ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	21WC010820
Case Name	Lisa Baird v. Solace Hospice
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	***Corrected Decision***
Commission Decision Number	
Number of Pages of Decision	9
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Haris Huskic
Respondent Attorney	Lauren Serafin, Peter Havighorst

DATE FILED: 6/20/2024

/s/Stephen Mathis, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LISA BAIRD,

Petitioner,

vs. NO: 21 WC 010820

SOLACE HOSPICE,

Respondent.

CORRECTED DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary disability, and permanent disability, and being advised in the facts and law, reverses the Decision of the Arbitrator and awards workers' compensation benefits for the reasons stated below.

Petitioner testified she worked for Solace Hospice (hereinafter "Respondent") performing holistic care for hospice patients. Petitioner testified on direct examination that some of her duties with Respondent included toileting, bathing, dressing, feeding, and transferring hospice patients/residents that were incapable of performing these tasks on their own. Petitioner was assigned nine patients. Petitioner testified that she would have to feed each resident three times a day- breakfast, lunch, and dinner- approximately 27 times per day. Petitioner was required to wear rubber-soled shoes. Petitioner's job duties required a lot of standing, sitting, bending, lifting, and crouching.

According to the Incident Report Petitioner started her shift at 7:00 am on March 25, 2021. She testified that she had taken no breaks until the accident took place. Petitioner testified that she had gone down to get a resident from the salon about 1:15 p.m., as the patient/resident

had her hair done and had missed lunch. Petitioner went to warm up food and get the patient a glass of water.

Petitioner described the dining area on cross examination as, "an open space in between, like outside of their rooms. We have a little kitchenette in one of the other rooms. And that's where we prepare their plates and that's where our water is." The floor of the dining room was tiled.

On cross examination Petitioner testified that she was carrying the resident's food and drink when "my (left) knee gave out and I fell and hit it on the floor, along with the food and drink." Petitioner testified that she was carrying a tray with a regular sized dinner plate and a glass containing 8 ounces of water and was walking to the table to feed the resident when she fell. Petitioner did not testify to any defects or hazards contributing to the fall.

On March 30, 2021, Petitioner presented to Northwestern Medicine complaining of left knee pain. She reported the onset of symptoms five days earlier when she took a step with her right foot, her left leg locked, and her ankle rolled, and she fell at work. Following a physical examination and an x-ray Petitioner was diagnosed with a sprain of the medial collateral ligament and an acute medial meniscal tear of the left knee. Additionally, there was a suspected diagnosis of avascular necrosis secondary to aggressive steroid therapy for asthma. Petitioner was ordered off work at that time.

An MRI was performed on April 2, 2021, at Northwestern Memorial Hospital. The impression of the radiologist was "Multifocal subchondral marrow edema, as described. Due to multi-focal bilaterality, consider avascular necrosis. Subchondral fractures could have similar appearance." The medical records indicate the April 2, 2021, left knee MRI was compared to a right knee MRI dated December 12, 2019. The left knee MRI showed mild degenerate changes on the anterior horn of the lateral meniscus, bandlike subcortical marrow edema of the lateral femoral condyle, similar small subcortical lesion, small defect noted posteriorly on the medial femoral condyle and the findings due to multifocal bilaterality avascular necrosis should be considered. Mild chondromalacia was also described.

Petitioner denied any prior medical treatment or complaints involving her left knee. Prior to March 25, 2021. Petitioner was able to work full duty without any restrictions prior to the March 25, 2021, work-related accident.

On April 7, 2021, Petitioner returned to Northwestern Medicine complaining of left knee pain. According to the medical records she reported her activities were limited by pain that was located around the patella and radiating down to her toes. She was ordered off work and prescribed crutches. Petitioner was to return to clinic in 4 weeks. The medical records reflect that Petitioner's diagnosis was contusion of the left knee, avascular necrosis of medial condyle of the left femur due to adverse effects of steroid therapy.

Petitioner transferred her medical care and first presented to Dr. Howard Freedberg, an orthopedic surgeon on April 27, 2021. The medical records document continued complaints of pain in the lateral aspect of Petitioner's left knee. The pain is described as constant with intermittent "pins and needles" sensation down to her toes. Dr. Freedberg prescribed a knee brace and home exercise program. Petitioner was kept off work and was directed to return to clinic in one week with MRI results. Dr. Freedberg determined that Petitioner was medically unable to work.

Petitioner returned to Dr. Freedberg on May 4, 2021; at which time he continued her off work status. He documented that Petitioner was to continue wearing a Shield's knee brace and that she was ambulating with crutches.

On May 25, 2021, Petitioner reported to Dr. Freedberg that her knee was sore from therapy. She stated that she was doing physical therapy three times per week which she noted was helping. Dr. Freedberg ordered continuation of the knee brace and physical therapy.

Dr. Freedberg released Petitioner to return to work with light duty restriction on June 14, 2021, and continued her on light duty throughout June and July. On August 10, 2021, Dr. Freedberg's clinical note elaborated on the light duty restrictions. He specified that "Patient is allowed to walk, but with breaks every 2 hours or as needed. Lifting as tolerated. Left knee sprain/strain."

On September 7, 2021, Petitioner reported to Dr. Freedberg that two weeks prior she was walking up the stairs and her left knee gave out after feeling sharp pain and she fell forward on the left knee. According to Petitioner her left knee was worse following that incident and she felt sharp, constant pain when walking. Dr. Freedberg noted that patient had failed extensive conservative measures and surgical intervention was now recommended pending medical clearance. At this appointment Dr. Freedberg gave Petitioner a note stating that she was medically unable to work.

Petitioner was seen in clinic by Dr. Freedberg on October 19, 2021. She reported her left knee was in constant pain. She reported increased pain since the prior office visit even with use of her knee brace. Petitioner had been taking Tramadol as needed and requested a refill. She reported her pain level as 8/10. On physical examination she expressed exquisite tenderness over the medial joint line. Dr. Freedberg discussed surgery as a current treatment option, specifically knee arthroscopy with possible core decompression of femoral condyles. Petitioner elected surgery and informed consent was obtained. Surgery was planned for October 26, 2021, at St. Alexius.

Petitioner underwent arthroscopic surgery on her left knee performed by Dr. Freedberg on October 26, 2021, at St. Alexius Medical Center. The post-operative diagnosis was left knee sprain/strain, possible avascular necrosis effusion. Post-operatively she was medically unable to work.

On December 14, 2021, Petitioner presented to Dr. Freedberg's office for post-operative follow-up 7 weeks following surgery. She was attending physical therapy two times per week. Dr. Freedberg had her off work with range of motion and weight-bearing as tolerated. She was to return to clinic in 4 weeks.

Petitioner began post-operative physical therapy at Northern Rehab Physical Therapy on November 11, 2021, on orders from Dr. Freedberg. She continued physical therapy through April 8, 2022. Petitioner reported that her initial injury occurred in March 2021, and she had to work light duty through August 2021. The physical therapy record documents that Petitioner was off work since August 2021. In the PT Discharge Summary from April 8, 2022, Petitioner stated that she felt stronger and able to perform regular work duties. Any soreness was reported as aching and fatigue that resolved with rest. Her self-reported pain score was 1/10. She was assessed as having returned to her prior level of function with good left knee stability. Petitioner was determined to be appropriate to return to full, unrestricted duty once cleared by her physician.

The medical records from Dr. Freedberg document that Petitioner was cleared to return to full-duty work without restriction effective January 18, 2022. She was directed to return to clinic for follow up in 4 weeks.

According to Dr. Freedberg's medical records he returned Petitioner to light duty work effective February 15, 2022. At her appointment she reported increased pain and tingling after long periods of standing or sitting.

On April 12, 2022, Petitioner was seen by Dr. Freedberg once again in follow-up. She had been released from physical therapy. She denied any numbness or tingling and self-rated her pain score at 3/10. She reported increased pain after prolonged periods of activity. Dr. Freedberg noted that she could work full duty and was to return to clinic in 4 weeks.

Petitioner presented to Dr. Freedburg on May 10, 2022, for follow up of her left knee. She reported that her knee hurts toward the end of her shift at work. On physical examination there was no swelling or effusion and no tenderness to palpation. Dr. Freedberg released petitioner to unrestricted full-duty work and discharged from care. Dr. Freedberg documented that Petitioner had achieved MMI.

At hearing Petitioner testified that she continues to work for Respondent taking care of hospice patients. She still experiences left knee pain at the end of her shift. Petitioner takes over the counter Tylenol for pain. She has made some adjustments at work to accommodate her left knee, she does not do a lot of bending, takes the elevator instead of the stairs, and takes breaks to elevate her left knee more often. Petitioner characterized her knee surgery as "a success".

The Arbitrator found that Petitioner failed to prove accident and denied the claim. The Commission relies on the nature of Petitioner's job with Respondent and the credible testimony of Petitioner to define the constellation of responsibilities that comprise her job. Petitioner testified that prior to the work accident she had no issues and no medical treatment for her left knee. She was able to work unrestricted full-duty up to the accident. The Commission finds that a preponderance of the evidence in the records supports a work-related aggravation of a pre-existing condition, under *Sisbro,Inc. v. Industrial Comm'n.,* 207 Ill.2d 193 (2003) i.e. avascular necrosis. Petitioner testified at hearing that she had begun her shift at 7:00 am and was scheduled to work until 7:00 pm. She was on her feet throughout that time until she fell, attending to the needs of 9 patients assigned to her care.

Petitioner testified that her responsibilities included bathing, dressing, transferring patients, feeding, toileting, and transporting patients to various activities. She described her job as being physically demanding including a lot of standing, walking, and operating a Hoyer lift.

On March 25, 2021, Petitioner had worked straight through from the start of her shift until the work-related accident which occurred at approximately 1:15 p.m. Immediately prior to the fall she had gone down to the salon to retrieve a resident who had gotten her hair done. Petitioner transferred the resident from the salon chair to the patient's wheelchair and returned her to the dining area where she would prepare and feed her lunch. Petitioner then walked to the kitchenette area where she warmed the food, poured a glass of water, and carried the items on a 12-inch tray and was returning to the resident when she fell.

It is clear that Petitioner was engaged in an activity that was causally connected to her employment when she fell. Petitioner's fall risk was directly associated with her employment. She was carrying a food tray to the resident in order to feed her. An injury is said to "arise out of" one's employment if its origin is in some risk connected with or incidental to the employment so that there is a causal connection between the employment and the accidental injury. *Caterpillar Tractor Co. v. Industrial Comm'n,* 129 Ill. 2d 52,58 (1989). A risk is "incidental to employment" when it belongs to or is connected with what the employee has to do in fulfilling her job duties. *McAlister, 2020 IL 124848.* The record further shows that Petitioner gave timely notice to Respondent. The Commission finds that Petitioner did sustain a work-related accident and awards benefits accordingly. The parties stipulated to AWW of $640.00 at the time of the accident.

The Commission finds that Petitioner's employment as a Certified Nursing Assistant/ Hospice worker presents many unique risks of injury as it involves substituting one's own strength, mobility, and dexterity to support the needs of a person disabled either by the infirmities of age or illness. It requires lifting, turning and safely transferring patients who may be unable to assist or cooperate resulting in an increased risk of harm to the worker. While Petitioner was engaged in the rather benign task of carrying a food tray at the moment she fell, that act had been preceded by 6 hours of assisting hospice patients. The Commission finds that it

would be remiss if it failed to recognize the employment context in which Petitioner sustained her injury.
Applying a "chain of events" analysis the Commission finds that the injury was causally related to the fall Petitioner sustained while bringing a lunch tray to the patient/resident.

Petitioner asserts in her brief that she is entitled to TPD benefits when she worked fewer hours during several pay periods following her injury. The Commission notes that there was no testimony elicited from Petitioner linking the reduced hours to light duty work restrictions. Examination of the paystubs themselves only reflect the hours worked but make no mention of light duty restrictions or any other accident related reason for the reduced hours. For this reason the Commission finds that Petitioner failed to meet the burden of proof on the issue of entitlement to maintenance or TPD benefits.

Turning to the determination of TTD benefits due to Petitioner, Commission finds that Petitioner was temporarily totally disabled from April 7, 2021, through June 14, 2021, when Dr. Freedberg released her to light duty work. According to Petitioner's pay stubs which were entered into evidence, (PX8) Petitioner however actually returned to work on June 8, 2021.

The Commission finds that Petitioner is entitled to TTD benefits commencing April 8, 2021, though June 7, 2021, and again from November 8, 2021, through January 18, 2022, in the amount of $426.67 per week representing 18 weeks and 5 days.

Petitioner submitted in evidence a Consolidated Medical Bills Exhibit List (PX9) which reflects a total of $57,022.83 in unpaid medical bills. These bills reflect expenses incurred in the reasonable and necessary treatment and rehabilitation of Petitioner's left knee following her work-related accident on March 25, 2021. No evidence has been introduced rebutting the reasonableness or necessity of the treatment and the Commission finds that it is causally related to Petitioner's work injury.

Lastly, the Commission determines the permanency award. The Commission considers the five factors enumerated in section 8.1b(b) of the Workers' Compensation Act: "(i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b).

Regarding factor (i), the Commission notes no impairment rating has been submitted into evidence. The Commission therefore gives no weight to the factor.

Regarding factor (ii), at the time of the injury Petitioner was a CNA/hospice worker, which is a physically demanding job. Petitioner testified that upon completion of her medical treatment she returned to work for Respondent and still worked there at the time of hearing. The Commission gives moderate weight to this factor.

Regarding factors (iii) and (iv), the parties stipulated that Petitioner was 38 years of age at the time of the injury. She is now 41 years old. Dr. Freedberg released Petitioner to return to her employment with Respondent. The Commission finds no evidence to support impairment of earnings causally connected to the work accident and places more weight to this factor.

Regarding factor (v), the Commission notes that Petitioner underwent surgery on her left knee and was left with residual complaints. The Commission further notes that the medical records show avascular necrosis in Petitioner's right knee secondary to chronic steroid therapy for treatment of asthma in addition to a left knee sprain. No medical evidence was presented causally connecting any aggravation of the condition of avascular necrosis as a consequence of Petitioner's fall. The medical record shows that Petitioner was diagnosed with avascular necrosis in Petitioner's right leg dating back to December 12, 2019. According to the medical records from Northwestern Medicine the avascular necrosis was secondary to aggressive steroid therapy for asthma. For this reason, the Commission finds that Petitioner's condition of avascular condition was pre-existing and the only injury causally related to Petitioner's fall on March 25, 2021, was a knee sprain/strain and soft tissue injury to the left knee.

At the arbitration hearing Petitioner was not wearing a knee brace. She takes over the counter Tylenol when she has knee pain. Petitioner described the left knee surgery as "a success". The Commission finds it telling that Petitioner put on no medical evidence to attribute Petitioner's ongoing left knee pain and swelling to the aftereffects of the sprain versus the condition of avascular necrosis. The Commission places greater weight on this factor. Accordingly, the Commission finds that Petitioner sustained 10% loss of use of the left leg pursuant to Section 8(e) of the Act

For the foregoing reasons the Commission reverses the Decision of the Arbitrator.

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IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 5, 2023, is hereby reversed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $426.67 per week commencing April 8, 2021, through June 7, 2021; and commencing November 8, 2021, through January 18, 2022, representing 18 weeks and 5 days, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner related unpaid medical bills in evidence totaling $57,022.83 through May 10, 2022, pursuant to Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $384.00 per week for a period of 21.5 weeks, as provided in Section 8(e) of the Act, for the reason that the injuries sustained caused the loss of use of 10% of the left leg.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $65,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

June 20, 2024
SJM/msb
o-04/10/2024
44

/s/ *Stephen J. Mathis*
Stephen J. Mathis

/s/ *Deborah L. Simpson*
Deborah L. Simpson

/s/ *Raychel A. Wesley*
Raychel A. Wesley

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC032515
Case Name	Ma Guadalupe Garcia aka Eliza Hernandez v. Steak N Shake Enterprises, Inc.
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	***Corrected Decision***
Commission Decision Number	[24IWCC0271]
Number of Pages of Decision	26
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Damian Flores
Respondent Attorney	George Klauke

DATE FILED: 6/13/2024

/s/ Deborah Simpson, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse:	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify: Up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARIA GUADALUPE GARCIA, a/k/a/ ELIZA HERNANDEZ,

Petitioner,

vs. NO: 15 WC 32515
24 IWCC 271

STEAK & SHAKE ENTERPRIZES INC.,

Respondent.

CORRECTED DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, temporary total disability/temporary partial disability, permanent partial disability, and medical expenses, and being advised of the facts and law, modifies the Decision of the Arbitrator as specified below, and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made part hereof.

Findings of Fact – Testimony

Petitioner testified through an interpreter that on October 5, 2015 she was employed by Respondent and had been for about two weeks. She worked in "preparation" and worked six hours per day. If she wasn't preparing food, she was washing dishes. She was on her feet the entire shift. Before she worked for Respondent her health was "fine" with no history of back pain, back injury, or back treatment. On that day, she arrived at work at 9:00 a.m. She was bringing dishes to the dishwasher when she slipped and fell on her buttocks. She explained "it was already grease there and something happened with the machine – the dishwasher and then the soap came out." Her head then struck "some hard plastic that was there." She felt "a lot of pain" (10/10) in her back. The accident happened at 12:00 and the ambulance arrived at 12:10. She was taken to Presence Resurrection and she was admitted until October 10, 2015.

She was treated by Dr. Yapor at the hospital and started rehab therapy there. After an MRI, Dr. Yapor referred Petitioner to Dr. Vo, whom Petitioner first saw on February 15, 2016. Dr. Vo administered an injection, which did not provide relief and Dr. Yapor recommended a Kyphoplasty, in which they were "trying to glue the fracture back together." The procedure was performed on March 16th and she had postop physical therapy from March 30, 2016 through May 16, 2016. The physical therapy caused "pain, more pain." Dr. Vo stopped the physical therapy. On May 2, 2016, Dr. Vo noted that she was graduated to ambulating with a cane; previously she was using a walker. Petitioner last saw Dr. Yapor on June 21, 2016.

Petitioner saw Dr. Zelby for a §12 medical examination. He examined Petitioner for "about 5 minutes." Thereafter, she was unable to follow up with Dr. Vo or Dr. Yapor because it was no longer approved. Respondent brought her back to work on August 17, 2016 at which time she was still ambulating with a cane. She returned to her previous job in preparation. She had to rest after about an hour. Respondent allowed her to use her cane while working. She worked less hours than she did before the accident. She experienced 7-8/10 low back pain while working. She kept working despite the pain because she needed the money.

Petitioner saw Dr. Chen for a second opinion. He recommended "many restrictions" and another injection, which was administered on October 13, 2016. She noticed some improvement after that injection. He performed another injection and Petitioner was able to increase her hours of work. She had more physical therapy from November 30, 2016 through January 27, 2017. She had another injection on May 1, 2017, which helped "a little bit." She then saw Dr. Hussain who prescribed a gel, which helped her pain. She last saw Dr. Hussain on October 21, 2017, at which time he discharged her with permanent restrictions. She continued to work for Respondent with her restrictions and using her cane. She stopped working on March 14, 2020 because "they did not have any more work for" her. They were still open for drive-thru business during the pandemic. Initially, she wanted her job back but not anymore. Respondent never offered her job back and she had not worked anywhere since March 14, 2020.

Petitioner testified that she still used a cane to walk so that she wouldn't injure herself. She uses the cane to brace herself. She took over-the-counter medication for the pain. Her pain was 7/10 without medication, and it is reduced a little (to 6/10) with the medication. It can reach 10/10 without medication. When it was very cold she walked "like bending down." Her condition had affected how she performed activities of daily living such as bathing/dressing. She had "pain, pain" bending over to dress and "pure pain" while performing household chores such as sweeping. She used to walk an hour or an hour and a half. Now she becomes tired after walking two blocks.

On cross examination, Petitioner agreed that she applied for her job with Respondent under the name Eliza Hernandez. Before she worked for Respondent, she worked through employment agencies. In preparation she was preparing the food not assembling it. Washing dishes involved pushing "a dish rack through a dishwashing machine." She reiterated all she did was prepare food and wash dishes.

At the examination with Dr. Zelby, she spoke Spanish and there was an interpreter present. He asked her to move her arms/legs, to bend over, and to squat. She was not able to perform all the maneuvers Dr. Zelby requested. She did not remember whether she saw Dr. Zelby twice, nor any recommendations he made.

Respondent would not approve treatment with Dr. Vo or Dr. Yapor. However, she went to Dr. Chen. He was recommended to her, but she didn't know by whom. She has not seen any doctor since October 21, 2017. No doctor has prescribed her over the counter medication or her cane. Petitioner denied that at the last visit with Dr. Hussain on October 21, 2017 she indicated that she was doing much better and was able to perform her job without restrictions. Dr. Hussain discharged her but with "a lot of restrictions" for her "whole life."

Petitioner agreed that at that visit she reported 4-5/10 pain. She denied that when she was laid off she was told that it was reducing workforce due to COVID. She was simply told by the manager that her job was over; "she didn't explain anything." Petitioner had not looked for work since. Petitioner also agreed that she was a part-time worker for Respondent. However, she did not remember whether she worked 14 to 23 hours a week. She worked six hours a day for five days a week. She also did not remember whether Dr. Hussain's lifting restriction was 20 pounds rather than 15 pounds. No customer was allowed in the store when it was open for drive-thru only. During that period there were no dishes to wash, but she "only did the preparation on whatever was dirty [she] would wash it."

On redirect examination, Petitioner seemed to testify that when she was washing dishes it was the dishes from her food preparation. She did not currently have health insurance or money to pay a doctor. If she had insurance she would see a doctor. She had not worked since COVID. She was surviving with the help of her children, one of whom she lived with. She agreed that when she last saw Dr. Hussain she was doing a little bit better and the gel was helping her pain and was helping her perform her job. However, she still reported 4-5/10 pain. She no longer bought the gel Dr. Hussain prescribed because she did not have the money. She received pay while [she] was sick. That's it."

On re-cross examination, Petitioner agreed that the gel was Voltaren was over the counter. She did not have money for it. She still took Aleve and Tylenol because they relieve her pain better than the gel. She was unaware of services such as Medicaid or free clinics.

Ms. Jamie Blatnik was called by Respondent for which she worked as Division President. Because of COVID, Respondent closed the dining room at which Petitioner worked and went from being a 24-hour operation to 10:00 a.m. to 11:00 pm, drive-thru only operation. "That was directed by the State of Illinois." There was a reduction in work force and work hours. "Some individuals lost significant hours" and "others lost their jobs completely." She noted that 3rd shift workers without other availability were let go because there was no longer any 3rd shift. In addition, there

were no dishes to wash because they were not serving in the dining room. They sent letters explaining the situation in April of 2020.

Findings of Fact – Medical records

On October 5, 2015, an ambulance arrived and Petitioner was found sitting on a chair complaining of 10/10 pain in her low back, neck, and head. She reported slipping on water and falling backwards hitting her head and back on the floor. She denied loss of consciousness. "Excessive amounts of water surrounding the area where she fell" was noted by the EMTs. She was transported to the closest hospital ER, at Presence Resurrection Hospital.

At the ER, lumbar x-rays showed "questionable mild superior endplate compression fracture deformity at L1, indeterminant in age." The lumbar MRI was consistent with the x-ray finding of acute fracture at L1 and multilevel degenerative disc disease with only mild inferior foraminal narrowing but without evidence of canal stenosis. Head/cervical CT showed no acute pathology, though cervical spondylosis was noted. Petitioner was hospitalized for the acute fracture at L1. She was also found to have hypertension and reported at times she did not take her blood pressure medication. She was prescribed Norco, Morphine, and anti-hypertension medication.

Four days later, while still in the hospital, Petitioner was examined by FNP Koldenhaven. She noted the accident and that Dr. Yapor, a neurosurgeon, consulted and ordered a lumbar Aspen brace and physical therapy. They determined that Petitioner was not a surgical candidate. Rather, she was deemed a candidate for acute rehabilitation. Petitioner was considered medically stable but it was not safe for her to be transferred home. She was discharged to an apparently in-house acute rehabilitation facility. The rehab would include comprehensive evaluation, adaptation to disability, family/caregiver training, wheelchair fit/locomotion, energy conservation, increase of strength/endurance, gait training, skin care, bowel/bladder regulation, safety, coordination, and transfers. Prognosis/rehab potential was deemed good and the length of stay was anticipated to be 7-10 days.

On October 30, 2015, Petitioner was discharged from rehab to home in good, stable condition. It was noted that she was admitted with L1 compression fracture. Bracing and rehab were commenced and she was placed on pain management. She was found to have significant functional deficits. She was transferred to acute rehab care due to the complexity of her case and the need for coordinated therapies. She did well in therapy. She continued to complain of pain at discharge, but her functionality "improved greatly." She was discharged home at a modified independence level with functional mobility and would receive physical therapy from home health to address remaining deficits. She was to follow up with her primary care physician.

2/15/16 – Petitioner presented to Dr. Vo for constant left 8/10 low back pain; it ranged between 7-10/10 with no radiation to her legs. It started three months ago after she slipped on water at work and fell on her right buttock. She had seen Dr. Yapor who treated her conservatively

with bracing, rest, physical therapy, and pain medication (she had recently been weaned off opioids). Currently, she was taking Naproxen and Xanax.

Dr. Vo noted the results of the MRI, which were consistent with an acute fracture at L1. He opined that the fracture was likely the cause of her pain. He noted that she had failed conservative treatment. He recommended a therapeutic/diagnostic ESI and if that were not beneficial, he would agree with Dr. Yapor that she could benefit from a Kyphoplasty at L1. A week later, Dr. Vo administered a paramedian interlaminar injection at L1-2 for herniated lumbar disc and compression fracture. On March 8, 2016, Petitioner returned reporting no significant relief from the injection. She was taking Percocet for "moderately severe" pain. Dr. Vo would not recommend long-term opioid treatment. He noted the most recent MRI from February 1, 2016 showed edema at L1 indicating there was still inflammation from the L-1 compression fracture. He recommended a L1 Kyphoplasty to hopefully relieve her pain. On March 14th Dr. Vo performed a CareFusion® Kyphoplasty at L1 with insertion of CareFusion® bone cement for traumatic vertebral compression with delayed healing.

On May 2, 2016, Dr. Vo noted that Petitioner had attended 18 physical therapy sessions and graduated from a walker to a cane. He inquired about a back-belt a therapist had recommended. She took Aleve every four to eight hours *prn*. Dr. Vo noted a visit on March 26th, in which Petitioner reported over 50% improvement after the Kyphoplasty. At that time he concluded that she no longer needed Percocet. Dr. Vo, indicated he did not think Petitioner was at maximum medical improvement. He encouraged her to increase activity, continued physical therapy, advised her to alternate between Tylenol and Aleve, and decided against the brace because it may weaken her back muscles. He was unsure why she still reported the degree of pain she did. He would discuss with Dr. Yapor whether additional imaging was warranted.

Petitioner returned on June 13, 2016 after a new MRI. She reported being pushed hard in physical therapy which she felt made her pain worse. Dr. Vo indicated the new MRI "noted T12-L1 disc fragment versus Previous report stated disc bulge at this level." He wondered if that disc had worsened and was then the cause of her persistent back pain. He advised Petitioner to take the imaging to Dr. Yapor for evaluation. He held physical therapy. Petitioner returned to Dr. Yapor on November 10, 2015 reporting her pain was slightly better, but still quite painful. She was off work and wearing a brace. Dr. Yapor continued use of the brace and indicated another MRI would be taken in three months. Dr. Yapor's assessment was compression fracture of L1 vertebra with routine healing. He continued use of the brace.

An MRI taken February 1, 2016, showed compression deformity at L1, which appeared relatively recent and was associated with disc degeneration and eccentric disc herniation at T12-L1. At a visit on February 9th, Dr. Yapor noted that the MRI taken at three moths showed a slight progression of the compression fracture. Petitioner reported being in a lot of pain. Dr. Yapor's plan was "pain clinic." A repeat MRI taken on June 9, 2016. showed mild reversal of normal lordosis, evidence of Kyphoplasty on the right at L1, and mild-to-moderate anterior wedge shape

compression fracture of L1 vertebral body with subtle marrow edema, which was possibly chronic and related to the work related injury of October 5, 2015.

On June 21, 2016, Petitioner was referred back to Dr. Yapor for pain management. She had an ESI and Kyphoplasty, which did not help. The follow up MRI showed "the compression fracture was mostly healed. The extruded disc is smaller and very thin without any neural structures." Petitioner had no radicular pain.

Petitioner was initially evaluated by physical therapy on March 30. 2016. She exhibited "extreme difficulty performing usual work or household activities." She also had an elevated "fear avoidance." She had significant low back pain (4-10/10) with bilateral sciatic symptoms and required a walker for ambulation. Physical therapy was intended to improve lumbar stability and leg strength to allow return to prior level of functionality and to work. Her rehab potential was deemed good.

May 25, 2016 is the 19th and apparently last treatment note in the exhibit. Petitioner exhibited significant improvement in leg strength, but still complained of 6/10 pain with walking and transferring in/out of bed. She showed better tolerance for standing and better gait with a single point cane. She would benefit from additional professional physical therapy services for weakness, decreased range of motion, and pain. Her rehab potential was now deemed fair. On August 3, 2016, Petitioner was discharged from physical therapy because she did not return after her doctor visit.

On October 6, 2016, Petitioner presented to Dr. Chen for neck pain and low back pain with radiation to the left thigh and occasional numbness in her feet for over a year. She had an injection and Kyphoplasty, without significant benefit. She was initially covered by Workers' Compensation but was dropped after an §12 medical examiner found her at maximum medical improvement. MRIs showed lumbar/cervical bulging discs/spondylosis at multiple levels. Dr. Chen diagnosed low back pain, intervertebral lumbar disc degeneration and cervical/lumbar spondylosis without myelopathy/radiculopathy. He decided to perform a series of lumbar facet ESIs. A week later, Dr. Chen administered bilateral facet joint injections at L3-4, L4-5, and L5-S1 for lumbar spondylosis without myelopathy. On November 8, 2016, Petitioner reported she had moderate pain relief after the injections. Dr. Chen administered additional bilateral facet joint injections at L3-4, L4-5, and L5-S1 for lumbar spondylosis without myelopathy.

On April 3, 2017, Dr. Chen noted that Petitioner responded very well to physical therapy and the injections. Her pain level was now tolerable and was able to return to work at full duty for two hours a day with 10 minute break between hours. She was willing to increase her hours to see if she could tolerate it. He increased her allowable hours of work from two hours a day to four hours a day.

Two weeks later, Petitioner returned to Dr. Chen and reported she could not tolerate the increased hours of work and her low back pain recurred. He reduced her workhours to two per day and could consider a functional capability evaluation/work hardening after reasonable pain relief.

On May 1, 2017, Dr. Chen administered additional bilateral facet joint injections at L3-4, L4-5, and L5-S1 for lumbar spondylosis without myelopathy. He released her to work as of May 8, 2017 for two hours a day with no lifting over 20 pounds, a 10-minute break per hour, and no repetitive/forceful flexion, lateral flexion, or extension/rotation of the lumbar spine.

On June 10, 2017, Petitioner presented to Dr. Hussain for evaluation/treatment of her low back pain. She had injections and was sent back to work on August 27, 2016 with restrictions. She was doing reasonably well but her doctor moved and she has been out of medication, Flexeril. She rated her worst pain as 6-7/10. She exhibited positive single leg raises bilaterally, mild decrease in "DTRs," right worse than left, "with knee jerk of ¾." Dr. Hussain diagnosed lumbago, prescribed Voltaren, continued Flexeril, and continued physical therapy/work restrictions.

On October 21, 2017, Petitioner reported her pain was reduced significantly since she started using the Voltaren and was able to do her work without problem. Her pain was at 4-5/10 at its worst with activity. Dr. Hussain found Petitioner at maximum medical improvement, she was able to do her job under her current regimen, and released her from care *prn.*

Dr. Zelby testified by deposition on October 30, 2019. He is a board-certified neurosurgeon and Assistant Professor of Neurosurgery at Rush. He performed surgeries on the spine, peripheral nerves, and the brain. He performed §12 medical examination on Petitioner on July 27, 2016, reviewed medical records, and issued a report. She reported the accident in which she slipped on a wet floor while carrying pots which she estimated weighed three pounds. She fell, landed on her buttocks, fell backwards, and struck her head. She was taken to a hospital by ambulance and was an inpatient for three days. She was then in rehab for about another three weeks. She had injections and a Kyphoplasty, in which one injects the vertebral body with a compression fracture to stabilize the bone and sometimes to restore the height.

On examination, Petitioner had tenderness to palpitation of the upper-mid lumbar region "even with non-physiologic light touch." She had normal flexion and mildly diminished hyperextension/lateral bending. She was able to squat "almost all the way down," lying straight leg raises were positive in the back only, and sitting lying straight leg raises were negative. She brought a single-post cane but did not use it.

Leg strength was normal, sensation was normal, and reflexes were normal. Inconsistent responses included pain on superficial touching, pain on simulation, and diminished pain on distraction. The first MRI from October 5, 2015 showed mild loss of signal intensity at T2 and acute compression fracture along the superior aspect of L1 with mild loss of disc space height. He

also identified some other pathology, which appeared relatively minor. He concluded that Petitioner sustained a mild L1 compression fracture from the slip and fall accident; the fracture of the MRI was "clearly acute." The other spinal pathology was not aggravated by the accident. The MRI taken July 9, 2016 showed very mild kyphosis across the T12-L1 level and an interval Kyphoplasty. The compression fracture was healed and the increased signal had resolved.

Dr. Zelby thought his diagnosis/prognosis was similar to Dr. Yapor's. Her fracture had healed, she had normal neurologic exam, no significant kyphosis across the fracture, no radicular symptoms, and no MRI findings that would cause radiculopathy. He thought her prognosis was excellent. He saw no reason why Petitioner could not safely return to work at her prior job without restriction. "She would be at no increased risk for injury with a return to her full work duty." "Although she reported complaints of pain, those complaints could not be corroborated with any objective medical findings." She needed no additional treatment for her spine, irrespective of cause.

Dr. Zelby performed a second §12 medical examination on Petitioner on February 25, 2019, reviewed subsequent records, and issued a second report. At this examination, Petitioner reported almost constant 5-7/10 pain, 8/10 with activity. She did not have pain radiating into her left buttock had numbness/tingling of both legs below her knees. That happened once or twice a week and lasted up to 30 minutes. "She rested and moved with no pain behaviors during the exam that was inconsistent with the reported level of pain, and her cane appeared to be a prop." After the first §12 medical examination she was sent back to work with a lifting restriction of 15-20 pounds and the ability to rest 15 minutes in every hour. His examination appears to be similar to the initial exam. However, this time she stated she could not squat and did not try. "There is no condition in her spine or nervous system that would have prevented her from squatting at least as well as she did in 2016."

After the 2019 examination, Dr. Zelby diagnosed healed wedge compression fracture of the L1 vertebra. The MRI from June 16th showed the fracture was healed and there was no other significant pathology. Once the fracture healed there should not be any residual pain and once it healed no additional treatment was necessary.

On cross examination, Dr. Zelby testified he performed §12 medical examinations for 15 to 20 years. He reviewed all medical records after the accident, but none from before the accident. The last record he reviewed was from Dr. Hussain dated October 21, 2017. He agreed that the last note he saw from Dr. Yapor was from June 21, 2016, at which time he kept her off work and referred her to pain management. While Dr. Yapor did not declare Petitioner to be at maximum medical improvement, "he thought there was routine healing of the compression fracture."

Dr. Zelby agreed that the job description he saw included occasional lifting up to 100 pounds, constant lifting of 15 to 20 pounds, and frequent lifting of 40 pounds. At the time of the accident, Petitioner was 52 and had a high body mass index. He agreed that as far as he knew,

Petitioner did not have back complaints prior to the accident. The injury was to the L1 vertebral body, not the disc. Normally, there is pretty good healing of a compression fracture within 3-4 months, and more complete healing within six to eight months. Petitioner had at most "mild" canal stenosis (narrowing) at T12-L1." That condition can be asymptomatic and he would not expect symptoms from that degree of narrowing.

The February 1st MRI showed "progressive healing" of the compression fracture, but he did not believe the healing was complete at that time. The finding of edema showed that the healing was not complete. He agreed that the Kyphoplasty was reasonable treatment. The MRI from June of 2016 showed the fracture had healed, but otherwise it was essentially unchanged from the prior study. He disagreed with the interpretation that the new MRI showed extruded disc fragments at T12-L1. All he saw was a disc/osteophyte, which was no different from the October 2015 MRI. He put no "emphasis whatsoever, on Waddell findings." They were present so he put it down. His "opinions were based on her inconsistency of symptoms in the context of the objective findings." He did not disagree with the AMA guides notation that Waddell signs were not valid in non-Anglo cultures because their reliability was tested only on English and North American patients. He disagreed with the opinions of Dr. Vo and Dr. Yapor recommending prospective treatment and with Dr. Hussain about permanent restrictions.

On redirect examination, Dr. Zelby agreed that he put Dr. Yapor's opinions in his July 27, 2016 report. Petitioner worked for Respondent for three to four weeks prior to the accident. He had no idea what physical tasks required in the job description that she actually performed in that time period. He was a bit incredulous that she could actually lift 100 pounds, but whatever she could do prior to the accident she should be able to do currently. There were no objective findings to suggest Petitioner required any restrictions. Dr. Zelby did not know in what language they communicated, but he is fluent in Spanish.

Conclusions of Law

The Arbitrator found Petitioner proved the stipulated accident on October 5, 2015 caused a condition of ill-being of her lumbar spine but only through July 27, 2016, the date of Dr. Zelby's initial §12 medical examination report. She awarded Petitioner 45 weeks of temporary total disability benefits from October 6, 2015 through August 16, 2016, and 100 weeks of permanent partial disability benefits representing loss of the use of 20% of the person-as-a-whole. She also noted that Respondent paid all medical bills ($106,601.46) and awarded Respondent credit of $9,067.95 in paid temporary total disability benefits.

The Commission agrees with the Arbitrator on the issues of causation and medical expenses. The Arbitrator found that causation ceased as of July 27, 2016, effectively finding Petitioner had reached maximum medical improvement on that date, based on Dr. Zelby's §12 medical examination report. We agree with the Arbitrator that Dr. Zelby was persuasive about Petitioner that she had reached maximum medical improvement based on the objective findings.

In addition, Petitioner's treater Dr. Vo noted on May 2, 2016, that he was not sure why Petitioner was in so much pain given the objective findings. Therefore, we also agree with the Arbitrator that medical benefits should be terminated as of July 27, 2016. Accordingly, the Commission affirms and adopts the Decision of the Arbitrator on the issues of causation, she reached maximum medical improvement as of July 27, 2016, and the Arbitrator's award of medical expenses incurred through July 27, 2016.

The Commission also agrees with the Arbitrator that Petitioner failed to prove her entitlement to temporary partial disability benefits because any loss of income was associated with lost time due to the COVID pandemic and not her disability. However, the Arbitrator awarded temporary total disability benefits through August 16, 2016, the day Petitioner actually returned to work, rather than the date of July 27, 2016, the date she could have returned to work based on the opinion of Dr. Zelby. Therefore, the Commission modifies the Decision of the Arbitrator to award temporary total permanency benefits from October 6, 2015 through July 27, 2016 for a total of 42&1/7 weeks.

In her decision, the Arbitrator noted that she found Petitioner a credible witness. Specifically, she didn't "find any material contradictions that would deem the witness unreliable." Since the Commission acts with the Arbitrator as co-finders of fact, we are cognizant that the Arbitrator actually observed the witnesses and the Commission sees no reason not to accept the Arbitrator's evaluation of Petitioner's credibility/veracity.

As noted above, the Arbitrator awarded Petitioner 100 weeks of permanent partial disability benefits. In addressing the statutory factors we are required to address when awarding permanent partial disability benefits, the Arbitrator stated that Petitioner was 53 years of age at the time of the accident and worked for Respondent part time, but did not ascribe any weight to that factor. She gave "less weight" to potential future earning loss, noting she was not employed at the time of arbitration and conceded that she had not looked for employment since her lay off due to COVID in March of 2020. In assessing the evidence of disability corroborated in the medical records, the Arbitrator briefly summarized her treatment. Thereafter, she wrote:

> "As the Arbitrator has found that Petitioner's lumbar spine condition of ill being after July 27, 2016 is unrelated to the October 5, 2015 work accident, any work restrictions that followed are also unrelated to the work accident. The Arbitrator notes, however, that Petitioner continued to work at Respondent until March 2020, and that as of October 21, 2017, Dr. Hussain noted that Petitioner was performing her job duties without restriction and without problems."

As to her current condition, Petitioner testified that she still used a cane to walk so that she won't injure herself. She uses the cane to brace herself. She took over-the-counter medication for the pain. Her pain was 7/10 without medication, and it is reduced a little (to 6/10) with the medication. It could reach 10/10 without medication. When it was very cold she walked "like

bending down." Her condition had affected how she performed activities of daily living such as bathing/dressing. She had "pain, pain" bending over to dress and "pure pain" while performing household chores such as sweeping. She used to walk an hour or an hour and a half. Now she becomes tired after walking two blocks. In addition, the medical records show ongoing complaints of significant pain which supports her testimony.

In assessing the statutory factors, clearly the Arbitrator relied heavily on Dr. Zelby's opinion about Petitioner's capacity to work without restrictions and the extent of her current condition of ill-being. While we agree that Dr. Zelby is persuasive that Petitioner was at maximum medical improvement as of July 27, 2016, we do not find him as persuasive as to the extent of her current condition of ill-being. In addition, we do not completely concur with the conclusion of the Arbitrator that causation of Petitioner's condition "terminated" as of July 27, 2016, but rather that she reached maximum medical improvement as of that date. Therefore, if she had disability after July 27, 2016, any restrictions and symptoms would still be related to her work-related accident/injury.

We note that while Dr. Zelby opined that she could return to work without any restrictions, her treating doctors kept her on significant work restrictions throughout. They imposed such restrictions even though she was returning to work at a relatively light physically demanding job. In addition, Dr. Zelby totally discounted the radiologist report of a disc fragment at the level she had the Kyphoplasty. In assessing the entire record before us, the Commission finds reasonable a permanent partial disability award of 162.5 weeks of benefits, representing the loss of the use of 32.5% of the person-a-whole.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated June 13, 2023 is hereby modified as specified above and is otherwise affirmed and adopted, and attached hereto and made a part hereof.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay reasonable and necessary medical services related to the injury of October 5, 2015 accident through the date of July 27, 2016, pursuant to §8(a) and subject to the applicable medical fee schedule in §8.2, of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner temporary total disability benefits of $201.51 per week for 42&1/7 weeks, commencing October 6, 2015 through July 27, 2016.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's request for temporary partial disability benefits is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay Petitioner permanent partial disability of $201.51 per week for 162.5 weeks, because the injuries sustained caused the loss of use of 32.5% of the person-as-a-whole, as provided in §8(d)2 of the Act.

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

June 13, 2024
DLS/dw
O-4/10/24
46

/s/*Deborah L. Simpson*
Deborah L. Simpson

/s/*Stephen J. Mathis*
Stephen J. Mathis

/s/*Raychel A. Wesley*
Raychel A. Wesley

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC032515
Case Name	Ma Guadalupe Garcia a/k/a Eliza Hernandez v. Steak N Shake Enterprises, Inc.
Consolidated Cases	
Proceeding Type	
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	13
Decision Issued By	Ana Vazquez, Arbitrator

Petitioner Attorney	Damian Flores
Respondent Attorney	George Klauke

DATE FILED: 6/13/2023

THE INTEREST RATE FOR THE WEEK OF JUNE 13, 2023 5.15%

/s/Ana Vazquez, Arbitrator

Signature

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Ma Guadalupe Garcia a/k/a Eliza Hernandez
Employee/Petitioner

v.

Steak N Shake Enterprises, Inc.
Employer/Respondent

Case # **15** WC **032515**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Ana Vazquez**, Arbitrator of the Commission, in the city of **Chicago**, on **October 26, 2022.** 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. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
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?
☒ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **October 5, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $***714.13*** the average weekly wage was $***201.51***.

On the date of accident, Petitioner was ***53*** years of age, ***married*** with ***-0-*** dependent children.

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

Respondent ***has*** paid all appropriate charges for reasonable and necessary medical services through 7/27/2016.

Respondent shall be given a credit of **$9,067.95** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**9,067.95**.

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

ORDER

The Arbitrator finds that Petitioner's lumbar spine condition was causally related to the October 5, 2015 accident through the date of July 27, 2016, and that the causal relationship of Petitioner's lumbar spine condition ended as of July 27, 2016.

Respondent has paid for all reasonable and necessary medical services related to the injury of October 5, 2015, pursuant to Sections 8(a) and 8.2 of the Act. Bills for medical services provided to Petitioner after July 27, 2016 are denied.

Respondent shall pay Petitioner temporary total disability benefits of **$201.51/week** for **45 weeks**, commencing **October 6, 2015** through **August 16, 2016**, as provided in Section 8(b) of the Act. Petitioner's claim for TPD benefits is denied.

Respondent shall pay Petitioner permanent partial disability benefits of **$201.51/week** for **100 weeks**, because the injuries sustained caused **20% 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.

Ana Vazquez

JUNE 13, 2023

Signature of Arbitrator

PROCEDURAL HISTORY

This matter proceeded to hearing on October 26, 2022 in Chicago, Illinois before Arbitrator Ana Vazquez. The issues in dispute are (1) causal connection, (2) unpaid medical bills, (3) temporary total disability ("TTD") benefits and temporary partial disability ("TPD") benefits, and (4) the nature and extent of Petitioner's claimed injuries. Arbitrator's Exhibit ("Ax") 1. All other issues have been stipulated. Ax1.

FINDINGS OF FACT

Petitioner testified via a Spanish translator. Petitioner testified that on October 5, 2015, she was employed in a food preparation position and as a dishwasher at Respondent. Transcript of Proceedings on Arbitration ("Tr.") at 19-20, 53, 54. Petitioner's job duties in food preparation included cutting tomatoes, lettuce, and other foods. Tr. at 54. Petitioner testified that washing dishes consisted of moving a dish rack through a dishwashing machine. Tr. at 55-56. Petitioner testified that she was on her feet during her entire shift. Tr. at 20.

Petitioner testified that she did not have a history of back pain or back injury prior to her employment at Respondent. Tr. at 21. Petitioner testified that she had not undergone an MRI of her back or injections for her low back prior to her employment at Respondent. Tr. at 21. Petitioner testified that she never missed work due to back pain. Tr. at 21.

Accident

Petitioner testified that on October 5, 2015, while carrying dishes to the dishwasher, she slipped on grease or soap and fell backward landing on her buttocks and hitting her head on hard plastic. Tr. at 22-23. Petitioner testified that she noticed a lot of pain in her back after the fall. Tr. at Tr. at 22-24. Petitioner testified that her manager called for an ambulance after the accident. Tr. at 24.

Medical records summary

The Rosemont Fire Department reported to the scene. Petitioner's Exhibit ("Px") 1. The Rosemont Fire Department record documents a consistent accident history. Px1 at 2. Petitioner complained of low back pain, neck pain, and head pain. She reported nausea that had subsided. Petitioner was transported to Presence Resurrection Medical Center by ambulance.

The records of Presence Resurrection Medical Center reflect a consistent accident history. Px2 at 13. Petitioner was seen by Dr. Wesley Yapor. Petitioner complained of headache, nausea, neck pain, and low back pain. Px2 at 13. Petitioner underwent diagnostic imaging, including an MRI of the lumbar spine which demonstrated an L1 compression fracture. Px2 at 37-38, 58-60. Petitioner was diagnosed with a closed head injury without loss of consciousness, cervical spondylosis, and a traumatic L1 compression fracture. Px2 at 2. Petitioner was not deemed a surgical candidate, and a lumbar Aspen brace and physical therapy were ordered. Px2 at 17. Petitioner was admitted at Presence Resurrection Medical Center through October 9, 2015. Px2 at 3, 5. Petitioner was then transferred to the acute rehabilitation facility within the same hospital and was discharged on October 30, 2015. Px2 at 256-257. While at the rehabilitation facility, Petitioner tolerated three hours of therapy per day. Px2 at 257.

Petitioner followed up with Dr. Yapor at Northwestern Neurological Associates, S.C. on November 10, 2015. Px3 at 1-7. Petitioner reported ongoing back pain. Petitioner had no radicular pain complaints. Px3 at 2. Dr. Yapor's diagnosis was compression fracture of the L1 lumbar vertebra with routine healing. He recommended continued use of a back brace and a repeat MRI in three months. Petitioner was kept off work. Px3 at 17.

Petitioner underwent an MRI of the lumbar spine on February 1, 2016 at Niles Open MRI, Inc. Px3 at 23. The MRI revealed the same compression deformity at the L1 vertebral body that appeared recent and was associated with disc degeneration and disc herniation at T12-L1. Px3 at 23. Petitioner returned to Dr. Yapor on February 9, 2016, at which time Dr. Yapor noted that Petitioner had slight progression of the L1 fracture. Px3 at 8-9. Dr. Yapor referred Petitioner to pain management and kept Petitioner off work. Px8-9, 18.

Petitioner presented to Dr. Hong X. Vo, a pain management physician, at Presence Resurrection Medical Center on February 15, 2016. Px2 at 1243. Dr. Vo documented a consistent accident history and Petitioner's ongoing low back pain. Petitioner denied referred symptoms to the lower extremities. Petitioner described the pain as achy and constant. Dr. Vo's assessment was back pain. He noted that Petitioner's back pain was most likely from the L1 compression fracture after a slip and fall at work in October 2015. Dr. Vo noted that Petitioner had failed multiple conservative treatments and recommended a left paramedian L1-2 epidural steroid injection, physical therapy, and prescription medication. Px2 at 1246. Dr. Vo noted that if Petitioner had no improvement with the epidural steroid injection, he agreed with Dr. Yapor's recommendation of a L1 kyphoplasty. Petitioner was kept off work. Petitioner underwent a left paramedian L1-2 interlaminar epidural steroid injection under fluoroscopic guidance on February 23, 2016. Px2 at 1264-1265. Petitioner again saw Dr. Vo on March 8, 2016, at which time Petitioner reported no significant pain relief following the injection. Px2 at 1291. Petitioner denied referred symptoms to the lower extremity. Dr. Vo's assessment was L1 compression fracture with delayed healing. Dr. Vo did not recommend long-term opioid treatment. Dr. Vo noted that the MRI of February 1, 2016 showed edema at L1, indicating that there was still inflammation from the compression fracture causing pain at that level. Dr. Vo recommended an L1 kyphoplasty to alleviate Petitioner's symptoms Px2 at 1292. Petitioner underwent an L1 kyphoplasty with insertion of bone cement under low pressure on March 14, 2016. Px2 at 1317-1318.

Petitioner followed up with Dr. Vo on May 2, 2016. Px2 at 1381-1384. Dr. Vo noted that Petitioner had completed 18 sessions of physical therapy and had graduated from a walker to a cane. Dr. Vo noted that Petitioner's pain was in the left lower back to the buttock and left upper thigh. Dr. Vo's assessment was L1 compression fracture with delayed healing. Dr. Vo recommended Petitioner continue with physical therapy.

Petitioner participated in 19 sessions of physical therapy at Athletico from March 30, 2016 through May 26, 2016. Px4. The physical therapy record of May 26, 2016 notes that (1) Petitioner demonstrated significant improvement in lower extremity strength, but continued to present with lumbar pain with walking and transferring in and out of bed, (2) Petitioner showed improved tolerance for standing exercises and gait with a single point cane, but required frequent breaks due to increased pain, and (3) Petitioner continued to be limited in lumbar range of motion in all planes due to pain. Petitioner testified that she noticed more pain with physical therapy. Tr. at 29.

Petitioner underwent a lumbar spine MRI on June 9, 2016 at Upright MRI of Deerfield, which demonstrated (1) mild reversal of normal lumbar lordosis, (2) evidence of kyphoplasty on right side of the L1 vertebral body, (3) mild to moderate anterior wedge shape compression fracture of the L1 vertebral body with subtle marrow edema involving the posterosuperior part, with the signal change noted as possibly chronic and related to the work injury on October 5, 2015, (4) thecal sac indentation at T12-L1 due to broad based predominantly central disc bulge associated with focal central disc fragment

extrusion pointing cranio-caudally measuring approximately 5.4mm in anteroposterior and 10.8mm in craniocaudal dimensions and osteophyte, (5) small synovial cyst at L3-4 along the posterior aspect of the left facet joint, and (6) mild bilateral foraminal stenosis at L4-5 on the left side due to broad based disc bulge with osteophyte and facet joint and ligamenta flava hypertrophy. Px3 at 24-25.

Petitioner returned to Dr. Vo on June 13, 2016. Px2 at 1404-1407. Dr. Vo noted that Petitioner's pain was in the middle lower back to the buttock and bilateral upper thigh and shin and was worse when she took a step. Dr. Vo's assessment was unchanged. Dr. Vo noted that the results of the MRI of June 9, 2016 showed a T12-L1 disc fragment extrusion versus a previously reported disc bulge at that level. Dr. Vo questioned whether the T12-L1 disc had worsened and was causing Petitioner's persistent low back pain. Physical therapy was discontinued, and Petitioner was referred to Dr. Yapor for further evaluation.

Petitioner saw Dr. Yapor on June 21, 2016, at which time he noted that the kyphoplasty did not help. Px3 at 10-11. Dr. Yapor noted that Petitioner had a small, extruded disc which was not causing any neural compression, and that Petitioner's follow up MRI showed that the compression fracture had mostly healed. Dr. Yapor noted that the extruded disc was smaller and very thin without compression of any neural structures. He noted that Petitioner did not have any radicular pain. Dr. Yapor's assessment was lumbar compression fracture with routine healing. Dr. Yapor referred Petitioner to Dr. Konowitz for a second opinion and kept Petitioner off work. Px3 at 10-11, 19-20.

Petitioner testified that she had an appointment with Dr. Zelby that was set up by the insurance company on July 27, 2016, and that Dr. Zelby examined her for about five minutes. Tr. at 33-34. Petitioner testified that she did not follow up with Dr. Vo or Dr. Yapor after her appointment with Dr. Zelby because the insurance company would not approve her treatment. Tr. at 34, 58.

On October 6, 2016, Petitioner presented to Dr. Yuan Chen at Top Pain Center for complaints of ongoing low back pain radiating to the side of the left thigh and neck pain. Px5 at 1-3. Petitioner testified that she did not recall who referred her to Dr. Chen. Tr. at 59. On exam, Dr. Chen noted that Petitioner was walking in a stable gait with no significant limping. Tenderness in the cervical and lumbar paraspinal areas and restricted range of motion in both areas were noted. Dr. Chen's assessments were (1) low back pain, (2) other intervertebral disc degeneration, lumbar region, (3) spondylosis without myelopathy or radiculopathy, lumbar region, and (4) spondylosis without myelopathy or radiculopathy, cervical region. Regarding treatment, Dr. Chen noted that since Petitioner had not responded to conservative treatment, he decided to perform a series of lumbar epidural facet steroid injections in the hopes of depositing anti-inflammatory medication into the irritated area to give Petitioner adequate pain relief so that she could tolerate physical therapy and reduce medication dosage. On October 13, 2016, Petitioner underwent bilateral facet joint injections at L3-4, L4-5, and L5-S1. Px5 at 4-5. On November 11, 2016, Petitioner reported moderate pain relief following the October 13, 2016 injections and that she was able to walk without a walker at home. Px5 at 6-7. Petitioner underwent bilateral facet joint injections at L3-4, L4-5, and L5-S1 on November 11, 2016. Px5 at 6-7.

Petitioner participated in 24 sessions of physical therapy at ATI Physical Therapy from November 30, 2016 through January 27, 2017. Px7. The physical therapy record of January 27, 2017 reflects that Petitioner reported feeling better.

Petitioner returned to Dr. Chen on April 3, 2017, at which time Dr. Chen noted that Petitioner suffered from chronic low back pain due to lumbar degenerative disc disease and spondylosis aggravated by a work injury, and that she had responded well to lumbar facet joint injections and physical therapy. Px5 at 8-9. Dr. Chen's assessments were (1) low back pain, (2) other intervertebral disc degeneration, lumbar region, and (3) spondylosis without myelopathy or radiculopathy, lumbar region. Dr. Chen noted that since Petitioner had made significant progress and had been able to tolerate two hours a day of regular duty work, he recommended she increase her work status to four hours a day for the following two weeks. Petitioner was also restricted from lifting more than 20 pounds and was instructed to (1) avoid repetitive or forceful flexion, lateral flexion, extension, and rotation of the lumbar spine, (2) avoid climbing, crawling, and stooping, and (3) take a 10-minute break every hour. On April 17, 2017, Dr. Chen noted that Petitioner had returned to work for four hours a day, and that Petitioner could not tolerate the increased hours of standing and working due to the recurrence of low back pain. Px5 at 9-10. Dr. Chen's assessments were (1) low back pain, (2) other intervertebral disc degeneration, lumbar region, (3) spondylosis without myelopathy or radiculopathy, lumbar region, and (4) myalgia. Dr. Chen instructed Petitioner to reduce her working hours to two hours per day. Px5 at 18. On May 1, 2017, Petitioner followed up with Dr. Chen and underwent bilateral facet joint injections at L3-4, L4-5, and L5-S1. Px5 at 11-12. Petitioner was kept on a two hour a day work restriction, was restricted from lifting more than 20 pounds and was instructed to (1) avoid repetitive or forceful flexion, lateral flexion, extension, and rotation of the lumbar spine, (2) avoid climbing, crawling, and stooping, and (3) take a 10-minute break every hour. Px5 at 17.

Petitioner presented at Northwest Surgical Specialists, P.C. on June 10, 2017 and was seen by Dr. Yasser Hussein. Px6 at 1-2. Petitioner reported that she had been doing reasonably well, had not seen her doctor as her doctor had moved offices, and that she had been without medication. On exam, Dr. Hussein noted a normal gait, decreased range of motion in the lumbar spine with flexion and extension, tenderness to deep palpation of the lumbar spine, and positive bilateral straight leg raises at 90 degrees. Dr. Hussein's assessment was lumbago/lower back pain. Dr. Hussein recommended the use of Voltaren gel 1% and Flexeril. Petitioner's work restrictions were maintained.

Petitioner followed up with Dr. Hussein on October 21, 2017. Px6 at 3-4. Dr. Hussein noted that Petitioner continued to work with restrictions of taking a 10-to-15-minute break every hour, no lifting over 20 pounds, and no bending. He also noted that Petitioner reported that since starting use of Voltaren, the pain had improved significantly. He noted that Petitioner sill had symptoms with activity, but was doing better throughout the day and was able to do her work without any restrictions and without any problem. Petitioner reported her pain as a 4-to-5 out of 10 at its worst with activity. Dr. Hussein's assessment was lower back pain, lumbosacral radiculopathy, and lumbago. Dr. Hussein noted that Petitioner was at maximum medical improvement ("MMI") and was discharged from his care. Dr. Hussein maintained Petitioner's work restrictions. Petitioner testified that she has not seen any doctor for any purpose after October 21, 2017. Tr. at 59.

TTD benefits and TPD benefits

Petitioner testified that she had worked at Respondent for two or four weeks prior to the accident, that she worked part-time at Respondent, and that she worked six hours a day, five days a week. Tr. at 19-20, 54, 64-65. The Parties' stipulated to an average weekly wage of $201.51. Ax1 at No. 5.

Petitioner testified that she returned to work at Respondent in food preparation on August 17, 2016. Tr. at 35, 57-58. Petitioner testified that she returned to work while still using a cane. Tr. at 35. Petitioner testified that after her return to work, she would do the preparation for an hour, and would sit down after. Tr. at 35. Petitioner testified that she was working less hours. Tr. at 36. Petitioner testified that after her return to work, she noticed pain in her low back. Tr. at 36. Petitioner testified that she continued to work with restrictions after seeing Dr. Chen on October 6, 2016. Tr. at 38. Petitioner continued working at Respondent until March 14, 2020. Tr. at 45. Petitioner testified that at that time, the manager told her that they did not have work for her anymore. Tr. at 45. Petitioner agreed that after the Covid-19 pandemic, Respondent shut its dining room and was selling through the drive-thru. Tr. at 67. Petitioner testified that she contacted Respondent to request her job back, and that she was not offered her job back. Tr. at 46. Petitioner testified that she had not returned to work at any other location since March 14, 2020 and that she did not try to work. Tr. at 46. Petitioner testified that she did not look for work anywhere after being laid off by Respondent. Tr. at 62-63. Petitioner testified that at the time of arbitration, she was not working. Tr. at 63.

Petitioner's Current Condition

Petitioner testified that she did not need to lift more than 20 pounds while working at Respondent. Tr. at 67.

Petitioner testified that she still has pain in her low back and continued to use a cane. Tr. at 46-47. Petitioner testified that if she attempts to walk without a cane, she notices increased back pain. Tr. at 47. Petitioner admitted that no doctor had prescribed her a cane. Tr. at 60. Petitioner takes over-the-counter Aleve or Tylenol once or twice a day for her back, and without medication, her pain level is a 7 out of 10 daily. Tr. at 47-48, 60. Petitioner testified that the Aleve and Tylenol help more than the Voltaren gel. Tr. at 77. Petitioner testified that when it is cold, she notices that she walks "like bending down." Tr. at 50. Petitioner testified that she notices pain when bending over to get dressed. Tr. at 50. Petitioner testified that she notices "pure pain" when sweeping. Tr. at 51. Petitioner testified that she notices that she becomes tired and experiences pain when she goes for walks. Tr. at 51.

Testimony of Jamie Blatnik

Jamie Blatnik, Respondent's Division President, testified on Respondent's behalf. Tr. at 80. Ms. Blatnik testified that she had duties over Respondent's Rosemont location, where this claim originated. Tr. at 80. Ms. Blatnik testified that the Covid-19 restrictions in Illinois occurred in March or April of 2020, that Respondent's indoor dining closed on March 17, 2020, and only drive-thru and delivery services were offered. Tr. at 81. Respondent's Rosemont location went from operating 24 hours to operating only during the hours of 10 a.m. and 11 p.m., and as a result there was no longer a third shift. Tr. at 81-82. Ms. Blatnik testified that sales went down significantly at Respondent's Rosemont location, and that there was a reduction in the work force and of work hours. Tr. at 81-82. Ms. Blatnik testified that letters were sent to employees in April 2020 informing them that they had been laid off due to a lack of business. Tr. at 83. Ms. Blatnik testified that a dishwasher would have received a letter, "since everything was outside, meaning delivery or drive-thru, we didn't have dishes, we weren't serving in the dining room…" Tr. at 83.

On cross examination, Ms. Blatnik testified that food preparation was still necessary after the Covid-19 related shut down, but it went down significantly as the amount of food that was sold went down significantly. Tr. at 86. Ms. Blatnik did not know if Petitioner was provided work at Respondent post Covid-19. Tr. at 88. Ms. Blatnik testified that some employees were rehired, all laid off employees had to reapply, and that she did not know if Petitioner had reapplied. Tr. at 88.

Evidence deposition testimony of Respondent's Section 12 examiner, Dr. Andrew Zelby

Dr. Zelby testified by way of evidence deposition taken on October 30, 2019. Rx1. Dr. Zelby testified as to his education and credentials as a board-certified neurosurgeon. Rx1 at 4-5.

Dr. Zelby examined Petitioner on July 27, 2016 and authored a report after his examination. Rx1 at 6. Dr. Zelby reviewed the diagnostic exams of October 5, 2015 and testified that Petitioner sustained a mild L1 compression fracture as a result of the slip and fall on October 5, 2015. Rx1 at 12. Dr. Zelby testified that the MRI of October 5, 2015 showed that the compression fracture was acute. Rx1 at 12. Dr. Zelby testified that he also reviewed the medical records of Dr. Yapor, Dr. Biacotakis, and Dr. Vo. Rx1 at 13-14. Dr. Zelby testified that after his evaluation and review of the records and diagnostic studies, he opined that Petitioner had a wedge compression fracture of the L1 vertebra, and that it was related to the accident of October 5, 2015. Rx1 at 15. Dr. Zelby testified that based on Petitioner's objective medical findings, treatment she had received, and the time elapsed since her injury, there was no medical basis to suggest Petitioner was not safely qualified to return to all of the same job duties that she performed prior to October 5, 2015 without restrictions. Rx1 at 15. Dr. Zelby testified that at the time he examined Petitioner, her reported severity of symptoms was inconsistent with her objective medical findings and natural history of her objective medical condition. Rx1 at 16. Dr. Zelby testified that Petitioner's reported complaints of pain could not be corroborated with any objective medical finding. Rx1 at 16. Dr. Zelby testified that Petitioner required no additional diagnostic studies or further treatment for her spine. Rx1 at 16.

Dr. Zelby examined Petitioner again on February 25, 2019. Rx1 at 16. Dr. Zelby reviewed additional medical records. Rx1 at 17. Dr. Zelby testified that Petitioner's cane appeared to be a prop, as she rested and moved with no pain behaviors during the exam. Rx1 at 18. Dr. Zelby testified that at that time, Petitioner had a healed wedge compression fracture of the L1 vertebra. Rx1 at 22. Dr. Zelby testified that there was no other diagnosis that could be made based on the findings of Petitioner's diagnostic studies. Rx1 at 22. Dr. Zelby testified that Petitioner's pain complaints could not be corroborated with any objective findings, as she had an essentially normal spine exam, normal neurologic exam, a healed compression fracture of the L1, and some mild degeneration in her spine. Rx1 at 22. Dr. Zelby explained that pain from an acute fracture of L1 can be painful but once healed there is not a residual pain and no medical findings to explain Petitioner's reported persistent complaints. Rx1 at 22. Regarding Petitioner's treatment with Dr. Chen, Dr. Zelby testified that once Petitioner had a healed fracture, there was no more treatment to do based on her objective medical condition. Rx1 at 23. Dr. Zelby testified that there was no medical basis for the facet injections and that treatment was not reasonable or necessary irrespective of cause. Rx1 at 23. Dr. Zelby testified that his opinion as to Petitioner's work status was unchanged, and that at that time, Petitioner had been qualified to return to work without restrictions for three years. Rx1 at 23. Dr. Zelby testified that since 2016, there was no medical basis to pursue any

additional directed treatment irrespective of cause and that Petitioner had no condition that was amenable to further directed treatment. Rx1 at 24.

On cross examination, Dr. Zelby testified that pain is associated with a compression fracture, and that there is good healing of the fracture in three to four months and more complete healing in six to eight months. Rx1 at 31. Dr. Zelby testified that he would not expect less than mild stenosis to generate any symptoms besides minor aching and stiffness. Rx1 at 32. Dr. Zelby agreed that the kyphoplasty was reasonable and necessary. Rx1 at 33. Dr. Zelby disagreed that there were extruded disc fragments at T12-L1, and that he saw a disc/osteophyte toward the right on all the studies, and that there was no difference in the studies of June 2016 than those of October 2015. Rx1 at 34. Dr. Zelby testified that if extruded fragments were present at the T12-L1 level, symptoms resulting from that would depend on the degree of compromise from that extrusion. Rx1 at 34. Dr. Zelby disagreed with Dr. Yapor's findings and recommendations for additional treatment as of June 21, 2016. Rx1 at 39. Dr. Zelby disagreed with Dr. Vo's and Dr. Chen's recommendation for ongoing treatment and with Dr. Hussein's recommendation of permanent restrictions. Rx1 at 39.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e). The burden of proof is on a claimant to establish the elements of her right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. *Board of Trustees v. Industrial Commission,* 44 Ill. 2d 214 (1969).

Credibility is the quality of a witness which renders her evidence worthy of belief. It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence and assign weight to witness testimony. *O'Dette v. Industrial Commission*, 79 Ill. 2d 249, 253 (1980); *Hosteny v. Workers' Compensation Commission*, 397 Ill. App. 3d 665, 674 (2009). Where a claimant's testimony is inconsistent with her actual behavior and conduct, the Commission has held that an award cannot stand. *McDonald v. Industrial Commission,* 39 Ill. 2d 396 (1968); *Swift v. Industrial Commission,* 52 Ill. 2d 490 (1972).

In the case at hand, the Arbitrator observed Petitioner's behavior and conduct during the hearing and finds her to be a credible witness. The Arbitrator compared Petitioner's testimony with the totality of the evidence submitted and did not find any material contradictions that would deem the witness unreliable.

Issue F, whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds as follows:

The Arbitrator finds that Petitioner has met her burden of proof that the October 5, 2015 accident caused an injury to the lumbar spine.

The Parties have stipulated to a compensable work accident occurring on October 5, 2015. The records document that Petitioner was transported to Resurrection Medical Center, where she underwent

diagnostic testing, and was diagnosed with and was treated for a compression fracture of the L1 vertebra. Petitioner continued to treat for a compression fracture of the L1 vertebra with Dr. Yapor and Dr. Vo through June 2016. The Arbitrator notes that while there is some indication of other pathology on MRI of the lumbar spine, the records of Dr. Yapor and Dr. Vo do not reflect the diagnosis of or the treatment for any other lumbar spine condition besides the L1 compression fracture. There was also no evidence of lumbar-related radiculopathy documented in Dr. Yapor's or Dr. Vo's records.

Dr. Zelby examined Petitioner on July 27, 2016 and February 25, 2019. He also reviewed Petitioner's treatment records and diagnostic studies in conjunction with his examinations.

Petitioner returned to her regular job duties at Respondent on August 17, 2016.

In October 2016, Petitioner sought treatment with Dr. Chen. Petitioner testified that she did not recall who referred her to Dr. Chen. Dr. Chen diagnosed Petitioner with spondylosis without myelopathy or radiculopathy in the lumbar region, a new diagnosis. Petitioner subsequently underwent multiple facet joint injections at the L3-4, L4-5, and L5-S1 levels. There is no formal causal opinion that Petitioner's delayed symptoms at other levels and treatment for same are related to the October 5, 2015 accident.

Dr. Zelby testified that the diagnostic studies of October 5, 2015 revealed a mild L1 compression fracture as a result of the work accident, and that the fracture had healed. Dr. Zelby also testified that there was no other diagnosis that could be made based on the findings of Petitioner's diagnostic studies. Dr. Zelby testified that as of July 27, 2016, Petitioner required no additional diagnostic studies or treatment. Regarding Petitioner's treatment with Dr. Chen, Dr. Zelby testified that once Petitioner had a healed fracture, no further treatment was necessary based on Petitioner's objective medical condition, and that there was no medical basis for the facet joint injections, which were not reasonable or necessary irrespective of cause. Dr. Zelby opined that Petitioner was at MMI as of July 27, 2016 and could return to work without restrictions as of July 27, 2016.

The Arbitrator finds Dr. Zelby's opinions persuasive. The Arbitrator notes that Dr. Zelby's opinions are consistent with the records of Dr. Yapor and Dr. Vo.

Having considered all the evidence, the Arbitrator finds that Petitioner proved that her lumbar spine condition (specifically, the L1 compression fracture) was related to the October 5, 2015 work accident, but failed to prove that her lumbar spine condition of ill-being and any ongoing need for treatment after July 27, 2016 was related to the October 5, 2015 accident.

Issue J, whether the medical services that were provided to Petitioner were reasonable and necessary and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

Consistent with the Arbitrator's prior findings, the Arbitrator finds that Petitioner's medical treatment was reasonable and necessary through July 27, 2016, and further finds that treatment after July 27, 2016 was not reasonable, necessary, or related to the October 5, 2015 accident.

Petitioner offered Px8 through Px15 at arbitration in support of her claim for unpaid medical bills. Respondent offered Rx2 in support of its dispute of Petitioner's claim. The Arbitrator notes that Px8 and Px15 are for medical services rendered prior to July 27, 2016, and that Rx2 reflects payment of the bills within Px8. Px15 reflects a balance of $0.00 suggesting the bill has been paid.

Bills within Px9 through Px14 are for medical services rendered after July 27, 2016. As the Arbitrator has found that treatment after July 27, 2016 was not reasonable, necessary, or related to the October 5, 2015 accident, Petitioner's claim for unpaid medical bills, as provided in Px9 through Px14, is denied.

Issue K, whether Petitioner is entitled to TTD benefits and TPD benefits, the Arbitrator finds as follows:

The Parties' have stipulated that Petitioner is entitled to TTD benefits from October 6, 2015 through August 16, 2016. Tr. at 10-11. Respondent, however, disputes that TTD benefits are owed to Petitioner, and claims that Petitioner was paid her full salary while off work due to the work injury. Ax1 at No. 8. Petitioner has claimed TPD benefits from August 18, 2016 through October 21, 2017. Ax1, No. 8. Respondent disputes Petitioner's claim for TPD benefits and claims Petitioner was released to full duty and worked. Ax1 at No. 8.

Petitioner offered Px19, which contains the document titled "Employee Earnings Record," or Petitioner's payroll records from Respondent from October 6, 2015 through January 23, 2017. Respondent offered the same document as Rx4 in support of its dispute of Petitioner's claim for TTD benefits. The document reflects that Petitioner received earnings for the claimed TTD benefits period.

Based on the prior findings and the record as a whole, the Arbitrator awards Petitioner TTD benefits from October 6, 2015 through August 16, 2016 and denies Petitioner's claim for TPD benefits.

Issue L, as to the nature and extent of the injury, the Arbitrator finds as follows:

The Arbitrator notes that pursuant to Section 8.1(b) of the Act, permanent partial disability shall be established using five enumerated criteria, with no single factor being the sole determinant of disability. Per 820 ILCS 305/8.1b(b), the criteria to be considered includes: (i) the reported level of impairment pursuant to AMA; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records.

With regard to criterion (i), the Arbitrator notes that an AMA Impairment Rating was not offered, and therefore the Arbitrator assigns no weight to this factor.

With regard to criterion (ii) and criterion (iii), the Arbitrator notes that at the time of the accident, Petitioner was 53 years of age and was employed part time at Respondent in food preparation and as a dishwasher.

With regard to criterion (iv), the Arbitrator notes that there is no evidence of reduced earning capacity in the record. The Arbitrator notes that Dr. Zelby opined that Petitioner was capable of returning to work without restrictions as of July 27, 2016, and that Petitioner returned to work at Respondent in the same capacity on August 17, 2016. While Petitioner testified that she was not working at the time of arbitration, Petitioner conceded that she has not attempted to look for work since being laid off by Respondent in March 2020, due to the Covid-19 pandemic. The Arbitrator assigns less weight to this factor.

With regard to criterion (v), the medical records reflect that following the October 5, 2015 accident, Petitioner suffered from an acute compression fracture of the L1 vertebra, which required Petitioner be admitted at Presence Resurrection Medical Center until October 9, 2015, at which time she was transferred to the hospital's in-patient rehabilitation facility and was discharged on October 30, 2016. Petitioner subsequently underwent a left paramedian L1-2 interlaminar epidural steroid injection on February 23, 2016 and an L1 kyphoplasty on March 14, 2016. Dr. Zelby testified that Petitioner's L1 compression fracture had healed as of July 27, 2016. Petitioner returned to her regular job duties at Respondent on August 17, 2016. As the Arbitrator has found that Petitioner's lumbar spine condition of ill being after July 27, 2016 is unrelated to the October 5, 2015 work accident, any work restrictions that followed are also unrelated to the work accident. The Arbitrator notes, however, that Petitioner continued to work at Respondent until March 2020, and that as of October 21, 2017, Dr. Hussain noted that Petitioner was performing her job duties without restriction and without problems.

Upon consideration of the foregoing evidence and factors, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 20% loss of the person as a whole, pursuant to Section 8(d)2 of the Act.

Ana Vazquez

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ANA VAZQUEZ, ARBITRATOR