ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	12WC016627
Case Name	Peter Olivo v. Sumitomo Electric Carbide
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remand Arbitration
Decision Type	Corrected Decision
Commission Decision Number	22IWCC0268
Number of Pages of Decision	41
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	Vitas Mockaitis
Respondent Attorney	Bradley Brejcha

DATE FILED: 9/27/2022

/s/ Thomas Tyrrell, Commissioner

Signature

22IWCC0268

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Peter Olivo,

Petitioner,

vs. NO: 12 WC 016627

Sumitomo Electric Carbide,

Respondent.

CORRECTED DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of causation, medical expenses, temporary total disability, maintenance, and permanent partial disability ("PPD"), and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below, and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part thereof.

The Commission vacates the Arbitrator's award of permanent partial disability benefits. The Commission remands this matter to the Arbitrator with instructions to order Respondent to provide a vocational assessment pursuant to Section 9110.10(a) of the Rules Governing Practice Before the Commission.

Section 9110.10(a) of the Commission's rules provides as follows:

> "(a) An employer's vocational rehabilitation counselor, in consultation with the injured employee and, if represented, with his or her representative, shall prepare a written assessment of the course of medical care and, if appropriate, vocational rehabilitation required to return the injured worker to employment. The vocational rehabilitation assessment is required when it can be reasonably determined that the injured worker will, as a result of the injury, be unable to resume the regular duties in which he or she was engaged at the time of injury." 50 Ill. Adm. Code 9110.10(a) (2016).

In so finding, the Commission found persuasive the case of *CDW Corp. v. Ill. Workers' Comp. Comm'n*, 2021 IL App (2d) 200562WC-U. In *CDW Corp.,* the Commission found that the claimant's injury "precluded her from returning to her usual and customary occupation." *CDW Corp.*, at P28. Both parties entered opinions from vocational rehabilitation consultants. The Appellate Court noted

that while these experts disagreed on whether a stable labor market existed for the claimant, they were in agreement that the claimant might benefit from vocational rehabilitation. *Id*., at P27.

The Appellate Court concluded, "In Section 9110.10(a), the only condition for a vocational rehabilitation assessment is that the work-related injury rendered the claimant unable to resume her regular duties. The Commission explicitly found that condition to exist. Therefore, a vocational rehabilitation assessment, which was never done in this case, is 'required.'" *Id.*, at P28.

In the instant matter, there is no dispute that Petitioner lacks the physical capacity to return to his former career as a warehouse picker. Both parties entered vocational consultant opinions that Petitioner would be a candidate for vocational rehabilitation services. Therefore, a vocational rehabilitation assessment pursuant to Section 9110.10(a) is required.

The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on April 21, 2021, is modified as stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED that Respondent shall pay reasonable and necessary medical expenses identified in Petitioner's Exhibit 18, subject to §8(a)/§8.2 of the Act. Respondent shall reimburse Medicare to the extent required.

IT IS FURTHER ORDERED that Respondent shall receive a credit of $69,791.05 under Section 8(j) of the Act.

IT IS FURTHER ORDERED that Respondent shall pay to Petitioner temporary total disability benefits of $220.00/week for 327-2/7 weeks, commencing August 10, 2012 through December 18, 2012, and from March 26, 2013 through February 22, 2019, as provided in Section 8(b) of the Act.

IT IS FURTHER ORDERED that Respondent shall pay to Petitioner maintenance benefits of $220.00/week for 55-4/7 weeks, commencing February 23, 2019 through March 17, 2020, as provided under Section 8(a) of the Act.

IT IS FURTHER ORDERED that Respondent shall receive credit of $5,969.85 for temporary total disability benefits paid to Petitioner on account of this injury, and a credit of $25,276.00 for permanent partial disability benefits already paid.

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $53,100.00. 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.

September 27, 2022
o: 5/24/2022
TJT/ahs
51

/s/ *Thomas J. Tyrrell*
Thomas J. Tyrrell

/s/ *Maria E. Portela*
Maria E. Portela

/s/ *Kathryn A. Doerries*
Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	12WC016627
Case Name	OLIVO, PETER v. SUMITOMO ELECTRIC CARBIDE
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Arbitration Decision
Commission Decision Number	
Number of Pages of Decision	37
Decision Issued By	Gerald Napleton, Arbitrator

Petitioner Attorney	CHRISTOPHER MOSE
Respondent Attorney	Bradley Brejcha

DATE FILED: 4/21/2021

INTEREST RATE WEEK OF APRIL 20, 2021 0.04%

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

PETER OLIVO
Employee/Petitioner

v.

SUMITOMO ELECTRIC CARBIDE
Employer/Respondent

Case # **12** WC **16627**

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 **Gerald Napleton**, Arbitrator of the Commission, in the city of **Chicago**, on **October 21, 2020**. 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 **January 25, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$16,770.00**; the average weekly wage was **$322.50**.

On the date of accident, Petitioner was **40** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$5,969.85** for TTD, **$0** for TPD, **$0** for maintenance, and **$25,276.00** for other benefits, for a total credit of **$31,245.85**.

Respondent is entitled to a credit of **$69,791.05** under Section 8(j) of the Act.

ORDER

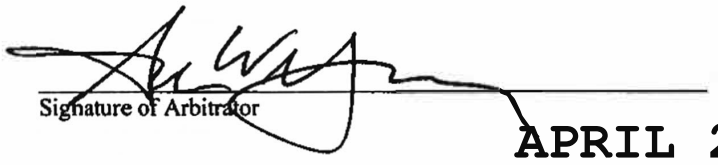
Respondent shall pay to the Petitioner the sum of $220.00 per week for a period of 382 and 6/7 weeks. Respondent shall pay temporary total disability benefits for the period from August 10, 2012 through December 18, 2012 and again from March 26, 2013 through MMI date of February 22, 2019 pursuant to Section 8(b) of the Act and shall also pay maintenance benefits at the TTD rate from February 23, 2019 through March 17, 2020 under Section 8(a) of the Act. Respondent shall receive a credit in the amount of $5,969.85 for TTD amounts previously paid.

Respondent shall pay for the reasonable and necessary medical treatment identified in Petitioner's Exhibit 18 in accordance with the provisions and Medical Fee Schedule of Sections 8(a) and 8.2 of the Act. Respondent is entitled to a credit under Section 8(j) for amounts that have been paid. Respondent shall reimburse Medicare to the extent required as evidenced in Petitioner's Exhibit 18.

Respondent shall pay permanent partial disability benefits of $220.00/week for 250 weeks as the Arbitrator finds that Petitioner sustained a loss of trade and is permanently partially disabled to the extent of 50% loss of use of the person as a whole. Respondent is entitled to a credit of $25,276.00 for PPD advances already paid.

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

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



Signature of Arbitrator

APRIL 21, 2021

PETER OLIVO v. SUMITOMO ELECTRIC CARBIDE
12 WC 16627

ARBITRATOR'S FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner's Testimony and Medical Treatment

The Petitioner testified that he worked for Respondent as a warehouse picker, first as a temporary employee for 10 to 12 months after which he was then hired to work full time. He testified that he had never had any back problems which required medical treatment before January of 2012. Petitioner testified that on January 25, 2012 he was unloading a truck in the warehouse by moving boxes to pallets which were on a forklift. He testified that the forklift driver had positioned the pallet about waist high and when he moved to place a box onto the pallet the forklift driver lowered the forks and the weight of the box of 60 or 65 pounds took him down. He testified that he noticed pain in his low back that progressed into his left side, buttock, hip, calf, and toe.

Petitioner testified that he went home and rested after the accident. He did not work the following day. The following Monday the Respondent directed him to go to the company doctor at Concentra where he was prescribed physical therapy. He continued to have pain in his lower back and pain and numbness in his left leg. Petitioner was referred to Dr. Charles Mercier. Dr. Mercier provided him with two epidural injections and ordered physical therapy. Petitioner testified that the injections helped for "[m]aybe like a few days." Petitioner was working light duty at that time.

Petitioner then sought treatment on his own with Dr. Theodore Fisher at Illinois Bone & Joint Institute. Dr. Fisher recommended surgery and on August 10, 2012 Petitioner underwent an L5-S1 microdiscectomy. Petitioner testified that he was still in pain in his leg and back after the surgery. He was referred for work hardening which he found difficult and testified that his back was still in pain. He did return to work on a light duty basis in December 2012 but testified that he had an episode at work in January 2013 when his left leg buckled causing him to feel unable to move. He was taken to the emergency room at Lutheran General Hospital where he was admitted and kept for the weekend. After he was discharged, he was able to return to work on a light duty basis where he mostly checked orders and boxed items.

Petitioner reported for a Section 12 examination with Dr. Steven Mather in March 2013. Petitioner testified that the exam was uncomfortable and painful for him. He testified that he was honest and cooperative with Dr. Mather, but that Dr. Mather was rude. After he saw Dr. Mather, light duty work was no longer available to Petitioner. Petitioner was not paid workers' compensation benefits at this time.

Dr. Fisher discussed the possibility of a three-level lumbar fusion with Petitioner and this surgery was ultimately performed on September 22, 2013. Petitioner testified that initially the surgery had gone well but there was an issue with the hardware in his back which required Dr. Fisher to perform another surgery to remove hardware. Petitioner then sought pain management treatment at the Health Benefits Pain Management Clinic where he saw multiple doctors.

Petitioner, over several years, underwent epidural injections, nerve blocks, and radiofrequency ablations as well as physical therapy and work-conditioning. Petitioner testified that these procedures only helped a little bit for a few days but then his pain returned. Petitioner also took pain medications such as Norco, Oxycodone, and Topamax.

Dr. Randolph Chang at the Health Benefits Clinic recommended Petitioner have a Spinal Cord Stimulator implanted. Petitioner underwent the implantation and had a trial performed but testified that it did not work well for him. After that, Dr. Chang referred him for a functional capacity evaluation, and this was performed at ATI physical therapy in 2016.

Petitioner continued to see Dr. Fisher who recommended an injection into his left sacroiliac joint. This was performed and provided pain relief for two days. Dr. Fisher then performed a fusion of his left SI joint on August 29, 2017 and Petitioner said that after his surgery he felt a little bit better, but he still had a lot of pain. Another Spinal Cord Stimulator trial was recommended but Petitioner declined because it did not work the first time.

At the request of his attorney, Petitioner saw Dr. Matthew Ross. He also sought treatment with a new doctor, Dr. Sameer Shah at Stellar Pain Management Group. Dr. Shah performed further nerve blocks and nerve ablations which only provided temporary relief. Dr. Shah recommended a trial of a newer model of a Spinal Cord Stimulator which Petitioner agreed to as it was a newer and improved model. This trial was beneficial, and Petitioner had a permanent Spinal Cord Stimulator installed on February 22, 2019. He testified that it helped and has made his life a more comfortable. He has been able to discontinue use of the Norco because of the benefit from the stimulator.

Petitioner testified that his present condition is painful and is a struggle. He has pain in his lower back all the time. Petitioner states the pain in his lower back is on the left side and it shoots down into his buttocks and left hip all the way down his left leg into his toe. He does have good days and bad days. On a good day he can put on his shoes without his back hurting, but this is rare. His uses an assistive device to help put on his socks. Cold weather increases his pain. He has good days in the summer, but the winter is difficult. His pain is worsened by standing and sitting for long periods of time or doing something aggressive like when he's in the shower or goes out walking. He testified that he can stand for about 20 to 25 minutes before his pain becomes severe, that he can sit for 20 minutes or up to a half-hour on a good day, though it does depend on the weather. He felt he could walk for 8 to 10 minutes before needing a break. He has a cane which he uses every day to help him with his balance. Petitioner also testified that his left foot is numb all the time. During his hearing, Petitioner asked to stand and sit at various intervals to get comfortable.

Petitioner further testified that he spends about half of his day lying down in order to relieve the pain. He cannot spend a whole day without laying down and testified that there has not been a day in the last year when he didn't spend some time laying down.

Petitioner underwent a second FCE in 2019 which took place over two days. He acknowledged the FCE findings that he could lift as much as 30 pounds and explained that he does not have a problem with upper body strength. He stated that he could hold a box, but he

could not hold it and walk with it for more than a few seconds because it will put pressure on his lower back.

Petitioner testified that he met with Vocational Counselors Ed Pagella and Ed Rascati. He affirmed that he is a high school graduate and can use a computer and had used the program Lotus Notes before, though it was 20 years ago. He testified that he has no experience with any other programs, including Microsoft programs. At hearing, Petitioner did not remember any recommendations or details for vocational rehabilitation or training with either vocational counselor.

On cross-examination, Petitioner re-iterated that his accident occurred when he was attempting to place a heavy box on a pallet when the forklift driver lowered the pallet causing the weight of the box to pull Petitioner down causing him to injure his back. He felt immediate back pain and dropped everything and stumbled but did not fall. He did not feel radiating symptoms immediately, but they did begin in his right leg and he testified that he told the company doctor about that he had pain in his leg. He continued to work in the six months following the accident on restricted duty, which was primarily checking orders and boxing them. He underwent his first surgery on August 5, 2012 and returned to work on December 19, 2012.

Petitioner was shown Respondent's Exhibit 11, a work-slip dated December 5th, 2012. When compared to the work slip in Dr. Fisher's subpoenaed records two additional boxes of "no standing" and "light duty" were checked off on the slip that was given to the employer. The Petitioner acknowledged that the process for submitting work slips involves giving HR a copy of the work-slip so that they can photocopy it. He denied checking the boxes himself. Petitioner opined that his HR representative may have checked them off. No testimonial evidence from Respondent was offered to confirm or rebut this.

Petitioner continued to work through March 25, 2013 at which time he underwent a Section 12 examination with Dr. Mather. Petitioner testified that he told Dr. Mather that he did have pain in his lower back and leg. He claims to have been unaware of any previously scheduled and missed Section 12 examinations.

Petitioner acknowledged that Dr. Fisher's March 13, 2013 restrictions authorized him to return to work with restrictions of no lifting over 25 pounds or repetitive bending or twisting. Petitioner testified that he did not seek employment within his restrictions at that time and focused on his back getting better. He has not worked since March of 2013.

When Petitioner was asked whether he attempted to find a job in March 2018 after Dr. Fisher had released him for sedentary work with the option to alternate sitting and standing, no lifting over 10 pounds, and no repetitive bending/twisting, Petitioner stated he was unable to go back to work. Around that time, he met with vocational counselor Ed Pagella. He recalled Mr. Pagella asking him to fill out forms but does not recall Mr. Pagella offering to help him find an accommodating employer. He did not recall following up with Mr. Pagella. He was unaware why Mr. Pagella stated that Petitioner was unable to identify prior employers for the past 20 years. The Arbitrator notes he was able to identify three during his testimony. He testified that he worked as a picker for North Shore Supply, a shipping clerk for Safety Kleen, and an

independent contractor and project manager with his sister who flipped houses. He testified that he has not filled out any job applications online, but he did recall calling people for employment and using the library when he needed a computer. Petitioner also testified to previously having some training with the Chicago Regional Council of Carpenters but did not complete the course.

Petitioner did not recall reading the vocational reports from Mr. Rascati which identified a number of potential employment positions. Petitioner acknowledged that he never followed up with Mr. Pagella or Mr. Rascati regarding job leads or vocational training. Petitioner admitted that he currently lives out of his car.

On Redirect examination, the Petitioner acknowledged that he was in some degree of pain and physical distress during the hearing. He explained that he is not taking pain medications because he has the Spinal Cord Stimulator instead of prescriptions from Dr. Shah. Regarding the discrepancy in the work restrictions on the work status note of December 5 2012, Petitioner said normally the doctor's office would fax a work status note to his employer and he would also get one himself and deliver it himself to his employer. He did not recall having any issues with his employer about what his restrictions were. He did go back to work on December 19, 2012 on light duty and didn't recall that he was ever questioned about his restrictions. Nor did he recall ever asking Dr. Fisher to clarify his work restrictions.

Summary of Medical Records

The Arbitrator was provided two bankers' boxes full of medical records. Petitioner's medical treatment begins at Concentra Occupational Medicine on January 30, 2012. At Concentra, Petitioner reported that he was lowering a box to a forklift and he jerked forward with the weight of the box. He used heat on his back and felt better the next day, but the pain returned after performing more lifting. Petitioner denied leg pain and stated that his pain did not radiate. Waddell signs were negative, and Petitioner was prescribed medication, physical therapy and given work restrictions of no lifting over 20 pounds, no prolonged standing or walking longer than tolerated, no bending, and no pushing or pulling over two pounds. X-rays showed degenerative facet sclerosis at L5-S1. Diagnosis was a lumbar and sacral strain.

On February 9th, the Concentra records show that Petitioner reported that his symptoms were improving and described his pain as moderate and dull in the left lumbosacral region and were aggravated by sitting and bending. On exam, he had pain at the L5 paraspinous area and the sciatic area on the left. His restrictions were continued, and he was advised to continue physical therapy. Physical therapy records from February 9th noted decreased lumbar flexion and limits in his ability to lift and the Petitioner reported that he had more pain than he had previously. On February 20th, he reported continued improvement and both work restrictions and physical therapy were continued. On February 27th, he reported that his pain was about the same on both the right and left side with right side pain being greater. No numbness or radiation noted. An MRI was ordered. On March 19th it was reported that his pain was unchanged and focused on the left lumbosacral region which is aggravated by bending or lifting. An MRI was performed on March 15, 2012 and revealed several findings consisting of degenerative discogenic disease between L3-S1, a disc protrusion at L3-L4 with mild facet arthrosis and central canal narrowing, a central disc protrusion at L4-L5 with mild facet arthrosis and central canal narrowing, and a

posterior 3mm disk bulge at L5-S1 with a superimposed left paracentral disk extrusion with left subarticular encroachment. Petitioner was referred to Dr. Charles Mercier for an orthopedic spinal consultation.

Petitioner saw Dr. Mercier, an orthopedic surgeon and specialist, on March 22, 2012. During the examination, Dr. Mercier noted pain at L5 upon extension. Dr. Mercier diagnosed Petitioner with a herniated disk at L5-S1 (center and left). Dr. Mercier recommended and performed a caudal epidural steroid injection on April 5, 2012 using fluoroscopy with an epidurogram and then performed a second a second epidural on May 11, 2012. Petitioner did not improve much after the injections and wanted to consider surgery.

Petitioner sought treatment with Dr. Theodore Fisher at Illinois Bone and Joint Institute on June 14, 2012. Dr. Fisher noted that Petitioner complained of left-sided low back pain which began with his injury while working for Respondent and which had persisted since that time. Dr. Fisher noted Petitioner had never had any back problems before this. Petitioner reported occasional episodes of numbness which extended to the toes of his left foot and last for approximately an hour but resolve when he walks. The doctor noted that Petitioner had been in physical therapy and had two prior epidural injections, the first providing relief for two weeks while the second was unhelpful. On exam, Dr. Fisher noted tenderness to palpation, pain with forward flexion which was relieved by extension. Dr. Fisher stated that the previous MRI revealed a broad-based herniation at L5-S1 with a large left paracentral component displacing the nerve root. Because of a positive response to the first epidural, Dr. Fisher recommended a left L5-S1 microdiscectomy. Dr. Fisher later had an occasion to review this MRI and noted that the herniation at L5-S1 could be seen displacing the transversing nerve root, and there was also a broad-based central disc herniation at L4-5 and an annular tear at L3-4.

Petitioner wished to proceed with surgery and underwent his first surgery on August 10, 2012 with Dr. Fisher. This surgery consisted of a left-sided L5-S1 hemilaminotomy, foraminotomy, needle facetectomy and microdiscectomy. Following surgery, Petitioner followed up with Dr. Fisher in August and again in September. He reported soreness in his lower back but did not complain of any radicular symptoms. He was able to walk three miles every other day for exercise. Dr. Fisher prescribed physical therapy and released him to work on a light duty basis. He began physical therapy on October 2, 2012 with United Rehab Providers. On November 1, 2012, Petitioner saw Dr. Fisher and reported that he would occasionally experience numbness in the lateral aspect of his left leg and rated his pain between 0/10 and 6/10. On exam, Dr. Fisher noted that straight leg raising produced slight numbness in the left leg. He recommended that Petitioner transition to a work conditioning program.

On December 5, 2012, Dr. Fisher noted that Petitioner had been in work conditioning and experienced a significant exacerbation of his symptoms. He was experiencing severe back pain from 5/10 to 10/10 and numbness and tingling in both legs, worse in the left than the right, and extending to the left foot and toes and occasionally to the right foot. On exam, Dr. Fisher noted reduced range of motion and decreased sensation in both thighs, the lateral left leg, the sole of the left foot and all his toes. A straight leg test was positive on the left and negative on the right. Dr. Fisher recommended an MRI with gadolinium and a Medrol Dosepak. The records from physical therapy on December 6, 2012 note that Petitioner was reporting increased back pain. Dr.

Fisher's records from December 5, 2012 show that the Petitioner was given work restrictions of no lifting over 40 pounds with no repetitive bending, twisting, or lifting.

An MRI was performed at St. Joseph Hospital on December 10, 2012 which showed mild annular bulging suggestive of an annular tear at L3-4, diffuse annular bulging at L4-5 with left lateralization that resulted in mild narrowing of the neural foramen, and at L5-S1 there was diffuse annular bulging with a suggestion of an annular tear and which resulted in mild bilateral foraminal stenosis. The MRI results were suggestive for paraspinal muscle strain, and myositis could not be excluded. Petitioner saw Dr. Fisher again on January 16, 2013. Dr. Fisher noted the MRI showed scar tissue at the left L5-S1 surgical site and disc herniations at L3-4 and L4-5, with an annular tear at L3-4 and at L4-5 the herniation had a left paracentral component. Dr. Fisher recommended an epidural injection and allowed Petitioner to work on a light duty basis of no lifting over 25 pounds, and no repetitive bending, twisting, or lifting. Dr. Fisher also suggested changing positions from sitting to standing every thirty minutes.

On January 17, 2013, Petitioner sought treatment at the emergency room of Lutheran General Hospital complaining of low back pain which radiated down to his toes. Petitioner reported he had been in physical therapy following surgery and was at work that day when his legs buckled and he was unable to ambulate. His co-workers helped him to a taxi and the taxi brought him to the emergency room. He also complained of numbness and tingling in his legs. He was admitted to the hospital and an MRI was performed. The radiologist noted the findings were limited due to motion. He opined that it showed degenerative disc disease at L3-4 and L4-5 with a diffuse disc bulge centrally located at L4-5 along with a prominent disc protrusion resulting in spinal stenosis. Petitioner was diagnosed with an acute-on-chronic exacerbation of low back pain due to lumbar disc disease and was prescribed a Medrol Dosepak and Norco. Petitioner requested an off-work slip for Monday January 21, 2013 but was given work restrictions of no lifting greater than 10 pounds.

On January 28, 2013, Petitioner underwent another epidural steroid injection at L4-5 and a repeat injection was provided on February 11, 2013. On March 13th, Dr. Fisher noted that Petitioner reported that the first injection did not help at all and the second one helped for one day only. He continued to report severe low back pain and decreased sensation to both feet and 1st toes. Dr. Fisher reviewed the MRI from December 10, 2012 and noted it showed evidence of the prior hemilaminectomy and discectomy at L5-S1, a broad based herniation at L4-5 which resulted in bilateral subarticular stenosis, left greater than right, and at L3-4 there was an annular tear and disc desiccation with loss of disc height. Dr. Fisher and Petitioner discussed the possibility of lumbar fusion and Dr. Fisher requested a lumbar discogram to evaluate whether he was a candidate for fusion.

On March 22, 2013 Petitioner underwent a discogram with Dr. Anas Alzoobi. At L4-5, the pressure was 60 psi and noted significant extravasation laterally to the left side and was concordant for Petitioner's every day pain. At L5-S1 the psi was 130 and this was concordant for everyday pain. At L3-L4 the pressure was 55 psi and was concordant for everyday pain. At L2-3 the pressure was 102 psi and was not concordant for everyday pain. The administrator therefore concluded this was positive L3-4, L4-5, and L5-S1 though negative at L2-3. A post-discogram CT scan was also performed and this showed that at L3-4 there was a disc bulge which resulted

in bilateral foraminal stenosis with the contrast from the discogram reaching the outer margin of the annulus possibly representing a full thickness tear of the annulus. The CT also showed at L4-5 a posterior-lateral left side bulge of the disc associated with mild spinal canal stenosis, mild foraminal stenosis on the right and moderate foraminal stenosis on the left with the contrast material again reaching the outer margins of the annulus suggesting a full thickness tear of the annulus. At L5-S1 a posterior disc bulge was seen as well as a soft tissue density on the left side, which was considered to be either extruded disc material or scar tissue from the previous surgery, and the contrast material from the discogram was again seen to be suggestive of an annular tear. The results of the exam indicated possible levels of discogenic disease and a failed laminectomy at L5-S1. The deposition testimonies of Drs. Fisher, Ross, and Mather note some level of disagreement on the exam's findings and validity.

Respondent had Petitioner examined pursuant to Section 12 by Dr. Steven Mather on March 27, 2013. His report is mislabeled as March 27, 2012 and should read 2013. Dr. Mather's report stated that he reviewed the MRIs of December 10, 2012 and January 17, 2013 and noted several mild objective findings. Dr. Mather stated that Petitioner showed several positive Waddell signs and it was "poor judgement" to offer a lumbar fusion and that performing a lumbar fusion based upon a discogram does not offer good results. He also opined that the discogram was not properly done because a discogram should not be pressurized to above 50 psi and this therefore invalidated the test. He concluded that Mr. Olivo's medical history, physical exam, and diagnostic testing did not correlate with each other which he felt indicated symptom magnification or functional overlay. He concluded that Mr. Olivo had sustained a lumbar sprain and could return to work without restrictions and did not require surgery. Dr. Mather's testimony is discussed in greater detail below.

When Petitioner returned to see Dr. Fisher on April 18, 2013, Dr. Fisher noted the discogram had shown concordant pain at the levels L3-S1 with disconcordant pain at L2-3. He noted the post-operative CT scan (mis-labeled an MRI) showed scar tissue on the left at L5-S1 from the prior surgery, and also showed disc herniations at L3-4 and L4-5 with a left paracentral component at L4-5 and an annular tear at L3-4. Based upon these findings and upon Mr. Olivo's reports of difficulties with activities of daily living, Dr. Fisher suggested that Petitioner undergo a lumbar fusion from L3 to S1.

Respondent had Dr. Mather issue an addendum to his Section 12 report on May 17, 2013. Dr. Mather stated that he reviewed the actual film of the MRI from March 15, 2012 and he opined it showed small central disc bulges that were noncompressive, He stated that patients without compression on nerve roots will not improve with a discectomy.

On August 15, 2013, Dr. Fisher noted that Petitioner continued to complain of severe lower back pain which was worse with activity. He had difficulty with sitting and standing, difficulty rising from the toilet, pain with sleeping and occasional radicular symptoms bilaterally going down his posterior thighs and legs to his feet. He walked with an antalgic gait and range of motion testing increased low back pain. Based upon MRI studies and CT scan taken after the discogram, Dr. Fisher concluded that Petitioner had disc herniations at L3-4 and L4-5 as well as post-laminectomy syndrome at L5-S1. Petitioner desired to move forward with surgical intervention.

On September 23, 2013 Dr. Fisher performed a 3-level microdiscectomy and interbody fusion from L3 to S1. After surgery, Petitioner reported significant improvement of his back pain with complete resolution of his right leg symptoms but reported continued numbness in his left foot and toe.

Petitioner began physical therapy at St. Elizabeth and St. Mary's Medical Center on December 17, 2013. Petitioner continued his physical therapy through January 31, 2014. He was re-evaluated on January 15th and January 31st and on both occasions found to have 60% impaired sensation to light touch.

On January 17, 2014, Petitioner was re-evaluated by Dr. Fisher and reported that his pre-operative severe pain had resolved along with his radicular pain in the right leg. He continued to experience radicular pain and numbness in the left leg, however, that extended to his left foot and toes. He also reported weakness in the left leg after walking. Dr. Fisher ordered continued physical therapy and Norco on a p.r.n. basis.

Respondent had Dr. Mather perform another Section 12 examination on February 27, 2014. Dr. Mather noted that Petitioner reported pain across his lower back that went into his left buttock, left lateral and anterior thigh and the medial aspect of his left foot. He reported that he needed his fiancé's help to put on his socks and shoes and could only drive for very short distances. During his exam, Dr. Mather noted that Petitioner was seated comfortably but on standing had limited range of motion limited by complaints of pain. Dr. Mather noted diminished reflexes at the left knee compared to the right, and that Petitioner could distinguish between sharp and dull sensation in the left dermatome despite his complaints of numbness. Petitioner reported he could not heel to toe walk because he was too weak and could not feel his feet. Dr. Mather reported that X rays taken in his office show that the screws at S1 were loose and did not engage the anterior cortex and no fusion was seen anywhere and the cages at L4-5 and L5-S1 were retropulsed. Dr. Mather recommended further surgery to revise the instrumentation and the cages and criticized the prior decision to proceed with fusion. He re-iterated his opinion that Petitioner's current condition was not causally related to his work injury as Mr. Olivo did not need his original surgery.

On February 27, 2014, Petitioner saw Dr. Fisher as well and reported continued back pain and radicular symptoms. X-rays taken showed that the spacer which had been placed at L5-S1 had moved to the right side, which was the asymptomatic side. Dr. Fisher prescribed a CT-myelogram to evaluate the screws, the position of the spacer and the fusion mass. This CT was performed on February 28, 2014 and showed the pedicle screws at L5 and S1 had loosened and caused some bony erosion and the spacer at L5-S1 had displaced. Dr. Fisher believed there was a solid fusion from L3 to S1 in the posterolateral gutters but that the interbody spacers had retropulsed slightly and were most likely causing nerve root irritation which produced symptoms in his lower extremities. Petitioner reported that his back was feeling better, but his main problem continued to be radicular symptoms in his left leg. On March 3, 2014, Dr. Fisher recommended surgery to remove the hardware.

On March 25, 2014, Dr. Fisher performed surgery removing the pedicle screws and removed the interbody spacers at L4-5 and L5-S1. Dr. Fisher explored the fusion and found it to be contiguous and without gross motion. On April 2, 2014, Dr. Fisher explained to Petitioner that he did not address the L3-4 and L4-5 levels in the first surgery because he wanted to have the smallest surgery possible and thus operated only at L5-S1.

Respondent had Dr. Mather issue another Section 12 report on April 29, 2014. Dr. Mather criticized Dr. Fisher's statement that he did not operate on Petitioner's L4-5 disc space in the first surgery because he wanted to perform the smallest surgery possible. Dr. Mather characterized this as a poor explanation because "one- and two-level discectomies" are done as in an out-patient setting anyway. Dr. Mather re-iterated his previous opinions that Petitioner's condition is not causally related to his injury because he stated the original MRI showed a non-compressive disc and because the lumbar fusion should not have been performed.

The records of Presence St. Joseph Hospital in Elgin show Petitioner began physical therapy on May 6, 2014. On May 27, 2014, Dr. Fisher noted that Petitioner reported back pain in the area of L5-S1 and increased numbness in his left leg with increased activity. On exam, Dr. Fisher noted decreased range of motion, difficulty bending, and decreased sensation to the left anterolateral leg, foot, and great toe. Dr. Fisher ordered an MRI in anticipation of an epidural injection.

An MRI was performed on May 29, 2014, which revealed post-operative changes from L3 to S1 with areas of enhancing signal which gave rise to a differential diagnosis of post-surgical granulation changes or infectious etiology. There was a suspected large posterior soft tissue seroma which extended into the left anterolateral recess of L3-4 and right anterolateral recess of L5-S1. Dr. Fisher stated the seroma which the radiologist observed was more likely a cerebrospinal fluid collection which resulted from a dural tear at the time of surgery. Dr. Fisher prescribed physical therapy which Petitioner continued at Presence St. Joseph Hospital on July 25, 2014 and through September 26, 2014. It was noted that Petitioner was moving residences and would continue therapy elsewhere. He described his pain as 8/10 and was still limited in activity. He had not met objective goals of walking 200 feet without weight shifting or rising from a chair without pain. A repeat MRI on August 5, 2014 showed a decrease in the seroma and surrounding edema and fluid at L4-5 and L5-S1.

Petitioner then began therapy at St. Joseph Hospital in Elgin on October 8, 2014 upon the referral of Dr. Fisher. Petitioner described previous electrical stimulation had been helpful. It was noted that he had decreased range of motion in all ranges and decreased strength as well.

On October 27, 2014, Petitioner followed up with Dr. Fisher where he reported moderate low back pain on the left side and an examination discovered decreased sensation to the L5 nerve distribution. He was taking Ibuprofen and Norco. X rays showed a contiguous bone between the transverse processes at L3-4 and L4-5 and extension-flexion films showed no gross motion. Dr. Fisher prescribed Cymbalta, an exercise program and a further lumbar MRI. The MRI was performed on November 7, 2014 which showed post-surgical changes and a possible seroma in the soft tissues of the posterior to the spinal canal at L4 and L5.

On November 19, 2014, Petitioner reported an increase in back pain and continued radicular symptoms into his left leg. Petitioner reported that he had completed physical therapy but that the exercises had increased his pain. Dr. Fisher noted he had reviewed the MRI from November 7, 2014 and noted a fluid collection near L4 and L5 where the spinous processes and lamina had been resected during surgery and also the presence of scar tissue near the left L5 nerve root. Dr. Fisher recommended a home exercise program, weight loss, and referred him to pain management for aspiration of the fluid collection.

On December 17, 2014, Dr. Fisher noted that Petitioner reported his symptoms were unchanged and that he still had numbness in the left posterolateral thigh, leg, dorsum of foot and great toe. Dr. Fisher recommended a CT-myelogram study in order to evaluate fusion and evaluate the fluid collection seen on the MRI with the possibility of aspiration in the future.

On January 23, 2015, Dr. Fisher noted that the CT-myelogram showed a fluid collection which was likely a seroma and that there was solid fusion at L3-4 and L5-S1, with a less solid fusion at L4-5 which did appear to be fused. He further noted that the CT scan revealed degenerative changes in the SI joints. Petitioner's main complaints were pain over the left side and some tingling in the left posterolateral thigh, lateral leg, dorsum of foot, and first 3 toes. Petitioner reported that his pain was 9/10 without Norco but was 4/10 after. On exam, Dr. Fisher noted Petitioner had decreased sensation of first 3 toes and a positive FABER test of the left SI joint with positive compression and positive posterior thigh thrust. Dr. Fisher diagnosed left sacroiliitis and recommended further exercise and weight loss as well as an injection into his left SI joint.

Petitioner underwent a lumbar/sacral/coccyx epidural steroid injection on February 9, 2015 by Dr. Jay Kiokemeister. When Petitioner saw Dr. Kiokemeister on February 16th, he reported he had little to no pain immediately after the procedure, but his pain returned over the next several days. This pain tended to be localized to the left SI joint with slight radiation to the lateral aspect of his left leg.

On March 2, 2015, Dr. Fisher noted that Petitioner reported the SI injection had eliminated his pain for an hour, but the pain had returned and worsened. Petitioner complained of continued left-sided low back pain and radiculopathy in the left leg extending to the first and second toes on the left. Dr. Fisher recommended a nerve ablation to the SI joint, with the possibility of a percutaneous fusion and spinal cord stimulator in the future.

On March 9, 2015, Dr. Kiokemeister referred Petitioner to see Dr. Alzoobi for consideration of the medial branch black and radiofrequency ablation which had been recommended by Dr. Fisher. Dr. Alzoobi performed the facet injections at L3-4, L4-5, and L5-S1 on April 23, 201. Petitioner reported improvement but it was temporary. Given the lack of benefit, Dr. Alzoobi concluded on June 11, 2015 that radiofrequency was not an option. He noted that Petitioner was waiting for an EMG and would decide the next step after that was performed. The EMG was done on June 19, 2015 and revealed a left L4-S1 nerve root/disc syndrome. Dr. Alzoobi concluded that a spinal cord stimulator would be an option along with any further surgical intervention that Dr. Fisher recommends. When Petitioner returned to see

Dr. Alzoobi on July 23, 2015, Dr. Alzoobi discussed a spinal cord stimulator again but noted he was leaving that clinic and Petitioner would have to address it with a new physician.

Respondent had Petitioner examined pursuant to Section 12 again by Dr. Steven Mather on April 30, 2015. Dr. Mather noted that Petitioner described the starting point of his pain as the left lumbosacral area, and Dr. Mather commented that it did not appear to start over the SI joint. He noted that Petitioner again exhibited limited range of motion on exam. Petitioner was able to heel to toe walk though there was slight weakness of the left foot dorsiflexors. He had numbness in the left L4 dermatome and reflexes were essentially absent in the left knee. Dr. Mather felt he had a positive straight leg raising on the left and hip range of motion was full and painless. Waddell signs were negative. Dr. Mather had X rays performed in his office and opined that they showed motion on flexion-extension views and a spondylosis on the left side at L4. He opined there was essentially no posterolateral fusion bone present from L4 to S1 and no interbody bone. Dr. Mather concluded that Petitioner had persistent left L4 radiculopathy and a non-union of his fusion from L4 to S1. He requested a CT myelogram be performed to further evaluate it and opined that Petitioner required another fusion at L4-5 and L5-S1.

Dr. Mather issued another report on June 13, 2015. In this report, Dr. Mather repeated his prior opinions that Petitioner's condition lack of fusion was not related to his work injury on January 25, 2012.

Petitioner was re-evaluated by Dr. Fisher on July 29, 2015. Dr. Fisher observed that the point of maximum pain was over Petitioner's left SI joint and that provocative tests for the SI joint (FABER, thigh thrust, compression and distraction) all reproduced increased pain centered at the left SI joint. Straight leg raising was negative and the patella reflex was diminished on the left. Based upon his findings and the reported relief after the SI injection, Dr. Fisher recommended a radiofrequency ablation to the nerves at the SI joint which he felt also might benefit the L5 radicular symptoms because the L5 nerve root moves anteriorly to SI joint itself.

Dr. Fisher also reviewed the report from Dr. Mather and specifically disagreed with Dr. Mather's opinion that there was a non-union of the lumbar fusion because Dr. Fisher had specifically tested the fusion during the surgery on March 25, 2014 and found it to contiguous and had no motion when he stressed it. Further, Dr. Mather stated that flexion and extension X-Rays did not show any motion, and CT scans performed on 12/24/14 showed a solid fusion from L4 through S1. Dr. Fisher further pointed out that an MRI taken seven weeks after the accident revealed a disc herniation extending behind the body of L5 and it can be seen displacing the S1 nerve root. He noted that this was consistent with the initial presentation of back pain, left lower extremity radiculopathy and gastroc-soleus weakness in the left S1 distribution and that his symptoms were present from the time of injury up through the date of his first surgery. This was inconsistent with Dr. Mather's belief that Petitioner had only sustained a sprain. Therefore, Dr. Fisher concluded, based upon a reasonable degree of medical certainty, that the Petitioner's injury caused a disc herniation at L5-S1 and that his current condition is a direct result of that. He further opined that a large portion of Petitioner's current symptoms were coming from the SI joint which was most likely secondary to increased forces from his L3-S1 fusion onto the SI joint.

Petitioner's care at the Health Benefits Pain Management Clinic (formerly by Dr. Alzoobi) was then taken over by Dr. Randolph Chang on September 18, 2015. Dr. Chang noted that Petitioner stated that the lumbar fusion and the subsequent injections had provided short term pain relief, but his pain had returned. Petitioner reported taking Norco four times per day along with Ibuprofen. Dr. Chang noted that Petitioner walked with an antalgic gait, could walk on his heels and toes with pain, and was tender to palpation at the sacroiliac joints. Range of motion to lumbar spine was limited to 50%. Dr. Chang recommended Petitioner undergo a spinal cord stimulator trial and to start Lyrica.

In his follow up four weeks later, Dr. Chang noted that Petitioner was still waiting for approval of a spinal cord stimulator and had could not tolerate Lyrica nor could he tolerate Neurontin or Mobic. Dr. Chang performed a spinal cord stimulator trial on February 5, 2016 but the Petitioner did not report good pain relief. Dr. Chang therefore recommended on February 11th that he undergo a diagnostic medial branch nerve block to the lumbar facet joints from L2 through L5 on the left side under C-arm guidance. This was performed on March 10, 2016 and was repeated on April 8, 2016.

In his follow up appointment on April 21st, 2016, Petitioner reported that he had significant relief from these nerve blocks. Dr. Chang therefore prescribed radiofrequency ablations to be done at the facet joints from L2 through L5 on the left side. During a follow up visit on May 19, 2016, Dr. Chang noted that Petitioner still reported pain which fluctuated with the weather but there was some overall improvement.

On June 16, 2016, Dr. Chang remarked that Petitioner had exhausted all of the interventional treatments which could be done and was being maintained by medications and therefore concluded he was at MMI. Petitioner continued to see Dr. Chang for prescriptions and on September 29, 2016 he prescribed a Functional Capacity Evaluation.

Petitioner underwent a Functional Capacity Evaluation on October 24, 2016 at ATI. Petitioner demonstrated that he was able to occasionally lift 39 lbs. above his head, occasionally lift 23.6 lbs. from desk to chair, occasionally lift 19.2 lbs. from chair to floor, and occasionally carry 37 lbs. It was further observed that he could sit for only 15 minutes duration, up to a total of 1 to 2 hours per day, stand for 20 minutes duration up to a total of 1 to 2 hours per day and walk short distances occasionally for a total of 2 to 3 hours per day. Petitioner was found to make a good effort and the results were considered valid. The therapist noted that Petitioner reported that Petitioner reported increased lower back and left leg pain at that time.

On December 8, 2016, Petitioner saw Dr. Darrel Saldanha at Midwest Anesthesia and Pain Specialists for pain management. He reported pain shooting from his left low back down his left hip and the side of his left thigh and into his big toe. The pain was worse with walking and better with Norco and Topamax. On exam, Dr. Saldanha noted a negative straight leg exam and no sensory deficits. Facet loading did reproduce Petitioner's pain, there was tenderness to paraspinal muscles and the SI joints, and Patrick's test was positive at the left SI joint and negative on the right. He reviewed the CT scan from December 24, 2014 and diagnosed lumbar radiculopathy, post-laminectomy syndrome, spondylosis, spinal stenosis, chronic pain syndrome, and sacroiliitis which were secondary to his accident of January 25, 2012.

Dr. Saldanha recommended an injection into Petitioner's left SI joint and on January 6, 2017, Dr. Saldanha performed a left-sided intraarticular Sacroiliac Joint injection. Petitioner later reported that the injection provided 90% reduction in his pain for about two days and then the pain returned. Dr. Saldanha referred Petitioner back to Dr. Fisher for further evaluation, though Petitioner's medications continued to be monitored and prescribed by the doctors at the Centers for Pain Control.

On February 16, 2017, Dr. Fisher noted that Petitioner continued to report radicular symptoms with a band like sensation into the left great toe but that his chief complaint was pain in the left posterior sacroiliac spine. He had undergone a spinal cord stimulator trial which did not help. He had an injection into the SI joint which eliminated his pain for 2 days. On exam, Dr. Fisher noted that Petitioner indicated the area over his left SI joint was the area of his maximum pain. Dr. Fisher performed provocative testing of the SI joint with FABER, thigh thrust, compression and distraction and all reproduced pain centered on the left SI joint. X rays taken that day showed subchondral sclerosis in the inferior two-thirds of the SI joint. Dr. Fisher recommended a percutaneous fusion of Petitioner's left SI joint.

Respondent had Petitioner examined pursuant to Section 12 again by Dr. Mather on May 20, 2017. Dr. Mather had X-Rays taken in his office and described them as showing the prior fusion at L4-5 and L5-S1 as "indistinct." He continued to opine that there was a non-union at L4-5 and L5-S1. He dismissed the diagnosis of a SI joint dysfunction as a "subjective" opinion by a physician "who wants to do surgery." He further noted that the Petitioner reported significant relief when the facet joints were injected and only got partial relief from the original sacroiliac block. Dr. Mather again recommended another CT scan be performed to evaluate Petitioner's fusion.

A CT scan on July 11, 2017 of Petitioner's pelvis showed some bony irregularity about the endplates of L4-5 and L5-S1 with calcified appearance of the discs with lack of complete fusion with screw tracts visualized in the sacrum and within L5 and significant irregularity. Hypertrophy of L4 and L5 posterior elements, and a cystic mass/collection of fluid at L4-5 and L5-S1 extending posteriorly into the laminectomy defect and paraspinal muscles was also seen.

On July 14, 2017, Dr. Fisher noted that Petitioner wanted to move forward with a fusion of the SI joint. He reviewed the CT scan and noted a solid fusion at L5-S1 and copious bone growth at L4-5 though it was difficult to tell if there was bridging. Dr. Fisher noted the questions from Dr. Mather regarding fusion versus non-fusion and agreed to order another CT scan. Petitioner next had an MRI on July 31, 2017 which showed moderate L4-5 stenosis with a left-sided protrusion and L5-S1 right-sided protrusion with moderate stenosis, along with a post-operative seroma. On August 14, 2017, a CT scan of Petitioner's pelvis showed a complete fusion at L4-5 and a sub-total fusion at L3-4 and L5-S1 along with multilevel facet arthropathy, and a posterior paraspinal seroma.

At an office visit with Dr. Fisher on August 18, 2017, Dr. Fisher noted that Petitioner localized his pain in the area over the left SI joint and that he had experienced relief of his symptoms for 48 hours after he had an injection into the SI joint. On exam, Dr. Fisher noted tenderness over this PSIS and a positive FABER maneuver. Dr. Fisher noted previous testing

was also consistent with sacroiliitis. Dr. Fisher noted a questionable lucent line present on at L4-5 on the CT scan but felt that the lack of motion on flexion-extension X rays meant a good chance of L4-5 fusion. Considering the prior success of the injection into the SI joint, Dr. Fisher diagnosed sacroiliitis and recommended a fusion of the SI joint.

On August 29, 2017, Dr. Fisher performed a surgical fusion of the left SI joint. On October 11th, Petitioner was evaluated and informed Dr. Fisher he was doing better in that his radicular symptoms were intermittent and his back pain was slightly improved though he continued to have a significant amount of back pain. On exam, Dr. Fisher noted an antalgic gait and slow, methodical movements with noticeable discomfort.

On November 27, 2017, Petitioner told Dr. Fisher that his symptoms had significantly improved after the fusion of his SI joint and that his pre-operative pain and the "band like" feeling to his left great toe had completely resolved, though he still had residual numbness in his left foot and some back pain as he was being weaned off of his medications. Petitioner saw Dr. Saldanha on January 3, 2018. Dr. Saldanha prescribed Percocet though he noted the cold weather was causing increased pain. Dr. Saldanha noted that Petitioner had previously undergone a trial of a Spinal Cord Stimulator from Medtronic in 2016 which didn't give good coverage, and the doctor noted that it was an older model and a trial of a newer system would be warranted.

On January 11, 2018 the Petitioner was examined by Dr. Matthew Ross at Petitioner's request under Section 12. Dr. Ross opined that Petitioner's lumbar and sacroiliac complaints were related to his initial injury and that the medical treatment to date had been reasonable and necessary. His report and testimony are discussed in greater detail below.

On January 24, 2018, Dr. Fisher re-evaluated Petitioner who reported back pain primarily in the left buttock. Dr. Fisher noted that the CT scan showed a bridging osteophyte but did not ensure completely the fusion was solid, though Dr. Fisher noted that he stressed the fusion during the last surgery, and it did not move. Dr. Fisher noted that Petitioner had previously had a spinal cord stimulator trial but recommended he have another to see if it could relieve his symptoms.

When Petitioner returned to Dr. Fisher on March 9, 2018, he reported continued back pain and numbness down to his left toe. He expressed a desire to work at a sit-down job, provided he would have the opportunity to change positions. On exam, Dr. Fisher noted a positive straight leg test, a positive FABER, and a positive thigh thrust test on the left. Dr. Fisher provided trigger point injection to the left PSIS and again recommended implantation of a spinal cord stimulator. Dr. Fisher completed a work status form which listed Petitioner's restrictions of sedentary work with no lifting over 10 pounds and no repetitive bending, twisting, or lifting and that Petitioner must be able to alternate from sitting to standing. Dr. Fisher did not check the box indicating Petitioner was at MMI.

Petitioner was last seen at Midwest Anesthesia and Pain Specialists on April 4, 2018 and the doctor continued to recommend a Spinal Cord Stimulator though he noted that it continued to be denied by insurance. He therefore discharged Petitioner finding him to be at maximum medical improvement.

The records from Stellar Pain & Spine Specialist show Petitioner saw Dr. Sameer Shah at Swedish Covenant Hospital on June 13, 2018. This was a referral from Dr. Rebecca Levine. Dr. Shah recorded that the Petitioner had right-sided gluteal pain and left lower back pain which radiated down his left leg. Petitioner informed the doctor of his long-standing history of back and leg pain and his prior surgeries which he described as given him minimal relief. Petitioner described his pain as throbbing in his lower back which radiated down his left leg with numbness and tingling which was made worse with prolonged walking. Dr. Shah noted that the Petitioner used a cane to assist with walking. On examination, Dr. Shah noted that Petitioner had decreased range of motion in his lumbar spine. He diagnosed Petitioner of having chronic spondylosis of the lumbar spine, chronic lumbar radicular syndrome and a chronic post-laminectomy syndrome of the lumbar region. Dr. Shah recommended another CT scan, x-rays, and a trial of a spinal cord stimulator. He referred Petitioner to a Dr. Choi for a psych evaluation prior to the trial of the spinal cord stimulator and recommended that the Petitioner wean himself from his pain medication.

An x-ray done at Swedish Covenant Hospital on June 13, 2018 showed a prior laminectomy at L4-5. It also showed that the facet joints appeared to be fused from L2-3 through L5-S1. There had also been a discectomy at L3-5. Mild degenerative disc disease was seen at L4-5 and L5-S1 as well as surgical fusion of the left sacroiliac joint. A CT scan was performed on July 3, 2018. This showed post-operative findings related to laminectomies at L4 and L5 with fusions from L3-L4 through L5-S1 and it further noted a four-centimeter fluid collection which extends to the dorsal epidural space which was felt to represent either a post-operative seroma or hematoma.

Petitioner followed up with Dr. Shah on June 28, 2018 and Dr. Shah recommended bilateral medial branch blocks from L2 through L5 for diagnostic purposes in order to evaluate for lumbar facet-based pain in addition to the spinal cord stimulator trial. The medial branch blocks were performed on July 20, 2018 and this was repeated on July 27, 2018. When Petitioner followed up with Dr. Shah on August 14, 2018, Petitioner reported a 90% improvement for one day after each injection, however he was back to his baseline after that. He had undergone his psychological examination for the spinal cord stimulator trial and Dr. Shah recommended further medial branch blocks with radio frequency ablations from L2 through L5 before considering the spinal cord stimulator trial. This procedure was performed on August 31, 2018 at Swedish Covenant Hospital and was repeated on September 7, 2018. When Petitioner followed up with Dr. Shah on September 20, 2018, the Petitioner reported improvement in his back pain, but he was experiencing numbness and tingling which were radiating into his hips. Petitioner reported increased pain while walking. Dr. Shah recommended a Medrol dose pack for the numbness and tingling and a caudal epidural steroid injection in order to treat the radicular symptoms. Dr. Shah performed the caudal epidural steroid injection on September 28, 2018. On October 16, 2018, Petitioner reported that his lumbar pain had improved 40%-50% but he was now focusing on pain over his SI joint and he was still experiencing some numbness and tingling into his legs which was not as intense as before. Dr. Shah therefore recommended an injection into Petitioner's right SI joint and another caudal epidural steroid injection. Dr. Shah also noted that the Petitioner was asking to hold off on the spinal cord stimulator as a last resort. The SI steroid

injection was performed on October 31, 2018 and the caudal epidural steroid injection was done on November 9, 2018.

When Petitioner followed up with Dr. Shah on November 21, 2018, he reported that the steroid injection had provided temporary relief and he continued to have worsening lower back pain and leg pain which he had reported had worsened due to the weather. Dr. Shah then made plans to provide a spinal cord stimulator trial as well as a third caudal epidural steroid injection until the spinal cord stimulator trial is approved, in order to provide some pain relief. The third caudal epidural steroid injection was performed on November 28, 2018. When Petitioner followed up with Dr. Shah on December 11, 2018, he reported that he continued to have significant lower back and leg pain and that the epidural injection had provided only temporary relief and his pain had returned to baseline. On January 4, 2019, Dr. Shah performed surgery to place spinal cord stimulation leads for a spinal cord stimulator trial. On January 15, 2019, the Petitioner followed up with Dr. Shah and reported 80% relief of his pain and he was able to walk without a cane.

Dr. Shah provided a permanent implantation of a spinal cord stimulator on February 22, 2019. When Petitioner followed up with Dr. Shah on March 21, 2019, he reported a great relief with his back and leg pain and had reduced usage of pain medication.

When he followed up with Dr. Shah on March 5, 2019, Petitioner reported that his pain was 60% better. On April 18, 2019, Petitioner returned to see Dr. Shah and informed him that the stimulator was providing relief for his leg pain, but he was having increasing pain in his lower back. Dr. Shah noted that the last radiofrequency ablation had been performed seven months ago and therefore recommended he undergo another from L2 through L5 bilaterally. This was performed on May 10, 2019 and repeated on May 17, 2019. Petitioner reported 80% relief from these procedures and Dr. Shah prescribed further physical therapy.

Petitioner underwent a Functional Capacity Evaluation on October 9, 2019 and on October 10, 2019. Petitioner's effort was found to be valid and reliable. Petitioner was able to meet the "light" physical demand level by lifting 10lbs from floor to waist, 20lbs from waist to shoulder height, and 15lbs overhead. During the FCE, the therapist noted that Petitioner could stand for occasional intervals and walk for occasional intervals, bend for occasional intervals, perform trunk rotations on an occasional basis, squat and kneel occasionally, and perform frequent reaching at waist height and overhead. It was noted that Petitioner lacked the physical capacity to return to his former job as a warehouse picker.

Petitioner returned to Dr. Shah on November 5, 2019 complaining of back pain across his lower back which he rated as 7/10. His pain diagram demonstrated pain going down both legs. He reported 70-80% relief from the radiofrequency ablation six months prior and wanted to repeat this. Dr. Shah recommended the ablations and reprograming of the Spinal Cord Stimulator. The ablations were performed on November 15, 2019 and November 22, 2019. Petitioner reported 90% relief from pain but in his follow up on December 24, 2019 reported that he was having increasing pain in his SI joint.

Testimony of Dr. Fisher

Dr. Theodore Fisher testified via evidence deposition on July 30, 2014. Dr. Fisher is a Board-Certified Spine Surgeon and has specialized in spine surgery since 2007. Dr. Fisher testified to the history that Petitioner provided on June 14, 2012 of low back pain with recurrent episodes of numbness in his left lower extremity extending to his toes and that he had previously had physical therapy and two epidural injections which had temporary relief. Dr. Fisher reviewed the MRI films which had been performed on March 15, 2012 and observed a "high intensity zone" at L3-4 consistent with an annular tear, a broad based central herniation at L4-5 with disc desiccation, and a broad-based disc herniation at L5-S1 with a larger left paracentral component displacing nerve roots. Because prior treatment had not been successful, he recommended a left-sided microdiscectomy at L5-S1. Dr. Fisher explained that L5-S1 appeared to be the most symptomatic level based upon his reports of pain and though the other discs had small herniations he wanted to do the smallest surgery possible. During the surgery, Dr. Fisher visualized the L5-S1 disc space and observed a loose piece of disc material that was extending behind the body of L5 which he believed had likely been causing Petitioner's symptoms.

Dr. Fisher testified that Petitioner appeared to be doing better post-operatively, but this was before he began lifting weights in therapy. He agreed that the increased symptoms which Petitioner reported on December 5, 2012 were consistent with the condition he had been treating and he believed the increase in pain was due to increased physical activity in work conditioning. He opined that as Petitioner progressed to lifting weights in work conditioning this exacerbated his condition and caused additional symptoms. Dr. Fisher also reviewed the MRI films taken on December 10, 2012 personally and noted that there was no recurrent herniation at L5-S1 but there was scar tissue consistent with the previous surgery. At L3-4 and L4-5, he observed disc herniations with an annular tear at L3-4 and a left paracentral component at L4-5. He recommended a lumbar discogram in order to see if he was a candidate for lumbar fusion.

Dr. Fisher acknowledged that the test discogram can be imprecise and needed to be viewed in conjunction with an MRI and the physical exam findings as well. A CT scan performed after the discogram can will detect the dye which was injected during the discogram and therefore can also give additional information such as whether the discs have tears in them. Dr. Fisher noted that the discogram showed Petitioner had pain at three levels that showed herniations on the MRI and the CT scan also showed these three levels, mild bilateral foraminal stenosis at L3-4 and at L4-5 there was central stenosis with right foraminal stenosis and moderate left stenosis.

Dr. Fisher stated that although Petitioner was a candidate for a 3-level fusion from L3 to S1, this would be a last resort. Petitioner was reporting severe pain and had tried injections, physical therapy, and medication but had not shown any improvement so Dr. Fisher offered it as an option and Petitioner chose to pursue it. Dr. Fisher reviewed the operative report and noted that he actually viewed disc herniations during surgery at L3-4, L4-5, and L5-S1 with the herniation at L4-5 being described as large. He explained that the prior laminectomy was performed on the left side of L5-S1 while the fusion surgery was approached from the right side which explained why he found a herniation at L5-S1. Dr. Fisher opined that all three of these findings were producing Petitioner's pre-operative symptoms to various degrees.

Dr. Fisher noted that on October 9, 2013 the Petitioner reported that he was doing very well and "felt like a million bucks" and that there was hope that Petitioner would be able to get back to full duty work. However, Dr. Fisher went on to explain that while Petitioner initially did well after surgery, the screws placed during surgery loosened and the disc spacers moved and irritated his nerve roots. This required a subsequent surgery to revise the hardware. In this surgery, he removed a cage which caused a tear of the dura which he subsequently repaired. As a result, this resulted in a fluid collection which developed posterior to Petitioner's lumbar spine and was seen on subsequent MRIs. Dr. Fisher testified that the fusion was solid, but he had continued pain due to the irritation of the nerve roots.

As of the date of the deposition, Dr. Fisher felt that Petitioner was not yet at maximum medical improvement. Dr. Fisher did agree that his condition was causally related to Petitioner's injury. He concluded that he sustained an acute disc herniation at L5-S1 at the time of the accident. He further explained that the other levels may have become symptomatic from the injury to L5-S1 along with the surgeries and the work conditioning because Petitioner had never had any problems in his lower back before his injury. He elaborated that the MRIs demonstrated he had a component of degenerative changes at L3-4 and L4-5, but these were asymptomatic prior to his injury. Accordingly, he concluded that the L3-4 and L4-5 discs were either accelerated or exacerbated by the injury itself or the subsequent treatment plus the work-conditioning where his symptoms had increased.

Dr. Fisher disagreed with the opinion of Dr. Mather that Petitioner never had a disc herniation and surgery was not necessary. Dr. Fisher pointed out that Dr. Mather claimed that L5-S1 only had degenerative disc disease but noted that the radiology report from the 3/10/12 MRI described a left-sided disc herniation at L5-S1 which was supportive of Dr. Fisher's own reading of the scan. Dr. Fisher pointed out that the radiologist's interpretation along with his own and the surgical findings all pointed to the existence of a herniated disc at L5-S1. Dr. Fisher also confirmed that he did not detect any Waddell signs or any indication that Petitioner was overreacting to pain – he believed that his exam findings were all consistent. On cross-examination, Dr. Fisher was shown Dr. Mather's May 17, 2013 report which discusses the MRI from March 2012 and notes that Dr. Mather didn't appear to comment upon the L5-S1 disc level.

Dr. Fisher was asked about his description of the March 15, 2012 MRI which he stated showed herniations when compared to the radiologist's interpretation who described disc protrusions. Dr. Fisher explained that a protrusion is a smaller herniation that hasn't extruded out of place although the L5-S1 disc space was discussed as an extrusion which has torn through the annulus. Dr. Fisher explained that a disc herniation is a generalized term which covers all protrusions, herniations, and tears. Dr. Fisher reiterated his opinion that the L5-S1 disc extrusion happened acutely during Petitioner's injury, while the L3-4 and L4-5 levels had some degeneration changes. Dr. Fisher acknowledged that his initial assessment from June 14, 2012 discussed only the disc herniation at L5-S1 and did not discuss the discs at L3-4 and L4-5. Dr. Fisher explained that he discussed these levels in the discussion of the diagnostic studies and in the section labeled "diagnosis" but reserved his final assessment for the L5-S1 which is where he believed the majority of Petitioner's problems were coming from and where Dr. Fisher wanted to perform surgery. Dr. Fisher also repeated that he did not address the L3-4 and L4-5 levels at the

time of the first surgery because he believed the radicular symptoms were coming from the L5-S1 level and he could alleviate those with a simple microdiscectomy, which has only a 6-week recovery time. Unfortunately, Petitioner failed to recover in work conditioning which led the doctor to look at other levels.

Dr. Fisher acknowledged that he did not treat petitioner until approximately five months after the accident and that Petitioner had treated with a Dr. Charles Mercier. He further acknowledged that he has no record of right lower extremity symptoms prior to the first surgery in August 2012 though he admitted that he did not review any of the prior treatment records from Dr. Mercier. Dr. Fisher stated that the first mention of lower extremity pain bilaterally was in December of 2012 and that there were no significant changes between the March 15, 2012 MRI and the December 12, 2012 MRI. He acknowledged that in his notes of the January 16, 2013 note he identified herniated discs in L3-4 and L4-5 in his final assessment. He explained, however, that he did identify and discuss them in his initial note from June 14, 2012.

Dr. Fisher denied that he based his decision to perform lumbar fusion solely on the results of the discogram. He explained that he considered the discogram, the MRIs, the CT scans, and his physical exam findings in conjunction with Petitioner's reports of severe pain. He stated the discogram is an important piece of information but not the only one. Regarding the amount of pressure used in discograms, Dr. Fisher noted that different pain management doctors use different amounts based on different techniques and he had no opinion regarding the appropriate amount of pressure.

Testimony of Dr. Ross

Dr. Matthew Ross testified via evidence deposition on August 1, 2018. Petitioner was examined by Dr. Ross at the request of Petitioner under Section 12. Dr. Ross is a Board-Certified Neurosurgeon and spine surgeon and examined Petitioner on January 11, 2018. In his exam, Dr. Ross noted Petitioner was in mild distress during the examination. The examination revealed mildly restricted mobility in his lumbar spine on forward flexion. Straight leg raising aggravated the back pain at 80 degrees on the right and 70 degrees on the left with pain radiating down his left leg as well. Bilateral bent leg raising and hip rotation aggravated the back pain. Sensation was diminished to light touch over the left medial shin as well as the dorsum of the left foot and great toe. Pinprick is diminished over the left medial and lateral lower leg as well as over the dorsum of the left foot and great toe. The lateral aspect of the left foot is mildly reduced. Vibratory sensation is present but diminished in the left foot. Proprioception is diminished in the left foot. Deep tendon reflexes were slightly reduced in the left knee, and absent in both ankles. Dr. Ross also observed that Petitioner was able to complete a physical exam without using a cane though he used a cane when coming in and out of the office. He requested Petitioner not use the cane during the exam and he was able to demonstrate walking without the cane. Dr. Ross described this as a common phenomenon for patients who use a cane as a kind of "security blanket." Despite Petitioner's complaints, Dr. Ross was pleased with Petitioner's mobility.

Dr. Ross found no evidence of any symptom magnification, though he observed that Petitioner's rating of his pain on a scale of 1-10 was higher than the average person – Petitioner was rating his pain as a 9/10 that sometimes exceeded 10/10 – to which Dr. Ross noted that

cognitive behavior counseling or therapy could help in terms of adjusting Petitioner's expectations.

Dr. Ross reviewed the medical records and concluded that Petitioner has chronic back and radicular leg pain following multiple spinal and left SI joint surgeries. His condition could be diagnosed as failed back surgery syndrome. Dr. Ross stated that Petitioner's ongoing pain complaints are causally connected to the work injury of January 2012 and/or the treatments he received in an effort to address the symptoms caused by the work injury. This is based upon the fact that he has been continuously symptomatic ever since the work injury. Dr. Ross felt that Petitioner had an exacerbation of his symptoms when he began work conditioning in December 2012 rather than a re-herniation. He did not see any evidence of a re-herniation.

The medical treatment Petitioner received including the microdiscectomy, discogram, lumbar fusion, revision of the fusion, spinal cord stimulator trial, sacroiliac joint block, and sacroiliac joint fusion were appropriate treatments for his condition caused by the work injury of January 2012. These were reasonable and necessary to treat his complaints of ongoing back and left leg pain. Dr. Ross testified that Petitioner complained of left leg pain prior to the August 2012 surgery but acknowledged that he had not reviewed all the records, nor had he reviewed the films from the March 2012 MRI.

Dr. Ross testified that that the fusion of the SI joint was indicated based upon the Petitioner's positive though temporary response to the SI joint injection, and this was confirmed by Petitioner's reports of doing well after the procedure. He opined that the SI joint became symptomatic due to the stress placed upon it after the 3-level fusion from L3 to S1, though it was possible the joint was injured in the original injury. At the time of his exam, Dr. Ross concluded that Petitioner's complaints were due to the condition of his lumbar spine rather than the SI joint because that joint had been fused.

Regarding the discogram, which was performed on March 22, 2013, Dr. Ross opined that lumbar provocative diskography is an important albeit imperfect tool in decision making regarding lumbar fusion surgery in patients with chronic back pain. Unfortunately, there is not perfect correlation between the results of diskography and the outcome from fusion surgery. Dr. Ross referenced Dr. Eugene Carragee's studies of diskography at Stanford University which indicate that the test predicts pain improvement following a fusion surgery in only 50% to 75% of patients. Good to excellent pain relief is seen in only 50% of patients following a positive diskogram. 25% of those patients further indicate that if they knew the amount of relief they would receive they would not have done it. The discogram Petitioner underwent on March 22,2013 was performed in a standard fashion. He had no criticism of the pain specialist's technique with the diskogram. Dr. Ross also explained that he almost never performs a lumbar fusion without first having a discogram done and he does rely upon them frequently. He used to perform discograms himself but as the surgeon he now has them done by a separate anesthesiologist. He was unconcerned about the level of pressure used in the discogram and felt that Dr. Mather's concerns were ill-founded. Based on the results of the test and the results of the CT Scan that followed the discogram along with Petitioner's complaints Dr. Ross believed fusion surgery was reasonable.

Dr. Ross recommended that he have a CT scan of the lumbar spine and sacroiliac joints with thin sections from L3-S1 in order to determine if there were solid fusions. If his fusions are solid, no additional surgery would be indicated. In that case, he advised that Petitioner enroll in a physiatry based chronic pain management program with cognitive behavioral therapy. When asked if a CT scan showed solid fusion at L3-4 and L5-S1 with L4-5 showing fusion at the facets, Dr. Ross agreed that this would indicate Petitioner had a solid fusion.

On cross-examination, Dr. Ross acknowledged the Petitioner did not immediately complaint of left leg pain after his accident. He testified that it is rare for a patient to have immediate radicular symptoms after experiencing a herniated disc because a herniated disc might cause direct pressure on a nerve or release chemicals which in time will aggravate a nerve. He reiterated his recommendation for an FCE and stated that he believed the Petitioner would be employable but that he would likely need vocational counseling and cognitive behavior counseling or therapy. He acknowledged a difference between a physical capability to perform some work and the likelihood of finding a job, which is a question for a vocational counselor.

Testimony of Dr. Mather

Dr. Steven Mather testified via evidence deposition on August 8, 2014. Dr. Mather is a Board-Certified spine specialist and first examined Petitioner at the request of Respondent on March 25, 2013. Dr. Mather took a history from Petitioner where the Petitioner reiterated that he injured his back lowering a box onto a forklift, underwent physical therapy, two injections, did not improve, and was referred to Dr. Fisher who performed an L5-S1 microdiscectomy which also did not improve his condition. Petitioner reported back pain and weakness and numbness in his legs at the time of the exam. Dr. Mather testified that Petitioner told him that he did not have any leg pain prior to the L5-S1 microdiscectomy. Petitioner further reported that he really did not get better after the surgery and that during work conditioning his legs started to give out and when he went back to work light duty his legs buckled when he was simply standing and stacking light parts. The doctor noted that Petitioner reported his legs continued to buckle and he had numbness in the calves and the outer aspect of the left foot and the soles of both feet.

Dr. Mather reported during his exam he observed the Petitioner's movements were slow and guarded, range of motion was limited to 5 degrees extension and forward flexion and reported pain with axial loading and axial rotation of the lumbar spine. He reported that Petitioner said it was too painful to walk on his tiptoes.

Dr. Mather also claimed that the Petitioner told him that he had no leg pain at the time of his exam but further testified that during his exam that Petitioner reported weakness and numbness in his calves. Dr. Mather stated that Petitioner stated he could not distinguish between a pinprick and a brush but nevertheless jerked away quickly during pinprick testing. Dr. Mather found reflexes to be symmetrical and reported that Petitioner had giveaway weakness during his exam and reported he could not sense whether his toes were pointing up or down. Dr. Mather found these reactions inconsistent and the doctor considered them to be non-organic. He testified that he found further found non-organic findings when manipulated Petitioner's toes up or down and the Petitioner was unable to tell which way they were pointing and when he reported he could not feel vibration in his feet.

Dr. Mather confirmed that he had reviewed all prior treatment records and concluded that Petitioner sustained a lumbar strain in his accident of January 25, 2012 and did not require any surgery because his pain was not nerve root pain or sciatic pain. Dr. Mather based his opinion on his belief that Petitioner had multiple non-organic pain findings and a normal physical exam.

Further, Dr. Mather testified that Petitioner should not have had a 3-level lumbar fusion because patients who have this procedure are never able to go back to heavy work and they frequently are worse than their pre-operative state. It was Dr. Mather's opinion that two of Petitioner's discs were of normal height and one had only minimal loss of height. Dr. Mather further opined that the discogram performed on March 22, 2013 was done improperly because the discs are supposed to be pressurized between 15 psi and 50 psi, but at pressures much higher than that it can cause pain in anybody. Dr. Mather was therefore critical of the decision to pressurize the L5-S1 disc to 130 psi. Dr. Mather also felt that a fusion was not indicated for the Petitioner because of his age, his clinical complaints, the number of levels involved, along with the kind of work he does and his transferrable skills. He therefore concluded that Petitioner did not require any further treatment for his work injury and that he could return to work full duty. Dr. Mather described his view of the March 15, 2012 MRI and stated that it showed a small central disc bulge that was non-compressive at L5-S1 and a non-compressive disc bulge at L4-5. He concluded that there was no nerve compression.

During Dr. Mather's second examination of Petitioner which occurred on February 27, 2014 – after Petitioner's fusion surgery – Dr. Mather noted a history of low back, left buttock, left thigh, and foot pain at that time. No right-sided pain was noted. He stated that he took X rays in his office which showed the pedicle screw at S1 appeared to be loose and the cages at L4-5 and L5-S1 appeared to have retropulsed near the spinal canal toward the nerves. At that time, he diagnosed the Petitioner as having signs of nerve compression, status post-fusion attempt at L3-S1 with loose hardware which was likely from the cages which had moved. He concluded that Petitioner needed another surgery to revise his hardware. He agreed that the revision surgery performed March 25, 2014 was reasonable and necessary but stated that the need for this surgical revision was not related to the work accident because he didn't think he needed surgery in the first place but instead needed a conservative program and maybe even work restrictions. Again, Dr. Mather emphasized that Petitioner did not have any radicular pain prior to his initial surgery.

On cross-examination, Dr. Mather acknowledged that there should have been a push for a core strengthening program, a functional restoration program, in an effort to find out what activities the Petitioner couldn't do, restrict him from those, have the employer make accommodations at work and maybe even do a vocational rehabilitation program if the employer did not accommodate him. Further, Dr. Mather admitted that Petitioner needed treatment and likely needed work restrictions as a result of his accident. Further still, Dr. Mather acknowledged that the medical records from Dr. Fisher recorded that the Petitioner had been complaining of numbness in his left leg prior to his first surgery. He further acknowledged that numbness in the left leg can be considered a radicular complaint. He maintained, however, that Dr. Fisher's report of numbness contrasted with "all the other medical providers."

Although Dr. Mather diagnosed Petitioner as having a back sprain, he acknowledged that Dr. Fisher reported observing a herniated disc at L5-S1 when he performed surgery on August 10, 2012 but observed that this was not consistent with his own reading of the 3/15/12 MRI. When asked if an MRI was more reliable than a surgeon's eyes, Dr. Mather observed that sometimes an MRI will show a disc herniation and the surgeon will miss it during surgery. When it was pointed out that Dr. Fisher didn't "miss" a disc herniation but rather stated he observed a herniation, Dr. Mather replied, "[t]hat's what he said." He acknowledged that he had no reason to disbelieve Dr. Fisher but only reiterated that he didn't see a disc herniation when he reviewed the MRI.).

Dr. Mather testified that he performs IMEs about 4-5 times per week and 95 percent of them are for the insurance industry. When discussing his belief that the Petitioner was inconsistent in his reports of numbness and jerking away when touched with pinprick, Dr. Mather acknowledged that he didn't ask the Petitioner how often he felt numbness in his legs. Dr. Mather maintained his opinion that Petitioner was malingering during his first exam based upon his belief that there were signs of symptom magnification. When describing Waddell signs, Dr. Mather acknowledged that some people say that Waddell signs are not signs of malingering but are signs of psychological overlay - but not in his opinion. He believes Waddell signs to be a sign of malingering.

When asked to read the radiologist report from the CT scan which was performed after the discogram on March 22, 2013, Dr. Mather acknowledged that the radiologist reported a likely full thickness tear of the annulus at L3-4 and acknowledged that this can be a painful condition. Regarding the radiologist's report of the L4-5 level, Dr. Mather acknowledged that it showed a disc bulge which caused mild right foraminal stenosis and moderate left foraminal stenosis and which was also consistent with an annular tear and that this could represent a painful condition. Regarding the L5-S1 disc level, he acknowledged that the radiologist reported findings consistent with either scar tissue or extruded disc material along the left nerve root and an annular tear.

Regarding the discogram itself, Dr. Mather acknowledged that only one of the disc levels – L5-S1 – was pressurized to a level that he felt was excessive. The levels at L3-4 and L4-5 were not pressurized excessively but were still reported as painful. Regarding the decision to perform a lumbar fusion, Dr. Mather insisted that the kind of work a patient does and their lack of transferrable skills are factors to consider when making such a recommendation because a doctor shouldn't offer a fusion to someone who only knows how to bend and lift for work because the patient would have to know what to do with their life after fusion. Asked if this was a decision for the patient to make, he responded, "You have to get inside their head and a lot of people don't do that."

Dr. Mather authored a subsequent opinion on Petitioner's care in April of 2015 where he opined that Petitioner has a nonunion at L4-L5-S1 with persistent left L4 radiculopathy and spondylolysis which would require a fusion at L4-L5 and L5-S1 with posterior segmental instrumentation, L3 to S1. Dr. Mather maintained his belief that this fusion surgery as well as the non-union were unrelated to the work accident at issue. In May of 2017 Dr. Mather reiterated his

opinion that Petitioner had a non-union at L4-L5-S1 which was not related to the work accident and was a result of the fusion surgery performed based on an improper discogram.

Testimony of Petitioner's Vocational Counselor – Edward Pagella

On September 21, Petitioner was examined by vocational rehabilitation consultant, Edward Pagella, at Petitioner's counsel's request to perform a vocational analysis. Mr. Pagella is a Licensed Clinical Professional Counselor and has consulted on matters before the Social Security Administration and the Railroad Retirement Board. At the time of their meeting, Petitioner was post L3-S1 lumbar fusion.

Mr. Pagella noted that Dr. Ross had recommended an FCE which had not yet been completed and that Dr. Fisher had restricted Petitioner to sedentary work wit the ability to alternate between standing and sitting with no lifting over 10 pounds and no repetitive bending, twisting, or lifting. Mr. Pagella noted that when he met with the Petitioner, he was advised that Petitioner needed to stand up every ten minutes and walk around because of back pain from sitting. Petitioner was under pain management at that time which involved taking narcotic medication at the time. Mr. Pagella testified that jobs may drug test candidates.

Petitioner was noted to be 46 years old at the time of this meeting and had a high school education. Petitioner advised Mr. Pagella of his prior work experience which consisted of working in a warehouse with Respondent since 2011 and North Shore Care Products prior to that. Mr. Pagella identified Petitioner's prior work as warehouse picker to have a Specific Vocational Preparation (SVP) level of two which means he would be considered an unskilled worker meaning it took him less than 90 days to learn a job and he would have no transferable skills. It was noted that Petitioner had not attended any training programs, was not certified in any other areas, and had no resume or job seeking skills at that time.

Mr. Pagella concluded that, based upon the restrictions set forth by Dr. Fisher, that Petitioner would be unable to return back to his former job as a warehouse picker because he was no longer able to be on his feet throughout the day and could only lift up to 10 pounds occasionally. He further concluded that sedentary work with no repetitive movements and a sit-stand option would require an accommodation from the employer and that there is not a stable labor market for such.

Mr. Pagella testified that it was possible that there was an accommodating position for the Petitioner and that Petitioner would be a candidate for retraining and rehabilitation. He offered to assist Mr. Olivo in attempting to find an accommodating employer though he cautioned that there are no guarantees especially when Petitioner would have to explain why he hasn't worked in 10 years and is on narcotic pain medication. A job which is an "accommodation" is not a viable occupation within the local or national economy because such positions do not exist in numbers. He therefore concluded that Mr. Olivo was unable to make any kind of contribution to the work force and that there was not a reasonably stable labor market for Petitioner.

After Petitioner underwent an FCE in October 2019, Mr. Pagella issued a second report on December 5, 2019. Mr. Pagella noted that this report indicated that it was fully reliable and reported Petitioner could lift up to 10lbs from floor to waist, carry up to 15 pounds, occasional pushing and pulling up to 30 pounds but would still need a sit/stand type of job. It was noted that the FCE revealed increased capacity over petitioner's previous restrictions of 10 pounds. The FCE did not note how long the petitioner could sit. Nevertheless, Mr. Pagella opined that there was not suitable employment within the economy for Petitioner and that Petitioner was permanently and totally disabled under the "odd lot" category. This was based upon Petitioner's high school education, no other certifications or degrees, a lack of transferable skills, and his physical limitations.

Mr. Pagella explained that Petitioner has no computer skills which will help him find work because he does not have the ability to use Microsoft Office, Word, Excel, PowerPoint, or to use any type of program which might be used by a specific company. The Petitioner, however, expressed that he would be able to learn how to perform an internet job search. Mr. Pagella was unaware if this had ever been done. He further explained that the ability to use Facebook or social media is not a computer skill in a practical environment.

He concluded while no employer would likely hire Petitioner it was possible that vocational services could find Petitioner an accommodating employer. He estimated these services would cost between $25,000 and $35,000. He further testified that he wouldn't recommend vocational services unless there was a good chance of finding the Petitioner a good result. The Petitioner, however, did not follow up with Mr. Pagella regarding vocational services. Mr. Pagella had no further contact with petitioner at any time after his initial examination.

On cross-examination Mr. Pagella acknowledged that Petitioner was unable to provide any employment history between the time he graduated high school in 1990 and 2010. He further acknowledged that while he believed that the Petitioner's use of narcotics could bar him from obtaining employment, he did not ask Petitioner how much Norco he was taking or how often it was taken. Similarly, he acknowledged that there could be employees who could accommodate a Petitioner on narcotics and that it was his recommendation to try and assist the Petitioner in finding an accommodating position.

Testimony of Respondent's Vocational Counselor – Edward Rascati

Respondent retained Edward Rascati, a Certified Professional Vocational Consultant, to address Petitioner's employability. Mr. Rascati has his own vocational consulting practice, EJR Consulting, which has been in operation since 1996. Mr. Rascati met with Petitioner on November 12, 2018. This was prior to the last Functional Capacity Evaluation and at that time, Mr. Rascati understood Petitioner's restrictions from Dr. Fisher to be no lifting beyond 10 pounds, no repetitive bending, twisting, or lifting, and a requirement that he alternate between sitting and standing. In his meeting with Petitioner, the Petitioner reported that he could stand for approximately 15 minutes and he could sit for 10 to 20 minutes at a time. He also noted that Petitioner had a felony conviction when he was 19 years old for retail theft and was taking Norco approximately four times daily for pain relief. Petitioner stated that he owned a smartphone and was able to handle e mail and attachments and could use a keyboard with two hands a little, and

he had previously used the program Lotus Notes when he was working for an old employer. Petitioner reported minimal daily activities. Petitioner told Mr. Rascati that he possessed a valid driver's license and can drive short distances.

Mr. Rascati noted that Petitioner worked as a warehouse picker for Respondent, which meant that he would write down part and order numbers, label, and perform quality control which meant ensuring that the orders that were accurate. He would then box, wrap, and scale packages for delivery utilizing a UPS shipping terminal and inputting recipient's information, printing, and applying the shipping label. The Petitioner identified three prior employers. He previously worked at North Shore Medical for approximately three years in essentially the same capacity as a warehouse picker. Prior to that he worked for SafetyClean for approximately one year doing UPS and FedEx labeling and shipping. He also worked as a warehouse picker and panel van driver for Associated Fastening Products.

Mr. Rascati concluded that Petitioner's work history along with DOT information would put Petitioner in the shipping and receiving clerk categorization as opposed to warehouse picker due to Petitioner's quality control and shipping and receiving experience.

Based on Petitioner's work history and Petitioner's qualifications, Mr. Rascati believed that Petitioner qualified for the occupational title of shipping and receiving clerk. Transferrable skills were noted as performing a variety of duties, making judgments and decisions, compiling data, taking instructions, and helping and handling. He noted Petitioner's good interpersonal skills and that he was friendly and pleasant. He noted Petitioner's consistent work history, his high school education, basic computer skills, and history of low wages. Mr. Rascati then reviewed the Department of Labor's Dictionary of Occupational Titles for a Shipping and Receiving Clerk and noted that this job required six months to a year of vocational training and required reasoning and math aptitudes at the 7th and 8th grade level.

Mr. Rascati recommended a Labor Market Survey to determine what employment opportunities existed for Petitioner. On December 4, 2018 Mr. Rascati was able to identify nine positions which he felt given the Petitioner's work history, skills, and in conjunction with his current level of physical function, would be available to him. He considered positions in customer service, light production, packaging, quality control, security gate guard, and usher positions. These possible positions included working as a collections representative, a sit-down assembly position, a picker/packer position, a customer service representative, call center work, and a front desk agent for the Hampton Inn. He testified that 8 of the 9 positions he found were within the restrictions set forth by Dr. Fisher and some required minimal computer skills. The wages for these positions ranged from $9.62 an hour to $16.83 an hour with the average being $12.61 per hour. Mr. Rascati acknowledged Petitioner may need to enhance his computer skills.

Mr. Rascati testified that he believed Petitioner would benefit from professional vocational services. He acknowledged the gap in employment could "raise an eyebrow" with prospective employers but that the Petitioner had an adequate explanation for this gap. He further testified that Petitioner would benefit from vocational services to prepare him for completing job applications, interviewing and addressing concerns about an employment gap and that there are several factors that go into a proper job placement for Petitioner.

A second vocational report was authored by Mr. Rascati on March 17, 2020. At this point Petitioner had completed an FCE which indicated Petitioner could lift 10 pounds floor to waist, 20 pounds waist to shoulder, 15 pounds overhead, 15 pounds carry, 20 pounds push and pull and, overall, that Petitioner was placed at the "light" level of physical function. Consistent with the FCE results, he found positions available as a gate guard and/or cashier/ticket seller. These jobs were categorized in the light duty restriction range. Alternatively, if it was deemed that the petitioner would be restricted at the sedentary level of physical function then possible position would be production clerk, customer service representative and/or security clerk. He again believed that the petitioner would benefit from professional vocational assistance. He confirmed that those nine positions identified in his earlier labor market survey would still be viable options for the petitioner given his restrictions following the FCE.

On cross-examination, Mr. Rascati acknowledged that Petitioner faced significant barriers to finding employment, such the Petitioner's physical limitations, and a lack of education beyond high school. Regarding Petitioner' past felony conviction when he was 19, Mr. Rascati disputed that this would be a barrier to finding employment apart from the field of armed security. Mr. Rascati noted that the petitioner's narcotic use at the time could potentially be a hurdle for employment but noted that employers are not allowed to discriminate against someone with chronic pain. It would certainly preclude him from particular occupations. Specifically, Mr. Rascati indicated if he was to pursue occupations as an airline pilot or a bus driver then certainly the effects of him taking narcotics could have an effect. However, he believed that would not be the case in the positions identified in his Labor Market Survey. Mr. Rascati identified that on page two of the FCE report it indicated that the petitioner was capable of lifting 15 pounds floor to waist, 15 pounds waist to shoulder, 10 pounds overhead, carrying 15 pounds and push pull 30 pounds occasionally. Mr. Rascati took these restrictions into consideration along with the sit stand perimeters as noted by Dr. Fisher. While Mr. Rascati was aware of the restriction from Dr. Fisher that Petitioner be allowed to sit or stand as needed, he did not review the positional tolerances tested in the FCE and was not aware that the longest period for which Petitioner could sit was 21 minutes on one day and 26 minutes on another. He indicated that the sit stand option would come into play of course but it is a misnomer to think that someone is only sitting at sedentary job or only standing. He indicated the job might be classified as sedentary but that person at a desk would be able to stand up and sit down and rotate as necessary and is not going to interfere with course of his employment.

Regarding his Labor Market Survey, Mr. Rascati, identified a position as a collections representative for Global Payments whose job solicitation asked for "one year of call center experience preferred, talk and type effectively at the same time." He acknowledged that Petitioner had no call center experience nor was it know if he could talk and type at the same time. It was also unknown if the job allowed a worker to sit or stand whenever he or she wanted. The survey also identified a position with RHM staffing doing sit-down assembly but it is unknown whether the job allowed an employee to sit or stand as required. The third job noted was as a picker/packer for Randstand, but Mr. Rascati was unable to ascertain the specific physical requirements of that job. The fourth through eight jobs identified were for customer service representatives which preferred bilingual and Microsoft experienced candidates that

could sit for long periods of time. The ninth job required occasional lifting up to 20 pounds which Mr. Rascati acknowledged was not "sedentary."

Mr. Rascati, however, stressed that that there is a difference between "preferred" as opposed to "required" in job descriptions. He also indicated that there was no identification on the job descriptions that stated explicitly that a sit-stand option was available as would seemingly be implied. He acknowledged that he was not identifying positions for which the Petitioner would be a perfect candidate but rather options that were available within his restrictions. He did not believe that the job descriptions stating the ability to sit for long periods of time would preclude the Petitioner from being allowed to stand up or stretch during the day. He was not aware of any position that required sitting for six to eight hours straight.

Mr. Rascati testified that he did not agree with Mr. Pagella's categorization that the petitioner's work was unskilled and that he had no transferrable skills. Specifically, Mr. Rascati noted that the petitioner was responsible for picking orders, writing down parts and order numbers, labeling items, performing quality control to ensure accuracy of orders, shipping duties, including boxing, wrapping, sealing and scaling for delivery, utilization of UPS shipping terminal as well as FedEx and driving panel van doing local deliveries. He confirmed that this would be considered skilled work by the Dictionary of Occupational Titles and that categorization in the shipping and receiving clerk position was appropriate. He also disagreed with Mr. Pagella's findings that the petitioner had zero transferrable computer skills. Specifically, he noted that the petitioner reported that he used a computer and was knowledgeable with handling attachments, uploading and downloading, and comfortable with traditional two-hand keyboarding. He also noted some experience with software programs.

CONCLUSIONS OF LAW

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

Petitioner had no prior problems with his lumbar spine before his accident on January 25, 2012. The records from Concentra demonstrate that he was complaining of low back pain immediately after the accident. They also reflect that Petitioner had some symptoms of sciatica, contrary to the assertions of Dr. Mather, in that they show he had pain at the sciatic area on the left side on February 9th. Moreover, when Petitioner first saw Dr. Fisher on June 14, 2012, he reported that he had experienced episodes of numbness in his left foot since the injury. Such numbness is a radicular symptom and is a sign of a herniated disc. As Dr. Ross noted in his deposition, disc herniations rarely produce radicular pain following an injury but usually take time before they produce such symptoms.

The Arbitrator further notes that the MRI in March 2012 revealed objective findings which were noted by the radiologist and then again by Dr. Fisher upon his own review of the films. The performance of epidural injections on the left at L5-S1 is a further indication of that ongoing left-side and radicular symptoms reported by Petitioner.

The Arbitrator finds the opinions of Petitioner's treating surgeon, Dr. Fisher and Petitioner's Section 12 examiner, Dr. Ross, to be more credible than the opinions of Respondent's Section 12 examiner, Dr. Mather. A fundamental issue in this matter is one of whether Petitioner sustained a herniated disk. Drs. Fisher and Ross opined that he did sustain a herniated disc whereas Dr. Mather believed that he did not based on a review of the MRI films. The testimony of Dr. Fisher notes that Dr. Fisher observed a herniated disc with his own eyes when he performed surgery on August 10, 2012. This is convincing evidence in favor of the existence of a herniated disk at L5-S1.

Both Dr. Fisher and Dr. Ross opined within a reasonable degree of medical and surgical certainty that Petitioner's herniated disc at L5-S1 was a result of his injury on January 25, 2012. Both Dr. Fisher and Dr. Ross concluded that, while Petitioner did begin to improve following the August 10, 2012 surgery, he suffered a setback in work conditioning which exacerbated his condition. Dr. Fisher's opinion was that Petitioner's subsequent problems with back pain and sciatica were either caused directly by his January 25, 2012 injury which served to aggravate his pre-existing condition at L3-4 and L4-5 or developed as a consequence of the medical treatment and the stress of work conditioning. It was therefore concluded that the L3-4 and L4-5 disc problems were either accelerated or exacerbated by the injury itself or accelerated or exacerbated by the subsequent treatment plus the work-conditioning where his symptoms were noted to have increased.

Dr. Mather's opinion that Petitioner suffered only a lumbar strain is simply not credible. Dr. Mather consistently disputed that Petitioner even had a herniated disk at L5-S1, despite the fact this was reported by the initial radiologist, Dr. Fisher (who also reviewed the MRI films), and, of course, is in direct conflict with the testimony of Dr. Fisher who testified to observing a herniated disc when he performed the hemilaminotomy on August 10, 2012. When Dr. Mather was advised that Dr. Fisher viewed the herniation during surgery, Dr. Mather only said that sometimes a surgeon doesn't see a herniated disc which is observed on an MRI. This doesn't apply to the situation here where Dr. Fisher did, in fact, observe the herniated disc. Dr. Mather also repeatedly failed to mention that Petitioner had complained of episodes of numbness in his left foot when he argued that the Petitioner showed no signs of radicular symptoms prior to the discectomy. The Arbitrator further notes that Dr. Mather originally stated in his report that Petitioner should have been released to work without any restrictions but in his deposition stated that he should have been placed on restrictions and given vocational rehabilitation rather than undergo the lumbar fusion performed by Dr. Fisher. The Arbitrator does not find Dr. Mather's conclusion that Petitioner was malingering during his exam to be convincing as it seems based primarily around a possible overreaction to a pinprick test. Dr. Mather testified that Petitioner jerked his leg away when he poked him with a pin, which he said was inconsistent with Petitioner's complaints of *episodic* numbness. Dr. Fisher and Dr. Ross disagreed with Dr. Mather's assessment on Petitioner's credibility. Further, the Arbitrator is not convinced that the discogram, being the imperfect diagnostic tool it is, was the precipitating factor that led to Petitioner's surgery. The evidence has shown that the discogram was one of several factors (e.g. the MRI films, Petitioner's Complaints, and Dr. Fisher's examination findings) that led Dr. Fisher to perform surgery. Lastly, the Arbitrator observed Petitioner's demeanor during his testimony and found Petitioner's testimony and complaints to be credible.

The Arbitrator finds that Petitioner's treatment, his immediate and ongoing complaints of pain, his post-laminectomy syndrome, his failed back syndrome, and his SI joint dysfunction are a continuing result of his original injury and the treatment received in response. Specifically, the Arbitrator finds that Petitioner's condition of SI joint dysfunction is a consequence of his injury based on the testimony of Dr. Ross who opined that the fusion from L3 to S1 put greater stress on Petitioner's SI joint, causing it to become painful and require medical treatment. Accordingly, the Arbitrator finds that Petitioner's condition of ill-being is causally connected to his injury of January 25, 2012.

With regards to the issue of whether the medical services that were provided to Petitioner reasonable and necessary, the Arbitrator finds as follows:

Having found that a causal connection exists between Petitioner's accident and his condition of ill-being, The Arbitrator further finds that Petitioner's medical treatment was reasonable and necessary to relieve the effects of his injury. The arbitrator finds that the surgeries performed by Dr. Fisher, the hemilaminotomy, the lumbar fusion from L3-S1, and the percutaneous fusion of the SI joint were all reasonable and necessary. This is based on Dr. Fisher's testimony and the opinion of Dr. Ross. The Arbitrator also finds Petitioner's pain management treatment to be reasonable and necessary to relieve the effects of his condition.

Petitioner's Exhibit #18 contains the following medical bills with the following balances:

	PROVIDER	UNPAID	PAID
1)	ATI Physical Therapy	$ 2,432.70	
2)	Hyde Park Surgical Center	$ 3,500.00	
3)	Illinois Anesthesia Specialist	$ 1,268.00	
4)	Illinois Bone & Joint Institute	$158,617.50	
5)	Injured Workers Pharmacy	$ 22,379.82	
6)	Integrated Health Care (Nu Wave Monitoring)	$ 7,800.00	
7)	Metro Health Solutions	$ 3,800.00	
8)	Midwest Imaging Professionals	$ 1,389.00	
9)	Midwest Anesthesia & Pain Specialists	$ 3,527.80	
10)	Northwestern Medicine	$ 2,168.53	
11)	Presence St. Joseph – Chicago	$259,958.99	
12)	Presence St. Joseph – Elgin	$ 16,189.44	
13)	Presence Medical Group (aka Lincoln Park Internal Med)	$ 1,200.00	
14)	Presence Health St. Mary & St. Elizabeth	$ 5,927.40	
15)	Stellar Pain & Spine Specialists	$ 7,040.00	
16)	Summit Pharmacy	$ 3,567.73	$ 6,803.84 by Medicare
17)	Swedish Covenant Hospital	$ 2,123.85	$170,623.20 by Medicare
18)	Total Rehab	$ 27,128.00	
19)	Windy City Anesthesia	$ 1,075.00	
20)	Windy City Medical Specialists	$ 8,170.00	
21)	Health Benefits Pain Management	$ 67,195.83	

22) United Rehab Chicago	$ 10,817.76	
23) Lincoln Park Anesthesiologist	$ 0	
Totals:	$617,277.35	$177,427.04

Respondent shall pay for the reasonable and necessary medical treatment identified in Petitioner's Exhibit 18 in accordance with the provisions and Medical Fee Schedule of Sections 8(a) and 8.2 of the Act. Respondent is entitled to a credit under Section 8(j) for amounts that have been paid. Respondent shall reimburse Medicare to the extent shown above.

With regards to the issue of TTD, the Arbitrator finds as follows:

Petitioner testified that he went home after his injury on January 25, 2012 and did not return to work until the following Monday on January 30th, 2012 and was then sent to Concentra. The records from Concentra show he was provided with work restrictions and the parties agree that Respondent provided Petitioner with light duty work until his surgery on August 10, 2012. He was thereafter paid TTD benefits through December 18, 2012 when he returned to work on a light duty basis.

Respondent's Exhibit #11 shows conflicting work status notes dated December 5, 2012 from Dr. Fisher. One of these notes, matches the Work Status Note found in Dr. Fisher's records which provides no lifting over 40 pounds with no repetitive bending, twisting, or lifting. The other work status note reflects the additional restriction of no standing. There is no testimony or other evidence regarding the discrepancy between these two. While Respondent argues that Petitioner modified Dr. Fisher's restrictions, there were witnesses to offer testimony regarding this issue. It does not appear that this potential modification caused any investigation nor was Petitioner ever disciplined. Further, Respondent has not sought a credit for TTD paid after December 5, 2012. By all accounts, Petitioner returned to work less than two weeks later on a light duty basis.

Respondent stopped accommodating Petitioner's light duty work restriction after Dr. Mather's report of March 25, 2013 which stated that he could return to work full duty. As previously mentioned, the Arbitrator does not find Dr. Mather's opinions on Petitioner's injury to be persuasive. The Arbitrator finds Dr. Fisher's opinion that Petitioner continued to require work restrictions to be more credible. Petitioner was unable to work and entitled to temporary total disability benefits as of the date of his Lumbar fusion on 9/23/2013 and there is no evidence to suggest that he was capable of returning to work at his former job with Respondent, which required lifting 75 pounds after that. The first FCE performed at ATI on 10/24/16 indicated that Petitioner was limited in his ability to lift and stand.

The Arbitrator finds that Petitioner is entitled to TTD benefits from March 26, 2013 up until the date that he reached maximum medical improvement. Petitioner last saw Dr. Fisher on March 9, 2018, but Dr. Fisher specifically declined to find him to be at MMI. When he set forth the restrictions on the work status note, he did not check the box indicating that Petitioner was at MMI. While a physician's assistant at Midwest Anesthesia and Pain Specialists did discharge him on April 4, 2018 finding him to be at MMI, this was because the recommendation for a

Spinal Cord Stimulator was not pursued. Respondent would not authorize it and Petitioner was not interested in it because his previous spinal cord stimulator trial did not help. Petitioner did not stop his medical care, however but rather sought treatment with a different doctor, Dr. Sameer Shah who performed more procedures for Petitioner, including ultimately implanting a Spinal Cord Stimulator on February 22, 2019.

The Arbitrator therefore finds that Petitioner reached maximum medical improvement on February 22, 2019 when he received the permanent Spinal Cord Simulator. Petitioner has continued to see Dr. Shah since that date, but the visits with Dr. Shah are simply for medication management and an occasional radiofrequency ablation. This treatment appears to be designed to simply maintain his condition and mitigate lingering complaints of pain.

The Arbitrator therefore finds that Petitioner was temporarily and totally disabled from August 10, 2012 through December 18, 2012 (a period of 18 and 5/7 weeks) and again from March 26, 2013 through February 22, 2019. The Arbitrator also finds that Petitioner is entitled to maintenance benefits at the TTD rate from February 23, 2019 through March 17, 2020. March 26, 2013 through March 17, 2020 is a period of 364 and 1/7 weeks. The Arbitrator has found that Petitioner has not met its burden to demonstrate that Petitioner is entitled to permanent total disability benefits due to an insufficient cooperation with vocational rehabilitation efforts. Vocational Counselor Mr. Rascati authored his final report - the final vocational report in this matter – which recommended that Petitioner would benefit from vocational rehabilitation services on March 17, 2020. As will be discussed later, Petitioner made no effort to follow up with either Vocational Counselor despite both counselors agreeing that Petitioner would benefit from vocational services and made no further effort to attempt to return to any kind of gainful employment. Accordingly, the Arbitrator finds that Petitioner is entitled to maintenance through March 17, 2020 and is not entitled to maintenance or PTD benefits thereafter.

The minimum TTD rate for Petitioner's date of injury of January 25, 2012 is $220. Respondent shall pay the sum of $220.00 for a combined period of 382 and 6/7 weeks, subject to a credit for amount of $5,969.85 already paid.

With regards to the issue of the nature and extent of the injury, the Arbitrator finds as follows:

The valid FCE performed on October 9th and October 10, 2019 demonstrates that Petitioner has severe functional limitations and could work at the "light" physical demand level which limits his ability to lift and also requires that he be able to sit and stand as needed. It was noted that he had trouble sitting and standing for long periods of time.

There is no dispute that Petitioner lacks the physical capacity to return to his former career as a warehouse picker. Edward Pagella, the vocational counselor retained by Petitioner, opined that Petitioner should fall in to the "Odd Lot" category of permanent total disability because though he has some ability to function there is no reasonably stable labor market for him, based upon his narcotic use, education, lack of skills, and functional limitations. Mr. Pagella discussed the possibility of finding an employer who would be willing to accommodate his severe limitations but opined that the possibility of an accommodation does not make for a

reasonably stable labor market. In addition to acknowledging that it was possible that Petitioner may be able to find an accommodating position he further testified that Petitioner would be a candidate for retraining and rehabilitation. He offered to assist Mr. Olivo in attempting to find an employer but Petitioner did not follow up with Mr. Pagella. He testified that he wouldn't recommend vocational services unless there was a good chance of finding a good result for the Petitioner.

A claimant is permanently and totally disabled when he is incapable of performing services except for those for which there is no reasonably stable labor market. *A.M.T.C. of Illinois, Inc. v. Industrial Comm'n*, 77 Ill.2d 482, 487, 389 N.E.2d 804, 34 Ill.Dec. 132 (1979). However, Inability to perform strenuous work is not enough to constitute permanent total disability. *Id.* If an employee can perform some form of employment without seriously endangering health or life, he or she is not entitled to a total disability award. *Id.* The Arbitrator acknowledges that Petitioner has substantial functional limitations. In such a case where the evidence demonstrates substantial but not a complete inability to work the burden is on the employee to prove there is no reasonably stable labor market but the burden then shifts to the employer to show that some kind of suitable work is regularly and continuously available. *Sterling Steel Casting Co. v. Industrial Comm'n,* 74. Ill.2d 273, 384 N.E.2d 1326, 1329 (1979).

Mr. Pagella's testimony is competent and credible, however, his testimony is stale in part as it ignores the fact that Petitioner is no longer on narcotic pain medication as he was able to stop taking narcotic pain medication after the successful spinal cord stimulator implantation. Removing this hurdle from Mr. Pagella's considerations makes his opinion slightly less persuasive. Further, the Arbitrator points to the fact that Mr. Pagella acknowledged that an employer may be willing – if not legally obligated to – accommodate petitioner's legal narcotic use if its use did not affect petitioner's ability to perform his job.

Mr. Rascati, Respondent's vocational counselor, agreed with Mr. Pagella that Petitioner would benefit from professional vocational services to address the difficulties Petitioner may have in finding work. Mr. Rascati's assessment of Petitioner's skills differed from Mr. Pagella's. Mr. Pagella classified Petitioner as "unskilled" based on his work history and lack of proficiency with Microsoft products. Mr. Rascati, based on Petitioner's work history, opined that Petitioner demonstrated skills in a variety of duties such as making decisions, gathering data, taking instructions, helping, handling, and having pleasant interpersonal skills. Further, Mr. Rascati believed Petitioner's existing ability to use a smart phone and computer provided a foundation upon which he could build future computer literacy with training.

Mr. Rascati acknowledged Petitioner had to address concerns that potential employers may have regarding his skills, gap in employment, physical limitations, and felony retail theft conviction from 20 years prior. In the Arbitrator's opinion, this is where professional vocational services could have proven beneficial. Again, Mr. Rascati noted Petitioner had factors working in his favor such as his demeanor, interpersonal skills, experience, and consistent work history prior to his accident,

Mr. Rascati believed Petitioner would be capable of performing in the capacity of customer service, call center worker, front desk agent, picker/packer, sit-down assembly worker,

or collections representative. He performed a Labor Market Survey where he found nine positions which he opined Petitioner would be capable of performing. Again, he acknowledged that these were positions where Petitioner may not be a perfect candidate, but they were options available within Petitioner's physical restrictions. The Arbitrator takes note of Mr. Rascati's opinion that light or sedentary jobs would likely not require Petitioner to sit for extended periods of time of or prohibit him from sitting or standing as needed. The Arbitrator notes that Petitioner did not submit any job logs reflecting potential employment positions that Petitioner attempted to secure. The Arbitrator notes a lack of follow-up from Petitioner regarding any attempt at proceeding with professional vocational services with either Mr. Pagella or Mr. Rascati. No evidence of any self-directed job search was submitted into evidence.

Based upon the above, the Arbitrator finds that the Petitioner is not permanently and totally disabled. The Arbitrator finds that Petitioner has not sufficiently demonstrated that there is no reasonably stable job market based upon Petitioner's inadequate effort to participate in any meaningful job search or participate in any professional vocational rehabilitation endeavors. That said, since Petitioner's permanent restrictions prevent him from returning to his pre-injury line of work Petitioner has suffered a loss of trade and is permanently partially disabled commensurate with a 50% loss of use of the person as a whole. Accordingly, Respondent shall pay PPD benefits of $220.00/week for 250 weeks. Respondent is entitled to a credit of $25,276.00 for PPD advances already paid.

ENTERED: 

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC025810
Case Name	Esperanza Castillo v. Suncast Corporation
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Corrected Decision
Commission Decision Number	22IWCC0329
Number of Pages of Decision	6
Decision Issued By	Stephen Mathis, Commissioner, Deborah Baker, Commissioner

Petitioner Attorney	Christopher Bassmaji
Respondent Attorney	Petar Milenkovich

DATE FILED: 9/14/2022

/s/Stephen Mathis, Commissioner
Signature

DISSENT: /s/Deborah Baker, Commissioner
Signature

22IWCC0329

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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ESPERANZA CASTILLO,

Petitioner,

vs. NO: 16 WC 025810

SUNCAST CORPORATION,

Respondent.

CORRECTED DECISION AND OPINION ON REVIEW

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

The Commission modifies the award based upon the finding that Petitioner's average weekly wage as reflected on the Request for Hearing (AX1) is $412.27. Petitioner is married with 3 dependent children. Therefore, Petitioner is at the statutory minimum TTD rate of $330.00. The Commission modifies the award of TTD to conform to the statutory minimum and awards the weekly rate of $330.00.

Petitioner asserts that the evidence supports an award of additional TTD benefits commencing December 8, 2020, through October 20, 2021, the date of hearing. The Commission finds that while Petitioner has not worked since August 11, 2016, she has failed to meet the burden of proof that her employment status since January 14, 2020 is causally connected to her work accident. Review of the record shows that Dr. Markarian released Petitioner to return to full-duty work on January 14, 2020. It was noted that Petitioner had not, at that time completed a functional capacity evaluation.

Petitioner testified at hearing that she did not return to work in January 2020 because she was helping her daughter who was experiencing complications with her pregnancy. Following that time, the pandemic negatively affected her ability to obtain employment.

On December 8, 2020, Petitioner had a telemedicine visit with Dr. Markarian. At that time, she reported 70% improvement and Dr. Markarian released her to modified work and full shifts. She returned to Dr. Markarian on December 16, 2020 and was released to "medium" work pursuant to the restrictions on her functional capacity evaluation. Dr. Markarian discharged her from care and declared her to be at MMI. Petitioner has failed to demonstrate by a preponderance of the evidence that her continued failure to obtain employment through October 20, 2021, is the result of her work injury versus unrelated factors. For the foregoing reasons the Commission denies the extension of TTD benefits from December 16, 2020 through October 20, 2021.

IT IS THEREFORE ORDERED BY THE COMMSSION that the Decision of the Arbitrator filed December 21, 2021, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $330.00 per week for a total of 178-5/7 weeks, commencing August 12, 2016 through January 14, 2020, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $330.00 per week for a period of 75 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 15% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner any outstanding, related, reasonable and necessary medical expenses subject to the medical fee schedule, as provided in Sections 8(a) and 8.2 of the Act, including the following:

Midwest Anesthesia and Pain Specialists- $11,037.43
Premium Healthcare Solutions- $4,900.00
ATI Physical Therapy- $35,569.64
Hyde Park Surgical Center- $28,125.00
Illinois Anesthesia Specialists- $2,362.00
Orthopedic Associates of Naperville/Chicago- $10,081.43
Joliet Open MRI- $2,558.00
EQMD- $10,764.06
Midwest Specialty Pharmacy- $360.50
Electronic Waveform Lab-$3,384.92
Adco Billing- $803.70
Vital Medical Network- $3,400.00
Prescription Partners- $3,758.45
Delaware Physicians- $694.14
Lakeshore Surgery Center (facility)- $11,649.20

Lakeshore Surgery Center (professional) $1,275.00
Western Touhy Anesthesia- $1,958.14
Imaging Centers of America- $1,800.00
Blue Cross/Blue Shie ld- $10, 668.00.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit for any benefits paid under Section 8(j) of the Act.

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.

September 14, 2022

SJM/msb
o-6/29/2022
44

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

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

DISSENT (IN PART)

I agree with the majority's decision to affirm the Arbitrator's findings as to causal connection and medical expenses. Additionally, I agree with the majority's decision to modify the TTD rate. However, I disagree with the majority's decision to deny Petitioner's request for additional temporary total disability (TTD) benefits.

The Arbitrator found Petitioner was entitled to temporary total disability (TTD) benefits for the time period of August 12, 2016 through January 14, 2020. The Arbitrator reasoned that during this time, Petitioner was either taken off work completely or given work restrictions for which Petitioner was not provided work accommodations. The Arbitrator declined to award TTD benefits for the time period of December 8, 2020 through October 20, 2021. The Arbitrator reasoned that "On January 14, 2020, Dr. Markarian indicated Petitioner could return to work without restrictions. Petitioner testified that she could not return to work following her full duty release because her daughter was pregnant and also because of COVID."

On review, Petitioner argues that after the August 10, 2016 work accident, Petitioner was placed off work by one of her treating physicians. On January 1, 2017, Respondent terminated

Petitioner's employment, which entitles Petitioner to continued TTD benefits as long as she has work restrictions. Petitioner's treating physicians continued to place Petitioner off work (or gave work restrictions) through January 14, 2020. Subsequently, Petitioner was released to work with restrictions on December 8, 2020 while she treated for her work injuries, and released to work with permanent restrictions on December 16, 2020. Since the work accident, Petitioner has not returned to work for Respondent, and in fact, has not worked anywhere. Respondent argues that Petitioner is not entitled to any TTD benefits whatsoever because Petitioner's condition is not causally related to the August 10, 2016 accident. Additionally, Respondent asserts "the Arbitrator notes that Dr. Pelinkovich had diagnosed Petitioner with a cervical strain and did not assign any work restrictions resulting from that diagnosis." Respondent made no other arguments as to TTD.

I find that Petitioner is entitled to TTD benefits for the additional time period of December 8, 2020 through October 20, 2021. Both the Arbitrator and the majority have found that Petitioner proved her cervical spine and right shoulder conditions are causally related to the stipulated August 10, 2016 work accident. In finding causal connection, the Arbitrator specifically relied on Petitioner's unrebutted testimony. The Arbitrator also found Dr. Markarian, Petitioner's treating physician for her right shoulder, to be more credible than Dr. Bare, Respondent's section 12 examining physician with respect to the right shoulder. Further, the Arbitrator found that Dr. Pelinkovich related Petitioner's cervical condition to the work accident, even if he disagreed as to the nature of the injury, diagnosing Petitioner with a cervical strain. I note that Dr. Pelinkovich never addressed the issue of Petitioner's work status and whether she could return to work in any capacity in either of his section 12 reports.

During the arbitration hearing, Petitioner testified that Respondent terminated her employment around December 2016 because she did not return to work after the "IME doctor" released her to full duty work. T. 28-29. Petitioner testified that she never returned to work for Respondent after the stipulated work accident. T. 25. Mr. Baunach, one of Respondent's witnesses, confirmed that Petitioner was terminated but noted that it occurred on January 1, 2017 per Respondent's "no-show" policy. T. 81-82, 90. Mr. Baunach testified that after 5 days of "no call/no show," when an employee has been scheduled to work, "we would consider that a resignation." T. 81. Mr. Baunach testified further that Petitioner did not return to work after Dr. Pelinkovic's December 4, 2016 section 12 examination addendum report. T.80. It was his understanding that Dr. Pelinkovich had released Petitioner to full-duty work in his December 4, 2016 addendum report. T. 80. Respondent's Exhibit 2 is a contract between Respondent and the Midwest Regional Joint Board (Union) which indicates that employees can be terminated after failing to return to work after a leave of absence that exceeds 6 months. Resp.'s Ex. 2, Art. 15.

The law in Illinois regarding entitlement to TTD supports Petitioner's claim for additional TTD benefits. It remains the law in Illinois that an at-will employee may be discharged for any reason or no reason. *Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Comm'n*, 236 Ill. 2d 132, 149 (2010). Whether an employee has been discharged for a valid cause, or whether the discharge violates some public policy, are matters foreign to workers' compensation cases. *Id*. An injured employee's entitlement to TTD benefits is a completely separate issue and may not be conditioned on the propriety of the discharge. *Id*. The proper test for determining whether an employee is entitled to TTD benefits is whether the

employee remains temporarily totally disabled as a result of a work-related injury and whether the employee is capable of returning to the work force. *Id*. **An employer's obligation to pay TTD benefits to an injured employee does not cease because the employee had been discharged--whether or not the discharge was for "cause."** *Id*. (Emphasis added.) When an injured employee has been discharged by her employer, the determinative inquiry for deciding entitlement to TTD benefits remains, as always, whether the claimant's condition has stabilized. *Id*.

I find that Petitioner could not return to work with the restrictions she had been given from December 8, 2020 through October 20, 2021 because Respondent had terminated her employment. Petitioner's testimony that she did not return to work on January 14, 2020 because she had to take care of her daughter and because of COVID does not negate the fact that Petitioner had no job to return to even if she wanted to return to work for Respondent on January 14, 2020. The evidence shows that Petitioner's treating physicians released Petitioner to work with restrictions from December 8, 2020 through October 20, 2021 (at which time she was released with permanent restrictions), however, Petitioner had no job to return to because she had been terminated by Respondent. Petitioner's condition had not stabilized during this time as she was actively treating for her work-related injuries.

Based on the established law in Illinois regarding TTD benefits as set forth above, I respectfully dissent.

/s/*Deborah J. Baker*
Deborah J. Baker

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	12WC017980
Case Name	Katie Harvey v. Country Financial
Consolidated Cases	
Proceeding Type	8(a)/19(h) Petition
Decision Type	Corrected Decision
Commission Decision Number	22IWCC0332
Number of Pages of Decision	7
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Fred Johnson
Respondent Attorney	Jack Shanahan

DATE FILED: 9/9/2022

/s/Stephen Mathis, Commissioner

Signature

STATE OF ILLINOIS) SS. COUNTY OF CHAMPAIGN)	☐ 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 Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KATIE HARVEY,

Petitioner,

vs. NO: 12 WC 017980

COUNTRY FINANCIAL,

Respondent.

CORRECTED DECISION AND OPINION ON REVIEW SECTIONS 8(a),19(l). and 19(k)

Timely Petition for Review under section 8(a) having been filed by Petitioner and notice given to all parties, the Commission, after considering the issues of further medical benefits, and penalties pursuant to sections 19(l) and 19(k) of the Act, grants the 8(a) petition and grants the petition for penalties for the reasons set forth below.

Petitioner sustained severe work-related traumatic injuries on June 7, 2011, which caused multiple fractures, traumatic brain injury, and a spinal cord injury that rendered her a paraplegic. The parties entered into a settlement contract on March 20, 2013, which kept Petitioner's Section 8(a) rights open. Subsequently, the parties executed additional stipulations which continued to keep Section 8(a) rights open.

Petitioner first filed a Section 8(a) petition on December 24, 2019, seeking payment for past and prospective physical therapy. Petitioner lives independently in her home with her now 12 year old daughter. Petitioner is 33 years of age at present. She is largely confined to a

wheelchair but occasionally can use a walker to stand and perform limited household tasks such as washing dishes.

Hearing on Petitioner's 2019 Section 8(a) petition was conducted before Commissioner Simpson on March 13, 2020. Evidence at that hearing included deposition testimony from Dr. Sanjiv Jain, Petitioner's treating physician who specializes in physical medicine and rehabilitation. Dr. Jain testified that among Petitioner's significant medical challenges and disability that she suffers from severe spasticity and flexion contractures of her hips which produce intractable pain. The spasticity and contractures are caused by increased tone secondary to her spinal cord injuries and paralysis.

Dr. Jain recommended a physical therapy regime targeted at improving Ms. Harvey's range of motion and stretching to decrease spasticity and painful contractures. Dr. Jain testified that physical therapy with a skilled practitioner also helps to build strength and optimize Petitioner's ability to make transfers and improve her balance to aid in her ability to stand with her walker.

On July 31, 2020, the Commission issued its Decision which provided for the payment of past and prospective physical therapy pursuant to Dr. Jain's care plan. Respondent did not appeal the Commission's award of benefits and prospective physical therapy as prescribed by Dr. Jain. Dr. Jain's plan of care anticipated physical therapy several times per week to reduce pain, improve range of motion, and optimize function. Since her condition is permanent, she will continue to require physical therapy for the foreseeable future.

Petitioner underwent a Section 12 evaluation at the request of Respondent by Dr. Cantrell on June 9, 2021. Dr. Cantrell noted significant bilateral hip flexion contractures and spasticity and acknowledged Petitioner's need for ongoing physical therapy. He noted the impact of these conditions on Petitioner's activities of daily living. Dr. Cantrell stated the opinion that Petitioner did not require physical therapy 2-3 times per week but would benefit from physical therapy on a once-every-other-week basis to maintain range of motion. Dr. Cantrell emphasized the need for Petitioner to strictly adhere to a home exercise program to help maintain her range of motion and control spasticity. Thus, the issues on review currently are the frequency of physical therapy services and penalties. Petitioner filed the currently pending Section 8(a) petition on September 3, 2021, which additionally seeks penalties pursuant to Section 19(l)and 19(k) of the Act.

Petitioner was receiving physical therapy 2-3 times per week in accordance with Dr. Jain's recommendation until August 26, 2021. On that date, Respondent's claims adjustor notified ATI that based upon the report of Section 12 provider Dr. Cantrell only 26 physical therapy sessions were necessary annually and that no further visits would be authorized for the remainder of calender year 2021.

At the hearing conducted before Commissioner Mathis on March 1, 2022, Petitioner testified that due to Respondent withholding authorization she did not have any physical therapy from August 26, 2021, through November 2, 2021. She testified that she needs the forceful stretching she receives in therapy to relieve the painful muscle contractures she experiences. Petitioner filed the currently pending Section 8(a) petition on September 3, 2021, which additionally seeks penalties pursuant to Sections 19(l)and 19(k) of the Act.

Petitioner testified that although she performs her home exercise program daily, she is unable to exert the stretching force on her own that is required to relieve the contractures. Without the frequent stretching at physical therapy Petitioner's function has deteriorated. She was unable to stand with her walker to perform household chores. The hip tightness caused her back to arch and she was unable to lie flat to sleep. She experienced back pain of such severity that Dr. Jain prescribed oxycodone. Petitioner testified that she took the oxycodone rarely due to side effects and fear of dependency.

Petitioner testified that since November 2, 2021 she receives only one session of PT every 14 days instead of 2-3 times per week as she had prior to August 26, 2021. She now experiences increased cramping leg pain. Her pain can no longer be managed by over-the-counter Tylenol or Ibuprofen. Her sleep is now disturbed by pain at night that causes her back to arch. She now experiences painful muscle spasms and twitching. Her pain score has increased, and her function has deteriorated since the decrease in physical therapy.

When Petitioner was receiving physical therapy 2-3 times per week, her pain was less and she did not require any prescription pain medication; her sleep was not interrupted by spasms, and her overall function was better. Petitioner never required oxycodone when she was receiving PT 2-3 times per week.

Dr. Jain testified by evidence deposition taken on December 7, 2021. Dr. Jain had last seen Petitioner on October 19, 2021. Dr. Jain testified that Ms. Harvey continues to require physical therapy secondary to her spasticity, contractures, tone, and decreased mobility both for transfers and ambulation. Petitioner sustained multiple fractures of the thoracic spine and a spinal cord injury with resultant spasticity. She is unable to straighten her lower legs due to contractures. She requires ongoing aggressive range of motion and stretching 2-3 times per week to enable her to bear weight and do activities in a standing position.

Petitioner is not able to do these therapies on her own. The therapy requires a passive stretch that she cannot perform independently because of her spinal cord injury and weakness in her legs. Dr. Jain's recommendation is that physical therapy be given 3 times per week. Therapy could at some point be reduced to twice per week in the future provided Petitioner is able to maintain her gains. Her need for therapy will continue into the foreseeable future. Attempts at decreasing the frequency of PT for Petitioner in the past have resulted in increased pain and loss of function. PT is critical to maintaining her function, and level of independence.

During the period when Petitioner's physical therapy was suspended due to lack of authorization she regressed in her function and independence in activities of daily living. Dr. Jain testified that Petitioner is a young woman with a young child and that she is trying to stay active. In Dr. Jain's opinion it is not in Petitioner's best interests to decrease the frequency of therapy. If therapy continues at the decreased frequency advocated by Dr. Cantrell Petitioner is at risk for increased pain, increased contractures, and decreased functional mobility.

The evidence deposition of Section 12 examiner Dr. Cantrell was taken on February 16, 2022. He performed an evaluation of Petitioner at the request of Respondent in June 2021. Dr. Cantrell acknowledged that an argument could be made for weekly physical therapy sessions for Petitioner as being beneficial. It's his opinion however, that physical therapy every 14 days is appropriate for a "maintenance" level of therapy. Petitioner reported to Dr. Cantrell that she could do her exercises at home by herself, but she is not able to do the sustained stretching that the therapist performs.

Dr. Cantrell admitted on cross examination that he has not seen any of Petitioner's medical records since June 2021, and he did not review Dr. Jain's December 2021 deposition. He has no knowledge of the basis for the opinions Dr. Jain expressed in his December 2021 deposition. Dr. Cantrell's report does not state any medical basis for his opinion that physical therapy every 14 days is appropriate for Petitioner.

Dr. Cantrell admitted to having no knowledge as to what impact not having physical therapy for a 14-day period had on Petitioner in 2021. The Commission notes that Dr. Cantrell's lack of knowledge concerning the impact the suspension of physical therapy services had on Petitioner's condition and functionality seriously undermines the credibility of his opinion regarding the recommended frequency of physical therapy services. Furthermore, the Commission finds that Dr. Jain's explanation as to why Petitioner requires multiple physical therapy sessions on a weekly basis is more persuasive and compelling.

The Commission notes that Petitioner sustained a severe and permanent injury at an early age and that the welfare and well-being of both Petitioner and her young daughter mandate the utilization of reasonable and necessary physical therapy to restore and maintain her function and independence to the degree medically possible. The Commission further finds that Petitioner did not require the use of oxycodone to control her pain when she was receiving physical therapy at the frequency recommended by Dr. Jain prior to August 24, 2021. For the foregoing reasons the Commission finds that Dr. Jain's plan of care for physical therapy sessions 2-3 times per week is reasonable and necessary. Dr. Jain was persuasive in his testimony that Petitioner's constellation of injuries, dictate the need for ongoing physical therapy at the frequency prescribed by his plan of care for the foreseeable future. On that basis the Commission finds that ongoing physical therapy 2-3 times per week should be authorized and paid for by Respondent.

Petitioner asserts that the failure of Respondent to authorize and pay for therapy at the frequency recommended by Dr. Jain has been without good cause, is vexatious, intentional, and

deliberate and that penalties under Sections 19(l) and 19(k) are warranted. The Commission is troubled by Respondent's reliance on Dr. Cantrell's Section 12 report of June 9, 2021, in justifying the decrease in frequency of physical therapy benefits to Petitioner to one session every 14 days. Dr. Cantrell's report stops short of *recommending* a decrease in the frequency of Petitioner's physical therapy sessions. He does not state any basis or medical justification for the decrease in frequency of physical therapy. He does not state an opinion that Petitioner will in anyway benefit from the decrease in services. Ironically, he makes his statement in the context of his commentary concerning the severity of Petitioner's "continued significant hip flexor spasticity" and the adverse impact on her activities of daily living.

Having carefully considered the entire record, the Commission gives greater weight to the opinions of Dr. Jain and finds that Petitioner is entitled to past and prospective physical therapy on the basis of 2-3 sessions per week as recommended by Dr. Jain to restore and maintain her function and manage her pain. Such an award of ongoing medical and palliative care is within the Commission's statutory authority, See *Gordon v. Tri-County Personnel,*98 WC30323, 2010 Ill. Wrk.Comp. LEXUIS 1017, aff'd, *Tri-County Personnel Mgmt. v. Ill. Workers' Comp. Comm'n.,* 2012 IL App (3d) 110609WC-U.

Petitioner seeks penalties and fees pursuant to sections 19(l) and 19(k) of the Act be imposed upon Respondent for its failure to authorize and pay for ongoing physical therapy for Petitioner. The Commission finds that Respondent's claims adjustor, without concern for the potential detriment to Petitioner, contorted the letter as well as the spirit of Dr. Cantrell's report s and intentionally and vexatiously withheld authorization for physical therapy to Petitioner for a period of ten weeks.

Petitioner is a young woman with a young child entirely dependent upon her. This unfortunate action adversely impacted the health and safety of a vulnerable young mother who is confined to a wheelchair for the rest of her life. Respondent's failure to authorize physical therapy caused Petitioner to suffer additional pain for which she was prescribed oxycodone, a highly addictive opiate which she did not require while she was receiving physical therapy per Dr. Jain's plan of care. The Commission finds that the decision to withhold physical therapy was intentional and vexatious and does rise to a level that compels the imposition of penalties and fees on Respondent in accordance with sections 19(l) and 19(k) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay outstanding physical therapy bills in evidence pursuant to Sections 8(a) and 8.2 of the Act. To the extent Medicare has paid any of the physical therapy bills, Respondent shall hold Petitioner harmless from any claims for reimbursement by Medicare.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and provide prospective physical therapy, 2-3 sessions per week, as prescribed by Dr. Jain, pursuant to Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Section 19(k) penalties in the amount of 50% of the sum of unpaid medical expenses pursuant to the fee schedule or negotiated rate.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner penalties pursuant to Section 19(l) in the amount of $5,640.00.

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 injury.

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

September 9, 2022

SJM/msb
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/s/ *Stephen J. Mathis*
Stephen J. Mathis

/s/ *Deborah J. Baker*
Deborah J. Baker

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