ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KRUS, KATRINA
Employee/Petitioner

Case# **12WC000393**

PEORIA PUBLIC SCHOOL DISTRICT
Employer/Respondent

On 10/9/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above 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.

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

1824 STRONG LAW OFFICES
MICHAEL K BRANDOW
3100 N KNOXVILLE AVE
PEORIA, IL 61603

5354 STEPHEN P KELLY
2710 N KNOXVILLE AVE
PEORIA, IL 61604

STATE OF ILLINOIS)
)SS.
COUNTY OF **PEORIA**)

☐ 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

Katrina Krus
Employee/Petitioner

Case # **12** WC **393**

v.

Peoria Public School District
Employer/Respondent

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 **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Peoria**, on **August 14, 2015**. 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 **March 22, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**19,240.00**; the average weekly wage was $**370.00**.

On the date of accident, Petitioner was **35** years of age, ***single*** with **1** dependent child.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $**222.00**/week for **12.5** weeks, because the injuries sustained caused the **2.5**% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Arbitrator Anthony C. Erbacci

October 6, 2015
Date

OCT - 9 2015

FACTS:

On March 22, 2011 the Petitioner sustained an undisputed accidental injury arising out of and in the course of her employment with the Respondent as a cafeteria manager. The Petitioner testified that she lifted a tote filled with food and felt a "pop" in her low back. The Petitioner testified that the next morning she reported her back pain to the Respondent and was directed to obtain treatment at IWIRC.

The Petitioner was seen at IWIRC on March 23, 2011and gave a consistent history of injury. She was diagnosed with a lumbar strain, prescribed medication and physical therapy, and given light duty work restrictions. The Petitioner followed up at IWIRC on April 1, 2011 and reported improvement in her symptoms. On April 6, 2011 the Petitioner returned and reported that her symptoms had worsened since her last visit and that she now had constant shooting pain down her left leg and numbness in her great toe. Examination was noted to demonstrate inconsistencies and hyper-exaggerations and it was noted that her symptoms could not be explained by a mechanical back problem. An MRI was ordered to rule out an occult malignancy or other cause and the assessment included symptom magnification.

An MRI was completed on April 20, 2011 and was reported to demonstrate mild levoscoliosis of the lumbar spine, mild diffuse disc bulging throughout the lumbar spine, and mild bilateral foraminal stenosis at L4-5.

On April 21, 2011 the Petitioner returned to IWIRC with continuing complaints of stabbing pain in her low back, constant throbbing down her left leg, and numbness in her big toe. The Petitioner reported her pain as being 10/10 and she also complained of urinary incontinence. The MRI was reportedly reviewed with the Petitioner and was noted to demonstrate no significant nerve root impingement, spinal stenosis, or cauda equine syndrome. The Assessment continued to be lower lumbar muscle strain and exam inconsistencies and hyper-exaggerations were again noted. It was also noted that the Petitioner's current symptoms and urinary incontinence could not be explained by the MRI. It was again noted that the Petitioner was symptom magnifying and she was directed to see her primary care physician to find the cause of her urinary incontinence which was indicated to be not work related. The Petitioner was released from care and directed to return to unrestricted work.

The Petitioner testified that she continued working for the Respondent through the end of the 2011 school year and that she then sought treatment with her primary care physician at Methodist Family Practice. The Petitioner testified that she then underwent testing for multiple sclerosis which was ruled out. The Petitioner continued to be treated at Methodist Family Practice during the summer of 2011 because of her back complaints.

The records of Methodist Medical Group demonstrate that the Petitioner was seen there by Dr. Karen Gellada on April 22, 2011 and reported a one year history of bilateral lower extremity pain, which were worse with activity, and difficulty walking. The Petitioner also reported that "3 months ago, Picked up something, hurt back". The Petitioner was noted to have complaints of bilateral lower extremity pain and numbness as well as headaches, numbness in both feet and hands, and urinary incontinence. The Petitioner was assessed as having lower extremity pain, sensory deficits, and urinary incontinence and she was referred for a neurological assessment to rule out multiple sclerosis.

The Petitioner returned to Methodist Medical Group on May 10, 2011 and was noted to have chronic low back pain which was exacerbated after lifting a heavy object at work. It was also noted that the Petitioner reported that "in the last few months" she noted low back pain with radiation into both feet which was worse with sitting or activity. She was assessed as having low back pain with radiation and she was prescribed Norco and physical therapy. The Petitioner returned on May 13, 2011 with complaints of worsening low back pain radiating into both feet. It was noted that a lumbar MRI showed disc bulges and the Petitioner was noted to have positive straight leg raise tests bilaterally with shooting pains of the outer feet at 20 degrees. The Petitioner was referred to the pain clinic and her dosage of Norco was increased. The Petitioner followed up again on May 23, 2011 and was again assessed as having low back pain.

On June 11, 2011, the Petitioner was seen at the Emergency Room at Methodist Medical Center for complaints of chronic pain. It was noted that the Petitioner reported a history of having pain in her lower lumbar spine for three years. The Petitioner also reported taking Norco and "going through" epidural injections for her back pain. The Petitioner was given an injection of Toradol in her right gluteus, provided Percocet, and discharged with instructions to obtain follow up care.

On June 13, 2011, the Petitioner returned to Methodist Medical Group complaining of uncontrolled bowel movements and low back pain. The Petitioner also reported increased left leg weakness and increased radiating pain on the left leg as compared to the right leg. The Petitioner was assessed as having back pain with radiation and fecal incontinence and an MRI was ordered. The Petitioner underwent the MRI of the lumbar spine that same day and the history noted by the radiologist was low back pain for three years and recent steroid injection. The Petitioner was noted to have numbness in the left foot, hypesthesia in the left leg and bowel incontinence. The MRI was reported to demonstrate minimal facet joint hypertrophy at L5-S1 and no acute findings.

On June 27, 2011, the Petitioner returned to Dr. Gellada with complaints of extreme back and left leg pain which was worse after a "back injection" 3 days earlier. It was noted that the Petitioner had been seen at the pain clinic and had received epidural shots and Topamax as well as Norco. It was further noted that the Petitioner rated her pain as 10/10 and that the duration of her pain was "3 yrs". The Petitioner was also noted to be working at Hucks as a cashier.

On September 13, 2011, the Petitioner went to Methodist Medical Center due to her back pain. The Petitioner reported that her left leg had given way and she fell and hit her left cheek The Petitioner was noted to report a two year history of chronic low back pain, for which she was being seen at the pain clinic, and that she "does a lot of lifting in her job". It was also noted that the Petitioner had undergone a left sacroiliac joint injection on September 9, 2011. The Petitioner indicated that she wanted a surgical consultation and she was requesting Norco. It was noted that the Petitioner had no signs of disc herniation or neurological compromise of the lower extremity and, objectively, hypersensitive skin reaction to palpation, straight leg raise bilateral to 75 degrees with no tingling or parasthesis, and good sensation. The Petitioner was directed to follow up with the pain clinic.

On September 19, 2011 the Petitioner underwent another MRI of her low back as well as an x-ray of her left hip. The history noted in the report of the MRI indicates that the exam was requested through the emergency room and that the Petitioner reported that she had fallen on September 11, that she had back pain in both buttocks which radiated into the left leg, and that since September 17 she had bowel and bladder incontinence. The MRI was reported to demonstrate no acute findings,

no disc herniation or spinal stenosis; normal appearance to the lower thoracic cord and conus medullaris; and mild facet degeneration. The left hip x-ray was reported to demonstrate calcification adjoining the roof of the acetabulum, which had increased from the Petitioner's previous study from May 6, 2009, but no fracture or significant narrowing of the joint space.

A nerve conduction study was then completed on October 24, 2011 and was reported to demonstrate a left mid and lower lumbar and sacral radiculopathy. Physical therapy was recommended for the Petitioner but she declined therapy at that time. The Petitioner was next seen by Dr. Rians at Great Plains Orthopedic on November 14, 2011. Dr. Rians' diagnosis was an L5 radicular pain with a normal MRI exam and a normal EMG. Dr. Rians recommended that the Petitioner be referred to a neurosurgeon to evaluate her condition given her history of incontinence. Dr. Rians took the Petitioner off work for a month at that point and suggested that she might need a CT myelogram to address the cause of her L5 radicular pain. Dr. Rians referred the Petitioner to Dr. Fassett at Illinois Neurological Institute.

On December 21, 2011, the Petitioner returned to Great Plains Orthopedic with continuing complaints of low back pain with left sciatica at the L5 distribution. The Petitioner reported that Dr. Fassett felt that he could not do anything for her given that her MRI was normal and did not show a nerve root impingement. Dr. Rains noted that her MRI did show some mild mass effect of the right L5 but that her symptoms were on the left. The Petitioner was then referred to Dr. Kube, pursuant to her request. Dr. Rains also recommended a CT myelogram and that was to be held off until the Petitioner saw Dr. Kube.

On December 29, 2011, the Petitioner saw Dr. Kube who took the Petitioner off work, ordered an MRI of the left hip, and recommended an SI joint injection.

On February 20, 2012, Dr. Fassett generated a report for Dr. Rians. Dr. Fassett reviewed the MRI of the Petitioner's low back which he noted to be completely normal. Dr. Fassett indicated that the Petitioner's left lower extremity pain was of unknown origin and that no neurosurgical interventions could alleviate the Petitioner's symptoms.

On February 27, 2012 a lumbar CT was completed and reported to demonstrate no significant findings.

On March 5, 2012 Dr. Rians noted that the CT myelogram was normal and that the lumbar spine could be ruled out as the source of the Petitioner's problems. Dr. Rians indicated that hip and SI problems were possible sources and he diagnosed possible femoral acetabular impingement.

An MRI of the left hip took place on April 5, 2012, and was reported to demonstrate a small amount of edema in the left paraspinous muscle which could be related to the steroid injection versus a muscle injury such as a strain. On April 19, 2012 the Petitioner underwent an SI joint injection by Dr. Kube and on May 1, 2012, Dr. Kube noted that the Petitioner reported that she had good results from the injection. The Petitioner then commenced a course of physical therapy and underwent a second SI joint injection on May 7, 2012. At a follow up visit with Dr. Kube on May 15, 2012, Dr. Kube noted that the Petitioner reported only temporary relief from that injection and he then recommended an SI joint fusion. Dr. Kube also placed the Petitioner on sedentary work restrictions. Thereafter, the Petitioner continued treating on and off with Dr. Kube or one of his assistants through November 13,

2012, when she was taken off work completely. As of the date of hearing, the Petitioner has not had the SI joint fusion recommended by Dr. Kube.

The Petitioner testified that she currently has difficulty walking and that she is unable to lift greater than five pounds. She testified that lifting anything greater than five pounds or "standing the wrong way" causes an increase in her pain. She testified that walking any distance causes her back to "pop".

On cross-examination, the Petitioner acknowledged that she told Dr. Kube that she did not have any problems with her low back prior to February 23, 2011 and she initially testified that she had no treatment for her low back prior to February 23, 2011. She later testified that she could have had treatment for her low back prior to February 23, 2011but she could not remember. The Petitioner testified that she did not remember treating with Dr. Capecci in May of 2009 or treating for complaints of severe back and leg pain in July of 2009. The Petitioner also testified that she did not recall receiving injections in her back or physical therapy prior to February 23, 2011. The Petitioner initially testified that she did not remember if she worked after the end of the 2011 school year but then acknowledged that she worked for Peoria Charter in the summer of 2011 and at a Huck's for four to five weeks in 2011. The Petitioner testified that she could not remember which Huck's she had worked at and that she did not remember if she worked anywhere else after May of 2011.

At the request of the Respondent, the Petitioner was examined by Dr. Gunnar Anderson on February 23, 2012 and again on October 22, 2013. Dr. Anderson's deposition testimony of November 20, 2013 was admitted into the record as Respondent's Exhibit 1. Dr. Anderson testified as to his examination findings and the medical records he reviewed relating to the Petitioner. Dr. Anderson noted that the Petitioner had treated with Dr. Capecci at Great Plains Ortopaedics in May of 2009 for complaints of bilateral leg pain and pain in her thigh and hip and was thought to have sciatica. He noted that a lumber MRI was performed on the Petitioner on June 18, 2009 and was reported to show no evidence of central canal stenosis or disc herniation but mild narrowing on the right side in the foramen at L5-S1 secondary to facet arthropathy and spurring. Dr. Anderson also noted that it appeared that the Petitioner had been treated with epidural steroid injections for complaints of low back pain with right leg pain in August of 2009. Dr. Anderson further noted the treatment rendered to the Petitioner at IWIRC and Methodist Medical Group, and the treatment rendered to her by Dr. Hauter, Dr. Fassett, Dr.Liu, Dr. Rians, and Dr. Kube.

Dr. Anderson opined that the Petitioner sustained a lumbar strain injury as a result of the March 22, 2011 work accident and that she reached maximum medical improvement from that injury by April 14, 2011. Dr. Anderson diagnosed the Petitioner as having pain complaints without any specific underlying physical diagnosis and he noted that the Petitioner has no objective medical findings to support her subjective complaints of pain. Dr. Anderson opined that the Petitioner has developed a chronic pain syndrome with significant psychological and emotional components and should be evaluated by a psychiatrist or neuropsychiatrist or psychologist specializing in pain syndromes. Dr. Anderson opined that the Petitioner's chronic pain syndrome is unrelated to her work accident and that there is no causal relationship between the Petitioner's work injury and her current condition of ill-being.

The August 19, 2013 deposition testimony of Dr. Kube was admitted into the record as Petitioner's Exhibit Number 9. Dr. Kube testified as to the care and treatment that he rendered to the Petitioner and he opined that the treatment was reasonable and necessary. Dr. Kube testified that

the Petitioner should remain at a sedentary work status and that she would benefit from the SI joint fusion which he continues to prescribe for the Petitioner. Dr. Kube testified that he was not aware of any pre-existing complaints or problems with medical treatment to the Petitioner's SI joint or her lower lumbar spine that pre-dated the March 22, 2011 accident and that he was not aware of any subsequent or intervening accident. Dr. Kube indicated that the Petitioner's lumbar radiculopathy was a function of SI joint inflammation which was causally related to the accident of lifting the totes. Dr. Kube noted that the onset of the Petitioner's symptoms was very contemporaneous to her accident without intervening issues. He further noted that the Petitioner had no previous problems or difficulties with her SI joint.

At the request of the Respondent, a review of all of the Petitioner's medical records was performed by Dr. Martin Lanoff and he issued a report dated January 30, 2014. The May 4, 2015 deposition testimony of Dr. Lanoff was admitted into the record as Respondent's Exhibit 2. Dr. Lanoff testified as to the medical records he reviewed and he opined that, as a result of her work injury, the Petitioner may have sustained a lumbar strain that should have improved within six to eight weeks of the injury. Dr. Lanoff indicated that the Petitioner current complaints of pain were out of proportion with her objective findings and he opined that her current back problems were unrelated to her work injury. Dr. Lanoff further opined that no treatment or testing six to eight weeks after the work injury was medically indicated and he testified that the sacral fusion recommended by Dr. Kube was neither reasonable nor necessary.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

The Respondent stipulated that on March 22, 2011 the Petitioner sustained accidental injuries that arose out of and in the course of her employment and that timely notice of the accident was provided to the Respondent. The Petitioner sought medical treatment the following day and was diagnosed as having a lumbar strain. She initially reported improvement in her condition but a few weeks later she reported that her symptoms had worsened and that she now had constant shooting pain down her left leg and numbness in her great toe. Examination was noted to demonstrate inconsistencies and hyper-exaggerations and it was noted that her symptoms could not be explained by a mechanical back problem. An MRI was ordered to rule out an occult malignancy or other cause and the assessment included symptom magnification. Thereafter the Petitioner began a long course of medical treatment with various physicians, none of whom found and objective basis for the Petitioner's complaints. Ultimately, the Petitioner came under the care of Dr. Kube who diagnosed her as having a lumbar strain, sacroiliac dysfunction and chronic pain from trauma. Dr. Kube injected the Petitioner's SI joint on two occasions and recommended a SI joint fusion for the Petitioner.

The Arbitrator notes that of all of the physicians who treated the Petitioner, Dr. Kube is the only physician that has opined that a causal relationship exists between the Petitioner's work injury and her current condition of ill-being. The Arbitrator finds Dr. Kube's opinion to be unpersuasive. In so finding, the Arbitrator notes that Dr. Kube was unaware of the Petitioner having received any treatment for her lower back or having any lower back complaints prior to her work injury. The Petitioner acknowledged that she told Dr. Kube that she did not have any treatment for her low back prior to her work injury and the medical records clearly demonstrate that the Petitioner had treated for

her low back prior to her work injury. Further, the medical records demonstrate that the Petitioner had complaints of pain radiating into both of her legs prior to her work injury. Dr. Kube testified that he was not aware of any pre-existing complaints or problems with medical treatment to the Petitioner's SI joint or her lower lumbar spine that pre-dated the March 22, 2011 accident.

The Arbitrator also notes that the Respondent's examining physician, Dr. Anderson, and the Respondent's record review physician, Dr. Lanoff, both opined that the Petitioner sustained a lumbar strain as a result of her work injury and that she reached maximum medical improvement from that injury within a relatively short period of time thereafter. Both Dr. Anderson and Dr. Lannoff testified that the Petitioner's pain complaints were not supported by any objective findings and they both indicated, as did the physicians at IWIRC when she was seen there in April of 2011, that the Petitioner was symptom magnifying. Both Dr. Anderson and Dr. Lanoff indicated, as did Dr. Fasset, that the Petitioner's MRI findings did not support the Petitioner's continuing complaints of pain. Both Dr. Anderson and Dr. Lanoff opined that there was no causal relationship between the Petitioner's work accident and her current condition of ill-being.

The Arbitrator further notes that the Petitioner's testimony on cross examination demonstrated that the Petitioner's memory of her prior medical care and treatment as well as her work history was so poor as to cause the Arbitrator to have serious doubts as to the reliability of the Petitioner's testimony.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner failed to prove that her current condition of ill-being is causally related to the work injury of March 22, 2011. The Arbitrator adopts the opinions of Dr. Anderson and Dr. Lanoff and finds that as a result of the work injury of March 22, 2011, the Petitioner sustained a lumbar sprain from which she reached maximum medical improvement by April 14, 2011.

In Support of the Arbitrator's Decision relating to (J.), Were the medical services that were provided to Petitioner reasonable and necessary/Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds and concludes as follows:

The findings and conclusions of the Arbitrator relating to the issue of Causation are adopted and incorporated herein.

The Arbitrator has adopted the opinions of Dr. Anderson and Dr. Lanoff and found that as a result of the work injury of March 22, 2011, the Petitioner sustained a lumbar sprain from which she reached maximum medical improvement by April 14, 2011. The Arbitrator finds therefore, that the Petitioner failed to prove that any of the medical care and treatment she received subsequent to April 14, 2011 was reasonable, necessary and causally related medical treatment for which the Respondent is responsible.

In Support of the Arbitrator's Decision relating to (K.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

The findings and conclusions of the Arbitrator relating to the issue of Causation are adopted and incorporated herein.

The Arbitrator has adopted the opinions of Dr. Anderson and Dr. Lanoff and found that as a result of the work injury of March 22, 2011, the Petitioner sustained a lumbar sprain from which she reached maximum medical improvement by April 14, 2011. The Arbitrator finds therefore, that the Petitioner failed to prove entitlement to any period of Temporary Total Disability after April 14, 2011.

In Support of the Arbitrator's Decision relating to (L.), What is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

The findings and conclusions of the Arbitrator relating to the issue of Causation are adopted and incorporated herein.

The Arbitrator has adopted the opinions of Dr. Anderson and Dr. Lanoff and found that as a result of the work injury of March 22, 2011, the Petitioner sustained a lumbar sprain from which she reached maximum medical improvement by April 14, 2011. The Petitioner testified that she continued to work for the Respondent through the end of the 2011 school year and that thereafter she worked for Peoria Charter in the summer of 2011 and at a Huck's for four to five weeks in 2011. Based upon the diagnosis of a lumbar strain, the Arbitrator finds that the Petitioner sustained a 2.5% disability to her whole person as a result of the work injury of March 22, 2011.