Request for Hearing form, Petitioner indicated that the bills from Dr. Cremer totaled $ 3,285.00. Petitioner submitted Dr. Cremer's bills as Petitioner's Exhibit 6 as well as a deposition exhibit attached to Dr. Cremer's deposition. The Commission finds that the bills from Dr. Cremer total $ 3,345.00, excluding the bill for a service date of January 11, 2008, which predated this accident. In the Request for Hearing form, Petitioner indicated that the bills from Dr. Hoffman totaled $ 4,672.84. The Commission [*3] finds that the bills from Dr. Hoffman, submitted as Petitioner's Exhibit 7, total $ 4,647.00. The Commission calculates the total amount of medical expenses submitted is $ 138,303.00 ($ 127,288.00 + $ 3,023.00 + $ 3,345.00 + $ 4,647.00). We conclude that Petitioner is entitled to only the amount of bills that he has submitted into evidence, which is $ 138,303.00.

Petitioner objects to Respondent's review of medical bills and contends that Respondent stipulated to the amount of medical expenses that Petitioner was claiming. We disagree with Petitioner's position. In the Request for Hearing form, Respondent indicated that it disputed the unpaid medical bills by having checked off the "disputes" box. The parties' initials are next to medical bills in the Request for Hearing form; however, there is no indication in the Request for Hearing form that Respondent stipulated to the amount of medical expenses. In the original copy of the Request for Hearing form, it is evident that the figure for the amount of medical expenses for "Advocate Illinois Masonic" had been

modified thereby modifying the total unpaid amount. It is likely that the parties' initials were added to reflect the changes [*4] made to the initial stipulation sheet and was not an agreement to the amount of medical bills. Moreover, there is nothing in the record that suggests that Respondent stipulated to the amount of medical expenses that Petitioner claimed. The only statement that Respondent indicated on the record with regard to medical expenses was that it waived foundational objections only. We do not interpret a foundational statement as an agreement to the accuracy of the bills or to liability of the entire claimed amount.

The Commission modifies the Arbitrator's decision also with respect to temporary partial disability benefits. We find that Petitioner is entitled to temporary partial disability at a rate of $ 251.40 for the period from October 6, 2009, through May 5, 2010. The Arbitrator concluded that Petitioner failed to prove entitlement to temporary partial disability benefits because if he were to work full time at his current position at Children's Memorial Hospital, his salary "approximates his salary as a paramedic candidate with Respondent." We find that the Arbitrator erred in calculating Petitioner's current wages based on a 40 hour a week schedule because Petitioner is currently employed [*5] as a part time employee for Children's Memorial Hospital and not full time. While it is true that no doctor has restricted Petitioner from part time employment, it is also true that Respondent refused to permit Petitioner to return. Moreover, we note that while Respondent required that Petitioner undergo a functional capacity evaluation, it also denied coverage for the functional capacity evaluation it requested.

Furthermore, we acknowledge that it appears that the only job search Petitioner conducted was returning to his former employer, Children's Memorial Hospital, to seek out his former position as a paramedic. Petitioner testified that his former position as a paramedic was no longer available to him and he accepted his current part time position on the IV Access Team. In awarding temporary partial disability benefits, the Commission finds it significant that Respondent failed to offer any vocational assistance after refusing to let Petitioner return to the Chicago Fire and Paramedic Academy. We find that Respondent has failed to comply with Rule 7110.70 that mandates that Respondent perform a vocational assessment. *50 Ill. Adm. Code § 7110.10* [*6] . Respondent references in its brief that Petitioner did not request vocational assistance. We find that there is no requirement that Petitioner request vocational rehabilitation before interim benefits can be awarded. *Roper Contracting v. Industrial Comm'n, 349 Ill.App.3d 500, 505-506, 812 N.E.2d 65, 70 (5th Dist. 2004)* (rejecting the employer's argument that claimant was required first to request vocational rehabilitation before maintenance could be awarded); *Greaney v. Industrial Comm'n, 358 Ill.App.3d 1002, 1019-1020, 832 N.E.2d 331, 347-348 (1st Dist. 2005)* (same).

Section 8(a) of the Act, in effect at the time of the accident, provided as follows:

> "Temporary partial disability benefits shall be equal to two-thirds of the difference between the average amount that the employee would be able to earn in the full performance of his or her duties in the occupation in which he or she was engaged at the time of accident and the net amount which he or she is earning in the modified job provided to the employee by the employer or in any other job that the employee is working."

820 ILCS 305/8(a) [*7] .

The parties stipulated that Petitioner's average weekly wage with Respondent was $ 877.10. Petitioner testified that his current net wages are $ 900.00 to $ 1,000.00 every two weeks. In Petitioner's brief, he asks for a temporary partial disability benefit rate of $ 251.40, which is based on weekly net earnings of $ 500.00 ($ 877.10 - $ 500 = $ 377.10) and which is the temporary partial disability benefit rate we conclude Petitioner has proven.

We find that we are unable to rely on Petitioner's Exhibit 10, which is comprised of only one wage stub for a pay period ending on October 24, 2009. Despite the fact that at the time of the arbitration hearings in March 2010 and May 2010, Petitioner had already been working with Children's Memorial Hospital for several months, Petitioner failed to present any other wage stubs. Petitioner's Exhibit 10 shows an hourly wage of $ 19.42 per hour and that he worked 62.75 regular hours. His gross pay for regular hours was $ 1,218.62. There also appears to be some differential pay that increased the gross pay to $ 1,267.01. His net pay was $ 723.22, which would have yielded weekly earnings of $ 361.61 and a temporary partial disability benefit rate [*8] of $ 343.66. We cannot rely on Petitioner's Exhibit 10 however because we are unable to determine what his net pay would have been without the differential pay included and because it conflicts with his testimony that his net earnings are $ 900.00 to $ 1,000.00 every two weeks.

The Commission addresses Respondent's arguments concerning jurisdiction and collateral estoppel and *res judicata*. Respondent argues that Petitioner's current claim is barred by Section 1(b)1 of the Act, the provision that defines

"employee," as that section excludes "duly appointed" members of the fire department. We find that the issue of jurisdiction is controlled by the recent appellate court decision, *Dodaro v. Illinois Workers' Compensation Comm'n, 403 Ill.App.3d 538 (2010), pet. for leave to appeal denied,* No. 111215 (March 30, 2011). As the Illinois Supreme Court denied the petition for leave to appeal, the appellate court's decision is final.

In Dodaro, the claimant injured herself during a training exercise while at the Chicago Police Academy. *Dodaro, 403 Ill.App.3d at 540.* The issue before the court was whether the claimant [*9] was a "duly appointed member" of the Chicago police department and therefore precluded from benefits under the Act. *Dodaro, 403 Ill.App.3d at 539.* The court, in applying rules of statutory construction under the *de novo* standard of review, first found that "the legislature intended the statutory exclusion to apply to individuals who have been formally admitted to the responsibilities and privileges of the Chicago police department." *Dodaro, 403 Ill.App.3d at 546.* The court then applied the clearly erroneous standard and concluded that the totality of the evidence supports a finding that the claimant was not formally admitted to the Chicago police department and, thus, was not a "duly appointed member" of the Chicago police department. *Dodaro, 403 Ill.App.3d at 546.* In so finding, the court cited several facts including the fact that the police recruits were not issued a badge or identification by the police department; they did not wear any insignia that demonstrated they were affiliated with the police department; they were not authorized to make arrests; and they were instructed not to [*10] act like police officers. *Dodaro, 403 Ill.App.3d at 546.*

The facts in this case are largely similar to the facts in Dodaro. In this case, Petitioner testified that as a candidate fire paramedic at the Chicago Fire and Paramedic Academy, he was not supplied with a badge or identification as a Chicago fire paramedic. Petitioner testified that his uniform consisted of basic blue pants and a blue shirt without a Chicago fire department emblem. Moreover, candidates engage in physical training and take classes in a classroom environment, and they are not performing any work on the street as an actual paramedic. Petitioner further testified that candidates are not considered paramedics until they graduate from the academy and are sworn in at Navy Pier. Petitioner also stated that once candidates graduate from the academy, they are given an increase in pay. The Commission concludes that Petitioner was not a "duly appointed member" of the Chicago fire department and, thus, is not precluded from benefits under the Act. The Arbitrator's finding with respect to jurisdiction is affirmed.

On review, Respondent argues that the doctrines of collateral estoppel and [*11] *res judicata* bar the current claim before the Commission. We disagree with Respondent's argument. Collateral estoppel prohibits the relitigation of an issue essential to and actually decided by the same parties. *McCulla v. Industrial Comm'n, 232 Ill.App.3d 517, 597 N.E.2d 875 (1992).* Collateral estoppel may be asserted so long as the party against whom its application is sought is identical in both actions, and the party had a full and fair opportunity to contest an issue which was necessarily determined in the prior proceedings. Id.

The issues presented before the Commission here are not the same issues that were presented before the Retirement Board of the Firemen's Annuity and Benefit Fund of Chicago ("fire pension board"). The issue before the fire pension board was whether Petitioner was entitled to receive duty disability benefits. The pension board found that he was not disabled and therefore not entitled to benefits from the Firemen's Annuity and Benefit Fund of Chicago because he was capable of returning to work. The issues before the Commission are jurisdiction, accident, causal connection, medical expenses, temporary [*12] disability benefits, temporary partial disability benefits, and penalties and attorneys' fees. The fire pension board made no determinations that are relevant to the issues on review here. The Commission concludes that Petitioner's claim is not barred by collateral estoppel or *res judicata.*

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision, filed on August 23, 2010, is modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $ 584.73 per week for a period of 73-5/7 weeks, that having been the period of temporary total incapacity for work under § 8(b), and that as provided in § 19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $ 138,303.00 for medical expenses under § 8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $ 251.40 per week for a period of 30-2/7 weeks representing [*13] temporary partial disability benefits as provided under § 8(a) of the Act.

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

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

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

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.

19(b) ARBITRATION DECISION

JOSEPH LOCASTO
Employee/Petitioner

v.

CITY OF CHICAGO/CHICAGO FIRE DEPARTMENT
Employer/Respondent

Case # [*14] **08 WC 51606**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kathleen A. Hagan,** arbitrator of the Commission, in the city of **Chicago,** on **March 3, 2010 and May 5, 2010.** After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES
A. [X] Was the respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [X] Was there an employee-employer relationship?
C. [X] Did an accident occur that arose out of and in the course of the petitioner's employment by the respondent?
F. [X] Is the petitioner's present condition of ill-being causally related to the injury?
J. [X] Were the medical services that were provided to petitioner reasonable and necessary?
K. [X] What amount of compensation is due for temporary total disability?
L. [X] Should penalties or fees be imposed upon the respondent?
N. [X] Other **Temporary Partial Disability and/or Maintenance Benefits**

FINDINGS

[*15] . On **May 6, 2008 and May 7, 2008,** the respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

. In the year preceding the injury, the petitioner earned $ **45,732.00;** the average weekly wage was $ **877.10.**

. At the time of injury, the petitioner was **31** years of age, ***single*** with **no** children under 18.

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

. To date, $ **45,732.00** has been paid by the respondent in salary continuation for one year. Respondent is entitled to an 8(j) credit of $ 30,488.00 (45,732.00 x 2/3= $ 30,488.00)

ORDER

. The respondent shall pay the petitioner temporary total disability/maintenance benefits of $ **584.73** /week for **73 5/7** weeks, from **May 8, 2008** through **October 5, 2009,** as provided in Section 8(b) of the Act, because the [*16] injuries sustained caused the disabling condition of the petitioner, the disabling condition is temporary and has not yet reached a permanent condition, pursuant to Section 19(b) of the Act.

. The respondent shall pay $ **152,788.84** subject to the Fee Schedule for medical services, as provided in Section 8(a) of the Act.

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

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

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

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

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice* [*17] *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.

August 17, 2010 Date

FINDINGS OF FACT

Petitioner, a 31 year old paramedic, testified that on May 6, 2008 and May 7, 2008, he was employed by the City of Chicago as a "candidate" in training at the Chicago Fire and Paramedic Academy. Petitioner was training to become a paramedic with the Chicago Fire Department. In Chicago, firemen and paramedics undergo the same training. Prior to his employment with the City of Chicago, Petitioner was employed as a paramedic with Children's Memorial Hospital and had been licensed as a paramedic by the State of Illinois for seven years. Petitioner is a high school graduate and completed paramedic school.

Prior to his admission to the Academy, Petitioner was examined and declared fit for duty by Respondent's physician and his own doctor. Petitioner testified that he was also required to pass a physical fitness and agility test prior to admission.

Petitioner testified that he would be sworn in as a Chicago Fire Department Paramedic [*18] upon his graduation from the Academy. Petitioner explained that prior to being sworn in as an officer, he received a lesser salary than a sworn paramedic, he did not carry a badge and he was not allowed to render medical assistance on behalf of the City of Chicago.

It was Petitioner's credible and unrebutted testimony that he was denied sufficient water breaks during two full days of rigorous physical training sessions at the Academy. Petitioner reported to the Fire Academy on May 6 and May 7, 2008 for training. Petitioner testified that the candidates participated in rigorous physical training in an extremely hot environment. Petitioner described virtually non-stop intense physical exercises with very limited water breaks. Petitioner described military style hazing with yelling and verbal abuse. Petitioner further described additional exercises assigned

as punishment for the entire group if a single candidate did not complete a task in a timely manner. Petitioner stated that following a 45 minute lunch break at noon, the candidates were required to exercise vigorously straight through until 4:30 pm with a single one minute water break. Petitioner admitted he did not request special [*19] permission to get a drink of water out of fear of punishment for the entire group. He provided the example of a female candidate who had requested permission to go the bathroom to vomit. The request was denied and the candidate was forced to vomit in a garbage can in front of the entire group of trainees and instructors.

After completing his first day of training, Petitioner experienced cramps in his right quadriceps. He went home that evening and drank Gatorade and water. He took Advil, iced his leg and studied. Petitioner reported for training the following morning on May 7, 2008 at 7:00 a.m. Petitioner testified that the candidates were required to work out straight through until lunch time with no water breaks. Petitioner gave examples of instructors yelling in candidate's ears to "quit or go the hospital" if they couldn't take it. Petitioner stated that five candidates did walk out. Petitioner testified that following a 45 minute lunch break, the workouts became more intense and lasted for longer periods of time. He noticed severe cramping in his right leg in the late afternoon. Petitioner described the floor as so sweaty he could barely perform push-ups because his feet were [*20] sliding in all the sweat. Petitioner testified that at the end of the training session his leg was so sore he had difficulty climbing into his SUV to drive home.

Petitioner took Advil that evening and continued to experience severe cramping in his right leg that evening. He hydrated and applied ice and heat to his leg. He was unable to sleep. At 5:30 a.m. he noticed his urine was tea colored and looked like blood. Petitioner phoned his instructor, L.T., to report his condition. L.T. instructed him to report to the emergency room.

Petitioner sought treatment at Illinois Masonic Hospital where he was diagnosed with rhabdomyolysis, acute kidney failure and compartment syndrome. Rhabdomyolysis is a condition of the kidneys that is caused when muscle tissue rapidly breaks down (due to over exertion and dehydration, crush injury or toxins) and releases myoglobulin (a protein) into the blood stream causing the kidneys to lose function. All of the physicians, including Respondent's examining physicians, Dr. Weber and Dr. Hirsch, and Petitioner's treating physicians, Dr. Fox, Dr. Cremer, and Dr. Hoffman, agreed Petitioner's rhabdomyolysis was caused by the rigorous workouts at the Academy [*21] (Rx1, Rx2, Px1, Px2, Px3).

The medical records of the emergency room reflect that orthopedic surgeons were consulted regarding the swelling of Petitioner's legs and compartment syndrome. Compartment syndrome is a condition which refers to the compression of nerves, blood vessels and muscle inside a closed space within the body. The compression leads to tissue death due to lack of oxygenation as the blood vessels are compressed by the raised pressure within the compartment. Compartment syndrome can cause subsequent loss of function including paralysis and possible amputation.

Dr. David Hoffman, an orthopedic surgeon, diagnosed compartment syndrome and performed immediate surgery. Petitioner underwent a fasciotomy wherein his right leg was cut open and left open for several weeks to relieve the pressure and swelling in the leg and allow the muscles to expand. Petitioner was in the ICU for approximately 15 days. He was placed on dialysis due to his rhabdomyolsis from dehydration. Petitioner required over 100 staples to close the fasciotomy. Dialysis continued for several months following Petitioner's hospital discharge on June 13, 2008 (Px3).

Following his discharge from the hospital, [*22] Petitioner followed up with Dr. Steven Fox, his primary care physician, Dr. Eduardo Cremer, a nephrologist, and Dr. Hoffman, an orthopedic surgeon. All three doctors opined that Petitioner's conditions of ill-being were causally related to the intense workouts and subsequent dehydration Petitioner suffered at the Academy. Petitioner also followed up with Commander Mark Edenburgh and physicians at the Chicago Fire Department. Respondent's physicians continued Petitioner off work through at least February 25, 2009 (Rx4).

Dr. Cremer last saw Petitioner on September 17, 2008. He recommended follow up labs in 8 weeks and released Petitioner to return to work from a renal standpoint to return to work at a regular job where he doesn't overexert himself and stays well hydrated (Px1). On November 11, 2008, Dr. Cremer released Petitioner to return to "regular activities" (Rx4). Dr. Cremer later testified that Petitioner should "absolutely not" return to the strenuous and intense rigors of the Academy training. Dr. Cremer opined that Petitioner should avoid anything that causes extreme exhaustion or severe muscle soreness. Petitioner's kidneys will never be normal. If Petitioner develops any [*23] type of muscle soreness he needs to be extremely cautious. He is to avoid non-steroidal anti-inflammatory medications and anti-biotics. Petitioner re-

quires yearly metabolic testing. He acknowledged that Petitioner could possibly run a marathon if he used extreme caution, conditioned properly and hydrated appropriately (Px1).

Dr. Hoffman last saw Petitioner on August 26, 2008. He opined resolved compartment syndrome and released Petitioner to return to work from an orthopedic point of view. He advised that Petitioner continue to follow up with his nephrologist (Px3).

Petitioner continued to follow up with Dr. Fox, his treating internist. On November 5, 2008, Dr. Fox provided a scrip stating that Petitioner was in excellent health and that he had been cleared for "unrestricted physical activity" (Px2).

Petitioner testified that he continued to follow up with Chicago Fire Department physicians and submit his lab results (Rx4). Petitioner stated that he was told by a Respondent nurse that he needed a written release from his doctor to allow him to enter the next Academy class in November, 2008. Petitioner obtained his November 5, 2008 release from Dr. Fox and met one week later with [*24] Commander Edenburgh, an M.D. and head of the Chicago Fire Department Medical Division. Petitioner testified that Commander Edenburgh accepted his note and told him that while he respected Petitioner's wish to return to the Academy, it was his opinion that Petitioner was not ready to return to the Academy.

Following this meeting, Petitioner continued to follow up with Dr. Fox and Chicago fire Department medical.

The records of the CFD Medical Division reflect a visit September 24, 2008 with a note stating Petitioner was following up with Dr. Cremer and undergoing renal function testing and would return in 8 weeks. Petitioner returned on October 24, 2008 and it was noted that his conditions were resolving and that they were awaiting lab results. Petitioner was to follow up again after his visit with Dr. Fox on November 5, 2008. The records reflect the next visit took place on December 9, 2008. Petitioner was noted to have an elevated Ca+ level and he was instructed to see both his renal and ortho physicians. The record of December 26, 2008 reflects that Petitioner was to follow up with his FCE and lab results. On January 20, 2009 it was noted that Petitioner was complaining of continued [*25] right leg cramping. He was instructed to follow up with his treating ortho and undergo repeat lab work. The last recorded visit contained in the record is February 25, 2009. Petitioner continued to complain of leg cramping and reported his labs had been completed the prior week (Rx4).

Petitioner testified that the Academy requested that he undergo a FCE. The CFD records reflect that Petitioner's treating ortho, Dr. Hoffman, ordered an FCE which was denied by the insurance company (Rx4). Petitioner stated that the FCE cost $ 2,000.00 and that his insurance coverage had lapsed and he couldn't afford the recommended FCE on his own.

In his report dated February 9, 2009, Dr. Fox opined that by virtue of Petitioner's renal injury requiring dialysis, it is highly likely that he has some permanent kidney damage. There are changes that occur in the kidney that make him less likely to concentrate urine appropriately, filter blood efficiently or maintain a completely normal glomerular filtration rate. Dr. Fox further opined that Petitioner is forever prone to recurrent bouts of acute renal failure and that he is irreversibly compromised by the events occurring due to the Academy training. [*26] Dr. Fox stated that Petitioner should not subject himself to the same rigors that he was put through at the Academy and that it would not be a wise thing to do (Px2).

Dr. Isaac Morcos, an occupational health physician with the Chicago Fire Department, issued a letter dated May 7, 2009. Dr. Morcos noted that Petitioner had completely recovered and had been returned to full duty without restrictions by his treating physicians Dr. Fox, Dr. Cremer and Dr. Hoffman. He noted that Dr. Hoffman requested a functional capacity evaluation that had been denied by the insurance company. Dr. Morcos opined that Petitioner was currently in stable condition, remained off duty and had exhausted all his injury and sick leave (Rx4).

On July 23, 2009, Dr. Fox issued a report clarifying his November 5, 2008 physical activity release. Dr. Fox noted that Petitioner had recovered from rhabdomyolysis renal failure and compartment syndrome requiring surgical release after an excessively aggressive training program at the Chicago Fire Academy in May, 2008. I wrote a note allowing for unrestricted physical activity in November, 2008. I want to clarify that at no time did I intend for this to mean that Petitioner [*27] could or should return to the Fire Academy (Px2).

On July 23, 2009, Dr. Fox prescribed additional physical therapy for Petitioner's ongoing complaints right thigh pain and cramping (Px2).

Petitioner was examined at Respondent's request by Dr. Kathleen Weber, a board certified internist and sports medicine specialist, on August 17, 2009. Dr. Weber opined that Petitioner's acute compartment syndrome, exercised induced rhabdomyolysis and subsequent acute renal failure were causally related to the incident. Dr. Weber further opined that the universal, reasonably accepted standard of hydration for intense type of exercise is to hydrate around 16 ounces every 15-20 minutes. Dr. Weber opined that Petitioner had no residual right leg disability as a result of compartment syndrome other than some muscle tightness she felt would be relieved with a short 2-3 three week course of physical therapy and home strengthening/stretching exercises. Following this treatment he would be a MMI. Dr. Weber opined that Petitioner could return to work for the Chicago fire Department. Dr. Weber testified that she assumed Petitioner would return to the Academy and she was not aware that he did not graduate. [*28] She acknowledged that Petitioner was now at a higher risk for rhabdomyolysis and admitted that she had not reviewed many treating records and had not seen an FCE. Dr. Weber testified that if Petitioner returned to the same rigorous training conditions at the Academy, he would have to be in great condition and would definitely need to be monitored throughout the training (Rx1).

Petitioner was examined at Respondent's request by Dr. Sheldon Hirsch, a board certified nephrologist, on December 8, 2009. Dr. Hirsch opined that Petitioner seems to have no residual deficits and is cleared to perform any work from a renal viewpoint. However, given the injury that he suffered, I advised him against any form of particularly strenuous exercise, which conceivably could lead to a recurrent injury. Presumably this would preclude him from returning to the fire department, assuming that strenuous training sessions would be necessary. I also would defer to an internist or neurologist regarding examination of his musculoskeletal system and whether there is any lingering injury or restrictions derived from his muscle injury. Dr. Hirsch specifically noted that Petitioner was not to return to work that [*29] included extensive exercise. Dr. Hirsch noted that Petitioner's subjective complaints were supported by objective findings (Rx2, Px8).

Petitioner was not paid temporary total disability benefits. Petitioner was paid salary continuation from May 8, 2008 through May 8, 2009. Prior to his acceptance at the Academy, Petitioner was employed as an emergency room paramedic at Children's Memorial Hospital. Petitioner testified that Children's granted him a three month leave of absence to complete his Academy training. After his leave extended to four months, Petitioner was required to resign. Petitioner further testified that many of his medical bills were covered by his group insurance through Children's. His group coverage through Children's lapsed and he subsequently had no insurance coverage.

Petitioner testified that he was not allowed to return to the Academy and was not offered any alternative employment by Respondent. In October, 2009 Petitioner sought employment with his past employer, Children's Memorial Hospital, as an emergency room paramedic and learned there no such positions available. Petitioner obtained part-time employment with Children's working on an IV Access Team beginning [*30] October 6, 2009. Petitioner and his team start IVs for patients throughout the hospital when the nurses are unable to do so. Petitioner testified he works two twelve hour shifts per week and earns a net weekly salary of $ 900 to $ 1000.00 per week. Petitioner offered a single pay stub for the week ending October 24, 2009 into evidence which documented an hourly rate of pay of $ 19.42 plus shift differentials (Px10). Petitioner eventually obtained group insurance coverage again through Children's and subsequently resumed his treatment with Dr. Fox.

Petitioner's present complaints include right leg cramping. Prolonged sitting increases the cramping pain. He stretches out his leg repeatedly to relieve his pain. Petitioner testified that he had gained about 20 pounds since his accident. He attributes his weight gain to his reduced activity level. He no longer plays sports or exercises vigorously per his physicians' instructions and his fear of re-injury. Petitioner has no future appointments scheduled with any of his treating physicians at this time.

CONCLUSIONS OF LAW

With respect to the issues "A", JURISDICTION, and "B", EMPLOYMENT RELATIONSHIP, the Arbitrator concludes that Petitioner [*31] was employed by Respondent as an unsworn paramedic candidate. He had not completed training and was not a "duly appointed member" of the Chicago Fire Department. He is therefore eligible for benefits under the Act. The Appellate Court has recently held that a Chicago police recruit in training is not a "duly appointed member" of the Chicago police department and that a recruit does not have full police powers until he or she completes training at

the police academy and is sworn in as a police officer. Dodaro v. Illinois Workers' Compensation Commission and The City of Chicago, No. 1-09-0447WC (Workers' Compensation Commission Division, August 3, 2010). The Arbitrator applies the same logic to a paramedic candidate.

With respect to the issue of "C", ACCIDENT, and "F", CAUSAL CONNECTION the Arbitrator concludes that Petitioner sustained an accident arising out of and in the course of his employment on May 6, 2008 and May 7, 2008 when he experienced severe dehydration resulting in rhabdomyolysis, acute kidney failure and compartment syndrome. The Arbitrator further concludes that Petitioner's present condition of ill-being is causally related to the accidents of May 6, 2008 and [*32] May 7, 2008. The Arbitrator relies on the credible testimony of the Petitioner, the treating medical records and the opinions of the treating and examining physicians including Dr. Cremer, Dr. Hoffman, Dr. Fox, Dr. Hirsch, and Dr. Weber.

With respect to the issue "J", MEDICAL, the Arbitrator concludes that Petitioner has incurred $ 152,788.84 in reasonable and related medical expenses for treatment provided to Petitioner to cure or relieve his condition. The Arbitrator finds Respondent liable for the payment of these bills pursuant to the Fee schedule. The medical bills are properly coded and admitted as Px4, Px5, Px6, and Px7.

With respect to the issue of "K", TEMPORARY TOTAL DISABILITY, and "N", TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, the Arbitrator concludes that Petitioner is entitled to temporary total disability and/or maintenance benefits from May 8, 2008 through October 5, 2009 and not thereafter. Petitioner began part-time employment with Children's Memorial Hospital on October 6, 2009. Although several physicians restricted Petitioner from returning to the vigorous strenuous activity of Academy training, no physician restricted Petitioner from returning to work [*33] as a paramedic. No physician restricted Petitioner to part-time work. Petitioner did not testify to a job search other than attempting to return to his old position at Children's and his new position at Children's as an IV Technician. Petitioner earns $ 19.42 per hour plus a shift differential. A full-time, forty hour work week at this salary approximates his salary as a paramedic candidate with Respondent. The Arbitrator therefore finds that Petitioner did not prove entitlement TPD or maintenance after his return to work on October 6, 2009.

With respect to the issue of "L", PENALTIES, the Arbitrator concludes that Petitioner is not entitled to penalties under the Act. The Appellate Court decision in Dodaro was not issued until after proofs were closed in this case. Respondent therefore had a legitimate dispute regarding the applicability of the Act.

Legal Topics:

For related research and practice materials, see the following legal topics:
Administrative LawAgency AdjudicationDecisionsCollateral EstoppelAdministrative LawAgency AdjudicationDecisionsRes JudicataLabor & Employment LawDisability & Unemployment InsuranceDisability BenefitsGeneral Overview

Illinois Official Reports

Appellate Court

***Mansfield v. Illinois Workers' Compensation Comm'n*, 2013 IL App (2d) 120909WC**

Appellate Court Caption	CINDY MANSFIELD, Appellant and Cross-Appellee, v. THE ILLINOIS WORKERS' COMPENSATION COMMISSION *et al.* (Naperville Park District, Appellee and Cross-Appellant).
District & No.	Second District Docket No. 2-12-0909WC
Filed	November 21, 2013
Held (*Note: This syllabus constitutes no part of the opinion of the court but has been prepared by the Reporter of Decisions for the convenience of the reader.*)	The Workers' Compensation Commission's award of 10% loss of the person as a whole for the back injury claimant suffered in a work-related fall was not against the manifest weight of the evidence, but the portion of the judgment modifying the calculation of claimant's average weekly wage to include her income from teaching piano lessons from her home was reversed and the cause was remanded for redetermination of the average weekly wage and benefits to which claimant was entitled.
Decision Under Review	Appeal from the Circuit Court of Du Page County, No. 11-MR-1459; the Hon. Terence M. Sheen, Judge, presiding.
Judgment	Affirmed in part and reversed in part; cause remanded with directions.

Counsel on Appeal	Anthony L. Russo, Sr., of Russo & Russo, Ltd., of Wheaton, for appellant. Jeffrey B. Huebsch, of Power & Cronin, Ltd., of Oak Brook, for appellee.
Panel	JUSTICE HARRIS delivered the judgment of the court, with opinion. Presiding Justice Holdridge and Justices Hoffman, Hudson, and Stewart concurred in the judgment and opinion.

OPINION

¶ 1 On March 19, 2004, claimant, Cindy Mansfield, filed two applications for adjustment of claim pursuant to the Workers' Compensation Act (Act) (820 ILCS 305/1 through 30 (West 2002)), seeking benefits from the employer, Naperville Park District, for injuries suffered to her low back, legs, neck, and arms on July 23, 2003 (No. 04WC13562), and on September 9, 2003 (No. 04WC13563).

¶ 2 Following a consolidated hearing, an arbitrator issued a separate decision for each case. Regarding the injury suffered on July 23, 2003, the arbitrator found that claimant proved she sustained injuries arising out of and in the course of her employment with the employer on that date. Specifically, the arbitrator found claimant "suffered a lumbar strain as a result of the initial injury on July 23, 2003, and that a causal relationship existed between said work injury and her condition of ill-being up through the date of the second injury on September 9, 2003, the subject of claim 04 WC 13563." However, the arbitrator found claimant failed to prove she was entitled to temporary total disability (TTD) benefits and medical expenses from July 23, 2003, the date of the first accident, to September 9, 2003, the date of the second accident. The arbitrator stated his intent to address the issue of the nature and extent of claimant's injuries in his order in case No. 04WC13563. Neither party sought review of the arbitrator's decision (No. 04WC13562) before the Commission.

¶ 3 Regarding the injury suffered on September 9, 2003 (No. 04WC13563), the arbitrator found claimant proved she sustained injuries arising out of and in the course of her employment with the employer on September 9, 2003, and "a causal relationship existed between the accident on September 9, 2003 and Petitioner's current condition of ill-being, including the need for the surgery she eventually underwent on December 13, 2004." The arbitrator determined claimant's average weekly wage was $437.50, and awarded claimant TTD benefits in the amount of $291.67 per week, from September 9, 2003, through July 5,

2005; permanent partial disability (PPD) benefits in the amount of $262.50 per week for 125 weeks, representing 25% loss of her person as a whole; and medical expenses in the amount of $108,554.15.

¶ 4 The employer filed a petition for review of the arbitrator's decision (case No. 04WC13563) before the Illinois Workers' Compensation Commission (Commission). On review, the Commission modified the arbitrator's decision finding claimant failed to prove a causal relationship between her injury on September 9, 2003, and her condition of ill-being after April 30, 2004. The Commission awarded claimant TTD benefits in the amount of $291.67 per week, from September 11, 2003, through April 12, 2004; PPD benefits in the amount of $262.50 per week for 50 weeks, representing 10% loss of her person as a whole; and medical expenses in the amount of $5,416.54. The Commission otherwise affirmed and adopted the arbitrator's decision.

¶ 5 Thereafter, both claimant and the employer filed petitions seeking judicial review in the circuit court of Du Page County. The circuit court modified the Commission's decision, finding claimant's average weekly wage was $517.56 and directing the Commission "to recalculate the average weekly wage and the benefits allowed in conformity with this Opinion." The court otherwise confirmed the Commission's decision.

¶ 6 Claimant appeals, arguing the Commission's findings regarding causation, average weekly wage, TTD benefits, PPD benefits, and medical expenses are against the manifest weight of the evidence. The employer cross-appeals, arguing the Commission incorrectly calculated claimant's average weekly wage as including profits from claimant's self-employment providing piano lessons in her home.

¶ 7

I. BACKGROUND

¶ 8 The following factual recitation is taken from the evidence presented at the consolidated arbitration hearing.

¶ 9 The 47-year-old claimant testified that she began work teaching various preschool classes for the employer in approximately 1999. Claimant worked between 12 and 20 hours each week depending on class offerings and student enrollment. Claimant also taught piano in her home. She worked approximately the same number of hours from home as for the employer.

¶ 10 On July 23, 2003, claimant assisted two-year-olds with a program for their parents. Near the end of the program, claimant felt a child standing immediately behind her. In an effort to avoid falling on the child, claimant leaped back and fell on her low back, bottom, and arm. As a result, claimant experienced soreness in her back, arms, and shoulders. According to a wage statement prepared by the employer, claimant continued to work, reporting 9.75 hours worked for the pay period including July 26, 2003, through August 8, 2003. Claimant testified she did not seek immediate treatment because she thought she had bruised something and it would heal.

¶ 11 Claimant testified she had never injured her back prior to July 23, 2003, and did not have chronic problems with her back. Claimant identified her family doctor as Dr. Brian O'Leary, an internist. Claimant first treated with Dr. O'Leary in approximately 1994. Dr. O'Leary's

treatment notes on April 18, 1994, reference claimant's 15-year history of muscle pain in the low back, and at times, in the neck and upper back. The treatment notes from 1994 through approximately 2008 make multiple references to claimant's fibromyalgia.

¶ 12 Claimant remained sore and at the direction of the employer sought treatment on August 7, 2003, with Dr. Vimal Patel, a doctor of osteopathy at Edward Corporate Health. Dr. Patel noted (1) tenderness bilaterally over the SI joint and (2) the lumbar spine X-rays were normal. Dr. Patel diagnosed lumbar strain and bilateral SI strain. He prescribed naproxen and a course of physical therapy. Dr. Patel's medical notes state that claimant was off of school and, thus, did not require specific work restrictions. A physical therapy evaluation prepared on August 8, 2003, states claimant suffered from chronic right knee pain, fibromyalgia, and hypertension, and had multiple abdominal surgeries. Claimant returned to Dr. Patel on August 21, 2003. She reported attending four physical therapy sessions and that it had helped significantly. Dr. Patel's treatment note states that claimant "for the most part *** feels better." Dr. Patel recommended one more week of physical therapy and no restrictions. Claimant was to resume work in September 2003, with the fall programming session. Claimant last attended physical therapy through Edward Hospital on September 4, 2003. A physical therapy summary noted claimant had attended four of nine visits.

¶ 13 The employer began new class offerings on September 8, 2003, and claimant resumed teaching for the employer. On September 9, 2003, claimant reached for a toddler who was running toward a classroom door and "fell into the door and made [her] back worse." Claimant sought treatment from chiropractor Dr. Brad Pins on September 11, 2003. Claimant gave a history of the work accident on July 23, 2003. Dr. Pins' treatment notes reference a "continuing trauma" following the work accident on July 23, 2003, and include a reference to the work accident on September 9, 2003. Dr. Pins recommended "extreme limited duty" on September 11, 2003, and removed claimant from work on February 12, 2004. Dr. Pins treated claimant two or three times a week until April 12, 2004. Claimant experienced pain throughout her treatment with Dr. Pins and reported minimal improvement.

¶ 14 Claimant underwent a magnetic resonance imaging (MRI) of her lower back on September 16, 2003, read by chiropractic radiologist Dr. John A. Aikenhead. Dr. Aikenhead's impression was L5-S1 left lateral herniation compromising the canal and the foramen and small Modic changes at the adjacent endplates.

¶ 15 On September 22, 2003, claimant completed an initial patient history with the Synergy Institute, a physical therapy provider. Claimant identified fibromyalgia as a previous injury. Further, claimant wrote she was unable to work for the employer because she could not pick up the children but she was teaching piano at home, although in pain. Claimant identified a herniated disc as her major complaint and reported losing work days since her July 2003 accident.

¶ 16 On October 28, 2003, claimant was examined by Dr. David Spencer, at the request of the employer. Dr. Spencer is an orthopedic surgeon with a spine surgery practice at Lutheran General Hospital, Park Ridge, Illinois. According to his treatment notes, claimant reported work accidents on July 23, 2003, and September 9, 2003. Claimant did not seek immediate treatment following the July 2003 accident because she had a history of back pain and

fibromyalgia and based on that history, believed she would get better. In a pain diagram, claimant noted occasional right leg "pins and needles," constant stabbing pain across the low back, and constant low back aching on the left side. The September 16, 2003, MRI showed degenerative changes and a small disc herniation on the left at L5-S1 without neurologic compromise. Dr. Spencer recommended claimant remain off work and prescribed four additional weeks of physical therapy. Dr. Spencer anticipated claimant would return to full activities without limitations following therapy.

¶ 17 Dr. Spencer's medical notes dated November 25, 2003, state claimant was improving and should continue physical therapy and remain off work until January 1, 2004. In a physical therapy reevaluation dated December 28, 2003, claimant reported she felt better overall but had regressed since her last session because she had cared for her sick children at home and stood in heels while attending a Christmas party. Dr. Spencer's medical notes dated January 8, 2004, state claimant was improving and would participate in a work-hardening program for three to four weeks, and then return to full-duty work. Claimant did not return to work.

¶ 18 At his deposition, Dr. Spencer opined that claimant "had a chronic pain syndrome and that she had suffered a back sprain or strain when she had misadventures at work and aggravated her back pain, and then it had largely resolved and that she would be left with her chronic fibromyalgia pain." Dr. Spencer characterized as "rather unbelievable" and "not physiologic" a report by claimant that sometime after she last treated with Dr. Spencer on January 8, 2004, she fell 6 to 8 times over the course of approximately 10 days due to a sharp pain in her back and leg. Claimant attributed her pain to a herniated disc. Dr. Spencer knew of no individual who "fell down uncontrollably because they had a disc herniation." Further, claimant's complaints were not consistent with a left-sided disc herniation. Dr. Spencer stated that the surgery claimant ultimately underwent in December 2004 was not related to the July 2003 and September 2003 work accidents.

¶ 19 Dr. O'Leary referred claimant for treatment with board-certified neurosurgeon Dr. Michael Rabin. In a report dated December 5, 2003, Dr. Rabin found claimant's September 2003 MRI "largely unremarkable." He noted some degeneration but no focal areas of compression and no disc herniations. Dr. O'Leary recommended claimant resume chiropractic manipulations "since that appeared to be leading to improvement."

¶ 20 Claimant testified she worked light duty for the employer from April 13, 2004, through November 12, 2004.

¶ 21 Dr. Pins referred claimant for treatment with Dr. Steven Mather, an orthopedic surgeon. In treatment notes dated April 15, 2004, Dr. Mather noted his review of claimant's September 2003 MRI, showing "a markedly degenerative disc at L5/S1 with a small left-sided herniation present." At the direction of Dr. Mather, claimant underwent a second MRI on April 22, 2004, which confirmed degenerative disc disease at L5-S1, with a circumferential disc bulge and moderate bilateral neural foraminal stenosis.

¶ 22 On April 30, 2004, claimant was examined by Dr. Andrew Zelby at the request of the employer. Dr. Zelby testified that he is a board-certified neurologist and reviewed the cervical, thoracic, and lumbar spine X-rays, and the MRI scans. Dr. Zelby found that claimant had degenerative disc disease at L5-S1. He did not agree with the chiropractic radiologist's

interpretation of the 2003 MRI scan. According to Dr. Zelby, the 2003 MRI scan did not show a herniated disc. He opined that based upon claimant's medical records, claimant was symptomatic before her July 2003 injury and the accident did not accelerate her degenerative disc disease beyond its normal progression. Upon physical examination, Dr. Zelby found many aspects of the exam were consistent with symptom amplification. He stated that claimant had likely reached maximum medical improvement three to four months following the July 2003 accident.

¶ 23 Claimant next sought treatment with Dr. Aruna Ganju, a neurosurgeon affiliated with Northwestern Memorial Hospital. In a treatment note dated June 10, 2004, Dr. Ganju diagnosed claimant with lumbar spondylosis at L5-S1 and recommended an epidural steroid injection and aquatic therapy. In treatment notes dated July 22, 2004, Dr. Ganju diagnosed claimant with degenerative disc disease, severe at L5-S1. On August 12, 2004, claimant reported to Dr. Ganju that she had been undergoing aquatic therapy and had three epidural steroid injections. Claimant reported her pain level as not tolerable. On September 23, 2004, claimant underwent a discogram and postdiscogram computed tomography (CT) scan of the lumbar spine, which revealed moderate to severe disc degeneration at the L5-S1 level.

¶ 24 Dr. Ganju referred claimant to Dr. John Liu, a neurosurgeon also affiliated with Northwestern Memorial Hospital who specializes in artificial disc replacement. On November 4, 2004, Dr. Liu noted that claimant had undergone "extensive conservative treatments" for more than a year and continued to experience severe low back pain. Dr. Liu recommended claimant undergo surgery. Claimant underwent an anterior discectomy and fusion of the L5-S1 disc space on December 13, 2004, and was returned to full-duty work on July 7, 2005. In his evidence deposition on November 6, 2007, Dr. Liu opined that claimant's low back pain worsened after her July 2003 accident and, thus, contributed to claimant's current state of ill-being. Dr. Liu stated he did not have any information regarding the second accident on September 9, 2003.

¶ 25 Following the consolidated hearing, the arbitrator found claimant proved her current condition of ill-being was causally related to her work accidents on July 23, 2003, and September 9, 2003. Specifically, the arbitrator found the accidents aggravated claimant's preexisting degenerative condition necessitating surgery on December 13, 2004. The arbitrator determined claimant's average weekly wage was $437.50, and awarded claimant benefits through July 5, 2005. The employer sought review only of the arbitrator's decision regarding the injury suffered on September 9, 2003. The Commission modified the arbitrator's decision, relying on the opinions of Dr. Spencer and Dr. Zelby that claimant had suffered a temporary aggravation of a chronic condition and was at maximum medical improvement on April 30, 2004. The Commission awarded claimant TTD benefits through April 12, 2004, "the period she was authorized off work by chiropractor Dr. Pins," and found claimant permanently disabled to the extent of 10% of the person as a whole. Thereafter, both claimant and the employer filed petitions seeking judicial review in the circuit court of Du Page County. The circuit court modified the Commission's decision, calculating claimant's average weekly wage as $517.56 and directing the Commission "to recalculate the average weekly wage and the benefits allowed in conformity with this Opinion." The court otherwise confirmed the

Commission's decision and this appeal and cross-appeal followed.

¶ 26 II. ANALYSIS

¶ 27 On appeal, claimant argues the Commission erred in finding her condition of ill-being after April 30, 2004, was not causally related to her September 9, 2003, workplace accident. In a workers' compensation case, the claimant has the burden of proving, by a preponderance of the evidence, some causal relation between her employment and her injury. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 63, 541 N.E.2d 665, 669 (1989). Compensation may be awarded under the Act for a claimant's condition of ill-being even though the conditions of his or her employment do not constitute the sole, or even the principal, cause of injury. *Brady v. Louis Ruffolo & Sons Construction Co.*, 143 Ill. 2d 542, 548, 578 N.E.2d 921, 924 (1991); *Fierke v. Industrial Comm'n*, 309 Ill. App. 3d 1037, 1040, 723 N.E.2d 846, 849 (2000). In order for an injury to constitute an accidental injury within the meaning of the Act, the claimant need only show that some act or phase of the employment was a causative factor of the resulting injury. *Fierke*, 309 Ill. App. 3d at 1040, 723 N.E.2d at 849. The relevant question is whether the evidence supports an inference that the accidental injury aggravated the condition or accelerated the processes that led to the claimant's current condition of ill-being. *Mason & Dixon Lines, Inc. v. Industrial Comm'n*, 99 Ill. 2d 174, 181-82, 457 N.E.2d 1222, 1226 (1983); *Freeman United Coal Mining Co. v. Industrial Comm'n*, 318 Ill. App. 3d 170, 173-74, 741 N.E.2d 1144, 1147 (2001).

¶ 28 Whether a causal relationship exists between a claimant's employment and his injury is a question of fact to be resolved by the Commission. *Certi-Serve, Inc. v. Industrial Comm'n*, 101 Ill. 2d 236, 244, 461 N.E.2d 954, 958 (1984). The Commission's determination on a question of fact will not be disturbed on review unless it is against the manifest weight of the evidence. *Orsini v. Industrial Comm'n*, 117 Ill. 2d 38, 44, 509 N.E.2d 1005, 1008 (1987). For a finding of fact to be contrary to the manifest weight of the evidence, an opposite conclusion must be clearly apparent. *Caterpillar, Inc. v. Industrial Comm'n*, 228 Ill. App. 3d 288, 291, 591 N.E.2d 894, 896 (1992).

¶ 29 In support of her assertion of a causal relationship between her September 9, 2003, workplace accident and condition of ill-being after April 30, 2004, claimant contends a medical journal article and medical treatises support a claim that Modic changes in the spine are indicative of an acute injury. At his deposition, Dr. Liu read from the September 2003 MRI report prepared by Dr. Aikenhead. Dr. Aikenhead noted "mild marrow edematous changes" at L5-S1. Dr. Liu volunteered that "mild marrow edematous changes" are "the swelling within the bone marrow" and "[t]hat's what's called a [M]odic change." Dr. Liu did not comment further regarding Modic changes.

¶ 30 In this case, the Commission relied on the opinions of Drs. Spencer and Zelby to find that claimant's condition of ill-being after April 30, 2004, was not causally related to her employment on September 9, 2003. Dr. Spencer testified that claimant reported to him a history of back pain and fibromyalgia. Dr. Spencer opined that claimant "had a chronic pain syndrome and that she had suffered a back sprain or strain when she had misadventures at work and aggravated her back pain, and then it had largely resolved and that she would be left with

her chronic fibromyalgia pain." Dr. Spencer stated that claimant's condition of ill-being after April 30, 2004, was not causally related to her September 2003 work accident. Dr. Zelby examined claimant on April 30, 2004. He reviewed claimant's cervical, thoracic, and lumbar spine X-rays, and the MRI scans. He opined that claimant's condition on April 30, 2004, was not related to her September 2003 work accident. Dr. Zelby found claimant had likely reached maximum medical improvement three to four months following the July 2003 accident.

¶ 31 Although Dr. Liu opined claimant's current condition of ill-being was causally related to her work accident on July 23, 2003, he did not have any information regarding the second accident on September 9, 2003. Claimant offered no medical opinion to support a causation finding regarding the work accident on September 9, 2003. Further, despite claimant's testimony that she had never injured her back prior to July 23, 2003, and did not have chronic back problems, Dr. O'Leary's treatment notes reference a 15-year history of low back pain.

¶ 32 In this case, there is sufficient evidence supporting the Commission's finding that claimant's low back condition after April 30, 2004, was not causally related to the September 9, 2003, workplace accident. It is not our function to reweigh the evidence, and based on the record, we cannot say that an opposite conclusion is clearly apparent. Accordingly, the Commission's finding that claimant's condition of ill-being after April 30, 2004, was not causally related to her September 9, 2003, workplace accident was not against the manifest weight of the evidence.

¶ 33 Claimant also argues that the award of TTD benefits and medical expenses was against the manifest weight of the evidence. However, since these arguments are based upon the premise that the Commission's causation finding was erroneous, these contentions can be rejected without further analysis. *Tower Automotive v. Industrial Workers' Compensation Comm'n*, 407 Ill. App. 3d 427, 436, 943 N.E.2d 153 (2011).

¶ 34 Claimant next argues the Commission's finding with regard to permanency is against the manifest weight of the evidence. We disagree.

¶ 35 A determination of the nature and extent of a claimant's permanent disability is a question of fact to be resolved by the Commission, and its finding in this regard should be given substantial deference and will not be disturbed on appeal unless it is against the manifest weight of the evidence. *Jewel Food Cos. v. Industrial Comm'n*, 256 Ill. App. 3d 525, 534, 630 N.E.2d 865 (1993). However, a claimant is entitled to a disability award only for the nature and extent of his disability that was caused by employment exposure. *Fitts v. Industrial Comm'n*, 172 Ill. 2d 303, 310, 666 N.E.2d 4, 7 (1996).

¶ 36 In this case, the arbitrator awarded claimant permanent disability of 25% after finding "a causal relationship existed between the accident on September 9, 2003 and Petitioner's current condition of ill-being, including the need for the surgery she eventually underwent on December 13, 2004." The Commission modified the arbitrator's decision, finding no causal connection between claimant's work accident on September 9, 2003, and condition of ill-being after April 30, 2004. Although finding no causal connection after April 2004, the Commission still awarded claimant permanent disability of 10%, stating:

> "In companion case 04 WC 13562, the Arbitrator chose to decide the issue of nature and extent of permanent disability with this case. Case 04 WC 13562 was not reviewed and became final. The Commission modifies the Arbitrator's Decision finding that Petitioner is permanently disabled to the extent of 10% of the person as a whole."

¶ 37 In case No. 04WC13562, the arbitrator found claimant "suffered a lumbar strain as a result of the initial injury on July 23, 2003, and that a causal relationship existed between said work injury and her condition of ill-being up through the date of the second injury on September 9, 2003, the subject of claim 04 WC 13563." As the Commission stated, neither party sought review of the arbitrator's decision in case No. 04WC13562, and it became final. Given the arbitrator's findings in case No. 04WC13562, the Commission's permanency award of 10% loss of the person as a whole was not against the manifest weight of the evidence.

¶ 38 Claimant next argues the Commission incorrectly calculated her average weekly wage. Claimant argues that her actual earnings should be construed to include the gross profit of her business, SCATHOME. On cross-appeal, the employer argues the Commission incorrectly calculated claimant's average weekly wage as including profits from claimant's self-employment, providing piano lessons in her home.

¶ 39 Section 10 of the Act sets forth the method of calculating compensation as follows:

> "The compensation shall be computed on the basis of the 'Average weekly wage' which shall mean the actual earnings of the employee in the employment in which he was working at the time of the injury during the period of 52 weeks ending with the last day of the employee's last full pay period immediately preceding the date of injury, illness or disablement excluding overtime, and bonus divided by 52; but if the injured employee lost 5 or more calendar days during such period, whether or not in the same week, then the earnings for the remainder of such 52 weeks shall be divided by the number of weeks and parts thereof remaining after the time so lost has been deducted. Where the employment prior to the injury extended over a period of less than 52 weeks, the method of dividing the earnings during that period by the number of weeks and parts thereof during which the employee actually earned wages shall be followed. Where by reason of the shortness of the time during which the employee has been in the employment of his employer or of the casual nature or terms of the employment, it is impractical to compute the average weekly wages as above defined, regard shall be had to the average weekly amount which during the 52 weeks previous to the injury, illness or disablement was being or would have been earned by a person in the same grade employed at the same work for each of such 52 weeks for the same number of hours per week by the same employer. *** When the employee is working concurrently with two or more employers and the respondent employer has knowledge of such employment prior to the injury, his wages from all such employers shall be considered as if earned from the employer liable for compensation." 820 ILCS 305/10 (West 2002).

¶ 40 The employer contends claimant's business income should not be included in the calculation of the average weekly wage because it does not represent "wages" earned while

working for an "employer." We agree. We find the very similar case of *Paoletti v. Industrial Comm'n*, 279 Ill. App. 3d 988, 996, 665 N.E.2d 507, 512 (1996), to be dispositive.

¶ 41 In *Paoletti*, the claimant sustained an injury to his back while working as a refuse scavenger for the employer. *Paoletti*, 279 Ill. App. 3d at 991, 665 N.E.2d at 509. The claimant also owned a landscaping business operated as a subchapter S corporation for which he performed both administrative work and manual labor. *Paoletti*, 279 Ill. App. 3d at 995-96, 665 N.E.2d at 511-12. As in this case, the claimant's tax returns showed the business did not pay him any wage or salary, but he did receive the net profits. *Paoletti*, 279 Ill. App. 3d at 996, 665 N.E.2d at 512. This court noted that "[t]he question of whether net profits should be considered in calculating a claimant's average weekly wage is of first impression in Illinois." *Paoletti*, 279 Ill. App. 3d at 996, 665 N.E.2d at 512. In holding that the claimant's business profits should not be included in the calculation of his average weekly wage, this court stated that it "would be legislating from the bench if [it] were to hold that 'actual earnings' should be construed to include net profit." *Paoletti*, 279 Ill. App. 3d at 996, 665 N.E.2d at 512.

¶ 42 Citing to a Tennessee Supreme Court decision, the *Paoletti* court went on to suggest an exception might exist such that business income could be included in the calculation of average weekly wage where evidence was presented of the wage of another employee performing similar duties as claimant. *Paoletti*, 279 Ill. App. 3d at 996, 665 N.E.2d at 512 (citing 2 Arthur Larson, Law of Workmen's Compensation § 60.12(e), at 10-684 through 10-685 (1992), and *P&L Construction Co. v. Lankford*, 559 S.W.2d 793, 795 (Tenn. 1978)). In *Lankford*, the claimant sought benefits under the Tennessee workmen's compensation law from his employer, a closely held corporation of which the claimant and his wife held a 50% interest. *Lankford*, 559 S.W.2d at 794. The claimant, however, received no direct compensation for his labor. The Tennessee Supreme Court rejected the trial court's holding that *Lankford*'s average weekly wage should be based on one-half of the net income of the corporation and instead held "[a] better measure of the employee's earnings would be the compensation paid by the same company to another employee performing the same or similar duties." *Lankford*, 559 S.W.2d at 795.

¶ 43 The *Paoletti* court stated the claimant's business income could not be considered as wages even under the *Lankford* analysis "because the claimant did not present evidence of what the wage would be of another employee performing similar duties as claimant alleged he performed for his landscaping business." *Paoletti*, 279 Ill. App. 3d at 997, 665 N.E.2d at 512.

¶ 44 We note the significant differences between *Paoletti* and *Lankford*. In *Paoletti*, as in the present case, the issue was whether income from the claimant's concurrent employment could be included in computing average weekly wage. In *Lankford*, the claimant was not concurrently employed and the issue related only to the method to be used in calculating his earnings. In fact, Tennessee's workmen's compensation law did not allow for the inclusion of wages from concurrent employment in calculating average weekly wage. In short, we question the relevance of the analysis utilized in *Lankford* to the issues presented in *Paoletti* or here.

¶ 45 Therefore, while we adhere to *Paoletti*'s holding that a claimant's business income should not be included in the calculation of average weekly wage, we decline to further recognize an exception to this holding based on *Lankford*. Accordingly, to the extent the Commission

included net profits of claimant's business in its calculation of her average weekly wage, the Commission erred.

¶ 46 We note the Commission affirmed and adopted the arbitrator's finding that claimant earned from the employer an average weekly wage of $247.97 in the year preceding her injury. Claimant was paid in 19 biweekly installments during the year preceding her injury and had earned $9,422.86. There was no indication in the record regarding how many days she worked during those weeks or how many hours per day she worked. The claimant's average weekly wage was properly calculated by dividing $9,422.86 by 38 (19 biweekly payments) for an average weekly wage of $247.97. We therefore reverse that portion of the circuit court's judgment modifying the Commission's determination of the claimant's average weekly wage, set aside the Commission's decision on the issue of average weekly wage, and remand to the Commission for recalculation of the claimant's average weekly wage and the benefits to which she is entitled which are dependent thereon, and for further proceedings.

¶ 47 III. CONCLUSION

¶ 48 We reverse that portion of the circuit court's judgment modifying the Commission's calculation of claimant's average weekly wage, vacate the Commission's calculation of claimant's average weekly wage, and remand the cause to the Commission for determination of claimant's average weekly wage and the weekly benefits to which she is entitled; and we affirm the circuit court's judgment in all other respects.

¶ 49 Affirmed in part and reversed in part; cause remanded with directions.

CINDY MANSFIELD, PETITIONER, v. NAPERVILLE PARK DISTRICT, RESPONDENT.

NO: 04WC 13563

ILLINOIS WORKERS' COMPENSATION COMMISSION

STATE OF ILLINOIS, COUNTY OF DUPAGE

11 IWCC 978; 2011 Ill. Wrk. Comp. LEXIS 1130

October 7, 2011

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

OPINION: [*1]

DECISION AND OPINION ON REVIEW

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

The Commission modifies the Arbitrator's Decision finding that Petitioner failed to prove a causal relationship exists between the accidental injuries she sustained on September 9, 2003 and her current condition of ill-being. The parties stipulated that Petitioner sustained accidental injuries arising out of and in the course of her employment on September 9, 2003. The Commission notes the following: Petitioner testified to what occurred that day. She saw chiropractor Dr. Pins on September 11, 2003, but did not give a history of what happened on September 9, 2003. Instead, Petitioner gave a history of a July 23, 2003 accident (companion case 04 WC 13562). On September [*2] 18, 2003, Petitioner called her primary care physician Dr. O'Leary and informed him that a herniated disc was discovered and that she was injured two months before (on July 23, 2003). Again, no history of the September 9, 2003 accident was given. Petitioner saw § 12 Dr. Spencer on October 28, 2003 and he noted the July 23, 2003 accident and that on September 9, 2003, Petitioner allegedly re-injured herself. This was the first mention of an accident other than the July 23, 2003 accident in the medical records. Petitioner saw Dr. Rabin on December 5, 2003, who noted the July 23, 2003 accident, but there was no mention of the September 9, 2003 accident. On April 15, 2004, Dr. Mather noted the July 23, 2003 accident and, "Apparently the patient had a small recurrence of pain on August 9, 2003 while trying to help a child at work reaching for a door." Petitioner saw Dr. Ganju on June 10, 2004 and he noted the July 23, 2003 accident, but there was no mention of the September 9, 2003 accident. On November 4, 2004, Dr. Liu noted the July 23, 2003 accident, but there was no mention of the September 9, 2003 accident.

Regarding causation, Dr. Liu opined causal connection to the July 23, 2003 [*3] accident and stated he did not have any additional information regarding an accident on September 9, 2003 to make any additional comments. § 12 Dr. Spencer opined that Petitioner had a chronic pain syndrome and that she had suffered a back sprain or strain at work which aggravated her back pain and then it had largely resolved and that she was left with her chronic fibromyalgia pain. Dr. Spencer opined no causal connection for the surgery performed by Dr. Liu on December 13, 2004 and the accidents of July 23, 2003 or September 9, 2003. § 12 Dr. Zelby opined Petitioner's work injury neither accelerated nor permanently exacerbated her preexisting condition and that she was at maximum medical improvement. Dr. Zelby opined that Petitioner's treatment after his April 30, 2004 evaluation and subsequent fusion surgery were not causally

connected to either the July 23, 2003 injury or September 9, 2003 exacerbation. The Commission gives more weight to the opinions of Drs. Spencer and Zelby than Dr. Liu.

The Commission further modifies the Arbitrator's Decision finding that Petitioner was temporarily totally disabled from September 11, 2003 through April 12, 2004, 30-4/7 weeks, the period she [*4] was authorized off work by chiropractor Dr. Pins. The Commission notes that Dr. Spencer sent Petitioner to physical therapy and released her to return to work light duty on February 8, 2004. Petitioner worked light duty from April 13, 2004 through November 12, 2004, then was authorized off work by Dr. Liu to prepare for the December 13, 2004 surgery. The Commission affirms the Arbitrator's granting of credit of $ 4,431.51 for TTD benefits and $ 462.15 for maintenance for a total credit of $ 4,893.66.

The Commission modifies the Arbitrator's Decision regarding medical expenses and awards the following:
-Dr. Pins, dates of service from 9-11-03 through 4-12-04: $ 5,790.00 billed; $ 1,226.90 paid by PDRNA WC; contractual discount of $ 276.30; balance due of $ 4,286.80 (Px6).
-M & M Orthropaedics, Dr. Mather, dates of service 4-15-04 and 4-22-04 : $ 1,822.00 billed; $ 787.51 paid by Petitioner's husband's health insurer Ingenix; balance due of $ 1,034.49 (Px9).
-Radiology Imaging Consultants, date of service 4-22-04: $ 200.00 billed; $ 104.75 paid by Petitioner's husband's health insurer Ingenix; balance due of $ 95.25 (Px23).
The total medical expenses awarded is $ 5,416.54 ($ 4,286.80 [*5] + $ 1,034.49 + $ 95.25). As reflected above, credits are already taken into account. Therefore, the Commission modifies the Arbitrator's Decision regarding credit for medical expenses. The Commission denies the medical expenses incurred after April 30, 2004 based on Dr. Zelby's opinion.

In companion case 04 WC 13562, the Arbitrator chose to decide the issue of nature and extent of permanent disability with this case. Case 04 WC 13562 was not reviewed and became final. The Commission modifies the Arbitrator's Decision finding that Petitioner is permanently disabled to the extent of 10% of the person as a whole. The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $ 291.67 per week for a period of 30-4/7 weeks, that being the period of temporary total incapacity for work under § 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $ 5,416.54 for medical expenses under § 8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $ 262.50 per week for a period of 50 weeks, as provided in § 8(d)2 of the Act, for the reason that the [*6] injuries sustained caused the permanent disability of the person as a whole to the extent of 10%.

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 that Respondent paid $ 4,431.51 in TTD benefits and $ 462.15 in maintenance for a total credit of $ 4,893.66.

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

No bond for the removal of this cause to the Circuit Court by Respondent is due pursuant to § 19(f)(2) of the Act. The probable cost of the record to be filed as return to Summons is the sum of $ 35.00, payable to the Illinois Workers' Compensation Commission in the form of cash, check or money order therefor and deposited with the Office of the Secretary of the Commission.

ATTACHMENT

ILLINOIS WORKERS' COMPENSATION COMMISSION ARBITRATION DECISION

Consolidated cases: **04 WC 13562**

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 **Peter M. O'Malley**, Arbitrator [*7] of the Commission, in the city of **Wheaton,** on **June 12, 2010.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

F. Is Petitioner's current condition of ill-being causally related to the injury?
G. What were Petitioner's earnings?
J. Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. What temporary benefits are in dispute?

Maintenance TTD

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

FINDINGS

On **September 9, 2003,** 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 [*8] earned $ **19,278.36;** the average weekly wage was $ **437.50.**

On the date of accident, Petitioner was **40** years of age, ***married*** with **2** dependent children.

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

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

Respondent shall be given a credit of $ **4,431.51** for TTD, $ **0.00** for TPD, $ **0.00** for maintenance, and $ **0.00** for other benefits, for a total credit of $ **4,431.51.**

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $ **291.67** per week for **95** weeks, commencing **September 9, 2003** through **July 5, 2005,** as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from September 9, 2003 through July 12, 2010, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $ **4,431.51** for TTD, $ **0.00** for TPD, and $ **462.15** for maintenance benefits, for a total credit of $ **4,893.66.**

Respondent shall pay reasonable and necessary medical services [*9] of $ **108,554.15,** as provided in Section 8(a) of the Act.

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

Respondent shall pay Petitioner permanent partial disability benefits of $ 262.50 per week for 125 weeks, because the injuries sustained caused the 25% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

9/27/10

Date

STATEMENT OF [*10] **FACTS:**

On July 23, 2003, Petitioner was 40 years old; married with two dependent children. The parties stipulated that their relationship was one of employee and employer and that the injury arose out of and in the course of her employment and that proper notice was given to the employer.

Petitioner testified that she started working for the Naperville Park District in the Fall of 1999 teaching preschool classes from gym to music. The children were two to four years old. Duties included running, jumping, hopping, carrying them if they cried or got hurt, bending, lifting and playing with them. This was a part-time job and she worked between twelve (12) and twenty (20) hours per week. She also worked part-time teaching music at home about the same number of hours each week. The Respondent knew she worked part-time at home and had no objection.

On July 23, 2003 (04 WC 13562), she was teaching a two year old class and putting on a show for the parents. One little girl left the show and got behind Petitioner. As she took a step back, she felt the little girl behind her and in attempting to avoid the girl, she leaped back and tripped and fell on her lower back, bottom and arms. She [*11] immediately felt sore in her back, arms and shoulders. She never injured theses parts of her body prior to July 23, 2003, nor did she have chronic problems with her back.

The first medical treatment she received was on August 7, 2003 at Edward's Corporate Health. She was referred there by Respondent. She testified that "I thought when I fell I bruised or, you know, strained something and I thought it would get better. But after a couple weeks it didn't." She saw Dr. Patel at Edward Corporate Health and her complaints were mainly lower back mostly on the left side. X-rays were taken and she received some physical therapy and medication. Dr. Patel diagnosed a lumbar strain and bilateral SI strain. (PX4). She was discharged on September 4, 2003 and returned to work September 7, 2003.

Petitioner was off work from July 23, 2003 to September 7, 2003. However, there would appear to be no explicit recommendation by any doctor expressly restricting her work activities. Indeed, at the time of her initial visit to Dr. Patel on August 7, 2003, Dr. Patel recommended physical therapy and noted that "[s]ince the patient is off of school we will not need any specific work restrictions." (PX4).

[*12] Petitioner testified that she felt great prior to July 23, 2003 and cannot remember making any complaints to doctors or anyone else about her back. She has never made a worker's compensation claim.

Petitioner testified that on September 9, 2003 (04 WC 13563), while teaching, one of the "toddlers" ran for the door to go out. Petitioner reached quickly to stop him and fell into the door which made her back worse. She felt much worse after this incident and called her family physician, Dr. O'Leary, who referred her to Dr. Brad Pins. She saw Dr. Pins on September 11, 2003, was sent for an MRI on September 16, 2003 and received physical therapy until April 12, 2004.

Respondent sent Petitioner to Dr. David Spencer for a § 12 examination on October 28, 2003, November 25, 2003 and January 8, 2004. Dr. Spencer did not take any tests but referred Petitioner to Synergy Institute where she was given physical therapy from October 28, 2003 to January 9, 2004.

Because the September 16, 2003 MRI showed a herniated disc at L5-S1, Dr. Pins referred Petitioner to M&M Orthopedics. She saw Dr. Steven Mather there who diagnosed a herniated disc at L5-S1 and recommended surgery. He sent her for another [*13] MRI on April 22, 2004.

Petitioner was sent to Dr. Andrew Zelby by Respondent for another § 12 examination on April 30, 2004. Petitioner was subsequently referred to Dr. Ganju and Dr. Liu at Northwestern Hospital by Dr. O'Leary. She saw Dr. Ganju on June 10, 2004 and was treated conservatively with physical therapy, three (3) injections, EMG and discogram. After the tests were completed, Dr. Ganju referred Petitioner to Dr. Liu for surgery.

Petitioner visited Dr. Liu on November 4, 2004. Following his examination and review of the records of Dr. Ganju, Dr. Liu recommended surgery.

On December 13, 2004, Dr. Liu performed an anterior lumbar fusion at L5-S1 at Northwestern Memorial Hospital. Dr. Liu released Petitioner to return to work on July 7, 2005.

Petitioner testified that she had been released for light duty by Dr. Pins on April 13, 2004 and that she worked light duty from April 13, 2004 until November 13, 2004. Respondent agreed to pay her $ 8.00 per hour plus maintenance of $ 92.43 per week during light duty service, but paid maintenance for only five (5) weeks from April 13, 2004 to May 14, 2004.

Dr. Spencer and Dr. Pins kept Petitioner off work from September 11, 2003 [*14] to April 2, 2004 and Dr. Liu removed her from work from November 13, 2004 to July 7, 2005. She stipulated that she was paid a total of $ 4,431.51 for T.T.D. and no medical bills were paid by Respondent.

Petitioner testified that since surgery, she feels much better but her left leg is not good, she gets sore in the back "but nothing like before", and she gets stiff from sitting. Her activities prior to July 23, 2003 included walking, running, a lot of water sports and cross country skiing. Now she is limited to walking, most household work, and "stuff in my yard as much as I can until it hurts and then I stop." She testified that she paid medical co-pays of $ 190:00, parking fees of $ 127.00 and travelling costs for doctor visits. She travelled 1,790 miles and got 14 miles per gallon of gas and paid an average of $ 2.06 per gallon.

Dr. Brad Pins testified to the type and number of treatments based on his records and to the amount of his unpaid bill.

Barbara Scanlon testified that Respondent knew Petitioner had two (2) jobs and had no objection to this situation. She also testified that she also had two (2) jobs while working for the Park District, and that Respondent knew she had [*15] another job and had no objection.

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner testified that she felt good and did not injure her lower or upper back prior to July 23, 2003, nor did she have any chronic complaints of back problems, other than the usual occasional complaint.

Petitioner further testified that on July 23, 2003 (04 WC 13562), while teaching pre-schoolers, a little girl got behind her and while stepping back, she bumped the child and fell backward onto her bottom and arms, injuring her lower back. She waited until August 7, 2003 before seeking medical attention at Edward Health Center because she thought she just bruised herself and it would get better. She told Dr. Patel at Edward how she fell and that her back hurt more on the left side than the right. She stated that if she is standing or walking she feels alright, but if she sits for long periods then it hurts. X-rays were normal and the diagnosis was lumbar strain and bilateral S1 strain. She was given physical therapy until August 28, 2003 and released for work on September 7, 2003. (Pet.Ex.4)

[*16] On September 9, 2003, or following the injury in question (04 WC 13563), Petitioner called Dr. O'Leary, her family physician, who in turn referred her to chiropractor Dr. Brad Pins for physical therapy. She saw Dr. Pins on September 11, 2003. Dr. Pins testified to the history given relating to the July 23, 2003 and September 9, 2003 injuries and

to her complaints regarding back, leg and arm pain along with some numbness. Dr. Pins commenced physical therapy three (3) times per week until April 12, 2004. Improvement was noted to be minimal. Dr. Pins placed Petitioner on extreme limited duty from September 11, 2003 to February 12, 2004 and then no work at all. An MRI at Vision MRI on September 16, 2003 revealed a herniated disc at L5-S1.

Dr. Pins testified that on October 14, 2003, Petitioner told him that while watering flowers, she hurt her back and fell down. His independent recollection was that her left leg gave out causing the fall. The incident in his opinion was insignificant and that the change in her complaints was minimal. He eventually referred Petitioner to M&M Orthopedics for a surgical consultation. (Pet.Ex.5).

Dr. Spencer, the Respondent's IME doctor, testified that [*17] he first saw Petitioner on October 28, 2003 and was told that she tripped and fell and thought she would get better "because she had a history of back pain and fibromyalgia." He noted that she complained of constant pain in her lower back and sometimes down the outside of her right leg. Dr. Spencer reviewed the MRI film taken September 16, 2003 and noted that it revealed degenerative changes and a small left-sided L5-S1 disc herniation. (Resp.Ex.2,p.11). Dr. Spencer further testified that Petitioner had a chronic pain syndrome history with chronic pain; that a symptomatic left-sided L5-S1 disc herniation would be characterized by pain in the left side of the lower back, into the left buttock and down the left leg and not by pain across the whole back and down the right leg; that the MRI scan finding of the disc herniation was not related to the falls. He ordered physical therapy and no work from October 28, 2003 until three or four weeks after January 8, 2004; his opinion was that she suffered a back strain which aggravated her prior back pain leaving her with her chronic fibromyalgia pain. He further testified that given the entire picture of the pre-existing pain, fibromyalgia, and [*18] the inconsistencies between the symptoms and the herniated disc that no structural abnormality occurred to her back from the slip and falls and that the surgery was not related to the falls. (Resp.Ex.3,p.12-17).

A review of the records of Petitioner's family's physician, Dr. O'Leary, appears to contain one complaint of pain in the back, in a note taken April 18, 1994. Dr. O'Leary's records refer to fibromyalgia several times, with the last such reference on July 24, 2000, or more than three (3) years prior to the initial accident. His notes mention physical therapy two (2) or three (3) times prior to 1998, but do not state what parts of the body required the therapy. (Resp.Ex.10).

Dr. Steven Mather examined Petitioner on April 15, 2004 and found that she complained of pain around the lumborsacral junction radiating to both sides and down the left leg. He examined the MRI film of September 16, 2003 and found a herniated disc at L5-S1 consistent with the work injury. (Pet.Ex.9).

At request of the Respondent, Dr. Zelby examined the September 16, 2003 MRI film and did not find a herniated disc at L5-S1. (Resp.Ex.4,p. 12-13). He also stated that Petitioner had complaints prior to her [*19] injury and there was no reasonable expectation that following a period of time to recover that she would not continue to have symptoms. He felt the need for surgery was not work related. (Resp.Ex.4,p. 16-18). He further testified that Petitioner told him she had no pain in her back prior to July 23, 2003, which he noted was contrary to what he found in the records from Edward Hospital, Edward Corporate Health, a chiropractor, Dr. Spencer, Dr. Rabin and physical therapist. (Resp.Ex.4,p.53-54).

Petitioner saw Dr. Ganju on June 10, 2004 and her records reflect that Petitioner complained of lower back pain; left lower extremity pain radiates to buttock and posteriorly to the left heel with numbness and tingling; left lower extremity weakness; describes lower back pain as sharp and left lower extremity as soreness; symptoms began in July 2003 and the physical therapy helped at times and at times made it worse. She was pretty active as a walker and runner but now unable to do these activities. On Naprosyn and Vicodin. (Pet.Ex. 11, p.4-5). Dr. Ganju ordered a discography on September 28, 2004 which was positive at L5-S1 but negative at L3-4 and L4-5. (Pet.Ex.11,p.11-12).

Petitioner was [*20] referred to Dr. Liu and was eventually examined on November 4, 2004. Dr. Liu indicated that he had read Dr. Ganju's notes and was told the same history and complaints. He recommended a single-level anterior lumbar interbody fusion. (Pet.Ex.11,p.1-2).

Dr. Liu testified that he performed surgery on December 13, 2004 and that he saw Petitioner on several occasions thereafter, the last being about a year prior to December 7, 2007. Dr. Liu noted that on March 17, 2005 Petitioner's overall back discomfort was 90% improved, whereas he normally expects 75% improvement; she was doing very well when he last saw her, was back at school and had no complaints about the surgery. (Pet.Ex.13,p.9-14). Dr. Liu was of the opinion

that the fall on July 23, 2003 contributed to her current state of ill-being. He relied on the patient's complaints, the discography and the September 16, 2003 MRI. He stated that the MRI revealed changes most consistent at the L5-S1 level where there is a decrease in internal signal of the disc space consistent with lumbar spondylosis. In addition, there was evidence of a left lateral herniation at L5-S1 compromising the foramen. (Pet.Ex.13,p.19-26).

Dr. Aikenhead testified [*21] that he is a doctor of chiropractic medicine and is a board certified diplomat in the Chiropractic Board of Radiology. He noted that he was licensed in Illinois in 1983 and his practice is restricted to radiology only. In addition, Dr. Aikenhead indicated that he has read tens of thousands of MRI's, x-rays and CT scans, mostly MRI's and CT scans, all of which were referred to him by M.D.'s. Dr. Aikenhead noted that there was no question in his mind that the September 16, 2003 MRI showed some degenerative changes at L5-S1 and a lateral herniation with some foraminal compromise at that level. (Pet.Ex. 15).

The Arbitrator notes that he has viewed the videotape surveillance submitted into evidence at RX2. The footage was filmed on November 16 and 19, 2004 and shows Petitioner driving her van to Gurnee Mills shopping center and walking throughout the mall with apparently her daughter and her daughter's friends. The Arbitrator notes that while Petitioner does not appear to exhibit any outward signs of pain or discomfort throughout the video, she also is shown doing nothing more than walking throughout the mall, holding little more than her coat and a plastic bag, and at one point sitting [*22] down to a meal in the food court. For that reason, the Arbitrator finds the video itself offers little if any probative value in the current dispute.

Based on the above, and the record taken as a whole, the Arbitrator finds that a causal relationship existed between the accident on September 9, 2003 and Petitioner's current condition of ill-being, including the need for the surgery she eventually underwent on December 13, 2004. More to the point, it appears that Petitioner may have suffered from a pre-existing degenerative condition with respect to her back, one that had required only minimal medical attention prior to the accident, and which was aggravated by the undisputed work accidents in question, first on July 23, 2003 (04 WC 13562) and again on September 9, 2003 (04 WC 14563). Along these lines, the Arbitrator chooses to place greater weight on the opinions of the treating physicians, and the medical records themselves, and finds the opinions of Respondent's § 12 examining physicians, Drs. Spencer and Zelby, to be unpersuasive.

WITH RESPECT TO ISSUE (G), WHAT WERE THE PETITIONER'S EARNINGS, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner testified that in addition to [*23] her work for Respondent she also taught music and piano out of her home, and that her employer was aware of this second source of income. Barbara Scanlon, a former employee and program coordinator for Respondent, substantiated Petitioner's claim in this regard, testifying that she knew Ms. Mansfield was working two jobs, and that the program manager, Michele Brooker, was also aware of this fact. Indeed, Ms. Scanlon noted that she herself had another job while working for Respondent.

Petitioner testified that the number of hours she worked in this second position varied from 10 to 20 hours a week, depending on the month.

Respondent submitted into evidence a wage statement for Petitioner, for the work she performed for the Naperville Park District, during the 52 week period leading up to the original injury, from the week beginning July 27, 2002 through the week beginning July 26, 2003. (RX9). This document shows that Petitioner worked a total of 447 hours and earned an amount totaling $ 9,422.86 during this period. The exhibit indicates that Petitioner was paid bi-weekly, and that she worked in 19 pay periods during the period in question, encompassing 38 weeks. Thus, Petitioner's [*24] average weekly wage while working for Respondent during the year leading up to the injury equaled $ 247.97 per week ($ 9,422.86 / 38 weeks).

As far as Petitioner's second job is concerned, Petitioner submitted into evidence joint income tax returns for her and her husband, Steven Mansfield, for 2001, 2002 and 2003. (PX19). A "Schedule C" form for 2002 for Cindy Mansfield as a sole proprietor of "SCATHOME", a business noted to provide piano lessons out of her home, reflects claimed gross receipts $ 17,975.00 and a net profit, after expenses, of $ 11,840.00. (PX19). A similar form, this one for 2003, reflects gross receipts of $ 13,501.00 and a net profit, after expenses, of $ 7,871.00. (PX19). Taking half of the net profits for the years 2002 and 2003, given a relevant period of July 2002 to July 2003, the amount of earnings from Petitioner' mu-

sic lesson business would equal $ 9,855.50 for the 52 weeks preceding the initial accident, for an average weekly wage of $ 189.53 ($ 9,855.50 / 52 weeks).

Therefore, based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner's earnings for the year preceding the initial injury totaled $ 19,278.36 ($ 9,422.86 [*25] + $ 9,855.50), and that her average weekly wage of $ 437.50 ($ 247.97 + $ 189.53).

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner submitted into evidence the bills of Dr. Pins (PX6), Dr. Mather (PX9) and Dr. Liu (PX14), as well as the records of Blue Cross/Blue Shield (PX16) and Ingenix (PX23), for bills paid. Respondent objected to the bills on liability as well as reasonableness and necessity grounds. Given that all the bills were incurred prior to the effective date of the amendment, on February 1, 2006, the fee schedule would not apply.

Dr. Pins testified that he was familiar with the usual and customary charges in the area and that his services were reasonable and necessary, and that his bill for services reflected the usual and customary charges. He testified that after deducting payments from Petitioner's insurance company and adjustments to the bill, there remained an unpaid balance of $ 4,286.08.

Dr. Liu testified that he was familiar with the treatment necessary [*26] for Petitioner's condition of ill-being and with the usual and customary charges for those services in the Chicago area. He further testified that the treatment rendered by the medical providers listed in the attachment to the Request for Hearing form (Arb.Ex# 1) was reasonable and necessary and that their charges for those services were usual and customary. (Pet.Ex.13 and 14).

Dr. O'Leary, Petitioner's family physician since 1994, made only one note in his records that she complained of a bad lower back on April 18, 1994 and that last note regarding fibromyalgia was made on July 24, 2000, though he treated her many times between 2000 and July 23, 2003 for all of her physical complaints.

Dr. Spencer and Dr. Zelby testified that Petitioner had only a sprain and that she had reached MMI by September 8, 2003, yet Dr. Spencer continued to send her for physical therapy and did not release her to return to work until on or about February 8, 2004. He did not see her after January 8, 2004. As previously noted, the Arbitrator chooses to place greater weight on the opinions of the treating physicians in this case, over that of Respondent's § 12 examining physicians, and therefore finds the [*27] opinions of Drs. Spencer and Zelby to be unpersuasive.

Therefore, based on the above as well as the record taken as a whole, including the Arbitrator's determination as to causation (issue "F", supra), the Arbitrator finds Petitioner is entitled to reasonable and necessary medical expenses in the amount of $ 108,554.15 pursuant to § 8(a) of the Act. Furthermore, the Arbitrator finds that Respondent is entitled to a credit for any and all amounts paid by its group carrier in medical bills on account of this injury, and that Petitioner is to be held 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.

Petitioner also testified that she incurred out of pocket expenses, including the payment of co-pays in the amount of $ 190.00, parking expenses in the amount of $ 127.00 and gas and toll expenses related to 1,790 miles in travel. However, Petitioner submitted no documentary evidence in support of these claimed expenses. Therefore, her request for same is hereby denied.

WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR [*28] FINDS AS FOLLOWS:

Petitioner testified that because of the pain in the lower back and numbness and tingling in both her legs, primarily her left leg, both Dr. Pins and Dr. Spencer removed her from work from September 11, 2003 to April 12, 2004, and that she

was not paid any TTD benefits for that period. In his report of September 11, 2003, Dr. Pins stated that Petitioner was placed on disability from September 11, 2003 with an indefinite date of return. (Pet.Ex.5).

Dr. Spencer testified that Petitioner could not work and he did not release her to return to work from October 28, 2003 until some unspecified time in the Spring of 2004. (Pet.Ex.9, p.13).

Dr. Pins further stated on February 8, 2004 that he would not release Petitioner to return to work until she was examined by a neurosurgeon. Dr. Mather's report of April 15, 2004 reflects that Petitioner started light duty on April 13, 2004. (Pet.Ex.9).

Petitioner then testified that she worked light duty from April 13, 2004 to November 13, 2004. She noted that her agreement was that Respondent would pay $ 8.00 per hour and that PDRMA would make up the difference. Petitioner indicated that she was paid $ 92.43 for five (5) weeks [*29] only and nothing thereafter. Also, nothing was paid toward TTD benefits with respect to her home income.

Dr. Liu ordered Petitioner not to work from November 13, 2004 (to prepare for surgery) to July 7, 2005 when he released her to full duty. Petitioner testified that she was not paid any TTD for this period. Petitioner testified that she only taught a couple of times at home after July 23, 2003. These sporadic or occasional wages would not preclude Petitioner from receiving full TTD benefits for the period in question.

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner was temporarily totally disabled from September 9, 2003 through July 7, 2005, for a period of 95 weeks. The Arbitrator notes that Petitioner worked light duty from April 13, 2004 through November 13, 2004, but that Respondent only paid at the agreed upon rate of $ 92.43 per week for five (5) of the 30-5/7 weeks that Petitioner worked light duty. However, instead of attempting to break this up between a period of maintenance versus TTD, and the varying amounts that would be due, the Arbitrator simply orders that Petitioner is entitled to the entire period in TTD benefits while [*30] allowing Respondent a credit for any and all amounts paid during the period in question, including TTD payments in the amount of $ 4,431.51 and maintenance payments of $ 462.15. (See Arb.Ex.# 2;PX22).

WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The medical records shows that as a result of her aggravating injury at work on September 9, 2003, Petitioner was eventually diagnosed as having suffered a herniated disc at L5-S1 and an exacerbation of her degenerative spine at the same level. Dr. Liu subsequently performed surgery on December 13, 2004 consisting of an anterior approach discectomy and fusion.

Petitioner testified that prior to the injuries her activities included walking, running, a lot of water sports and cross country skiing. Now she just walks and performs most duties at home, but nothing that puts pressure on her back. She presently feels good except for some back pain and numbness in her left leg.

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner suffered permanent partial disability to the extent of 25% person-as-a-whole pursuant to § 8(d)2 of the Act.

Legal Topics:

For related research and practice materials, see the following legal topics:
Workers' Compensation & SSDIAdministrative ProceedingsClaimsTime LimitationsNotice PeriodsWorkers' Compensation & SSDICompensabilityCourse of EmploymentRecreational ActivitiesWorkers' Compensation & SSDICompensabilityInjuriesAccidental Injuries