2019 IL App (5th) 180385WC-U

Workers' Compensation
Commission Division
Order Filed: April 24, 2019

No. 5-18-0385WC

IN THE

APPELLATE COURT OF ILLINOIS

FIFTH DISTRICT

PREMIUM TRANSPORT/EARL L. HENDERSON TRUCKING/CUSTOM PERSONNEL,	)	Appeal from the Circuit Court of Marion County
Appellants,	)	
v.	)	No. 2017 MR 135
THE ILLINOIS WORKERS' COMPENSATION COMMISSION *et al.*,	)	Honorable Daniel E. Hartigan,
(David L. Sloan, Appellee).	)	Judge, Presiding.

JUSTICE HOFFMAN delivered the judgment of the court.
Presiding Justice Holdridge and Justices Hudson, Cavanagh, and Barberis concurred in the judgment.

ORDER

¶ 1 *Held:* We affirmed the judgment of the circuit court, confirming a decision of the Illinois Workers' Compensation Commission which awarded the claimant benefits pursuant to the Workers' Compensation Act (820 ILCS 305/1 *et seq.* (West 2012)).

¶ 2 Premium Transportation/Earl Henderson Trucking/Custom Personnel (collectively referred to as Henderson), appeal from a judgment of the circuit court of Marion County, confirming a decision of the Illinois Workers' Compensation Commission (Commission) which awarded the claimant, David L. Sloan, benefits pursuant to the Workers' Compensation Act (Act) (820 ILCS 305/1 *et seq.* (West 2012)) for injuries sustained while working on December 20, 2012. For the reasons which follow, we affirm the judgment of the circuit court.

¶ 3 The following recitation of the facts relevant to a disposition of this appeal is taken from the evidence adduced at the arbitration hearing held on July 14, 2016.

¶ 4 The claimant testified that he was employed by Trucking as a truck driver. His duties included moving freight from plant to plant, swapping out trailers, and unloading trailers. On December 20, 2012, as he was driving a truck with a trailer back from having made a delivery in Florida, his truck and trailer were blown over on their side by a windstorm. According to the claimant, he lost consciousness.

¶ 5 The claimant was transported by ambulance from the scene of the accident to St. Anthony's Hospital in Effingham, Illinois. The records of St. Anthony's Hospital reflect that the claimant was confused during his examination. He complained of pain in his left arm, hand, and elbow; pain in his low back when he tried to move; dizziness; and lacerations. The claimant had a CT scan of his lower spine which revealed (1) no evidence of a cervical fracture or dislocation, (2) mild scoliotic deformity which might be due to spasm, (3) mild narrowing of the neural foramina at C3-C4 and C5-C6 due to degenerative changes, (4) small spurs at C3-C4 of unknown age, (5) possible broad-based disk protrusion at C5-C6, and (6) a possible transverse process fracture of the lumbar spine at L2 on the right. An x-ray of the claimant's left forearm revealed (1) no fractures; and (2) foreign bodies, possibly safety glass, in the dorsum of the

forearm. An x-ray of his left elbow revealed (1) no fractures, dislocation or fusion; and (2) foreign bodies, consistent with safety glass, in the subcutaneous tissues. An x-ray of the claimant's left hand revealed (1) no fractures, dislocation or fusion; and (2) foreign bodies consistent with safety glass. At the time of discharge, the following impression was noted: a head injury with loss of consciousness, a laceration injury to the left 4-5 knuckle, a 2 cm laceration to the left forearm, and multiple skin cuts from shattered glass. Follow-up treatment was recommended.

¶ 6 The claimant presented at Salem Family Health Center (Salem) on December 21, 2012. The records of that visit note a history of musculoskeletal symptoms, lacerations to the left arm, and soreness, and reflect that the claimant presented with injuries to his head, left hand knuckle, left forearm, and skin lesions. The claimant was prescribed pain medication.

¶ 7 He returned to Salem on December 28, 2012, and was seen by Mary Piper APN. The claimant complained of continuing pain in his left forearm and hand. Piper's assessment at the time of that visit was contusions of the left hand and late effects of an open wound on the upper extremity. No further diagnosis was made due to "overlapping symptoms."

¶ 8 The claimant was next seen by Piper on January 7, 2013. At that visit, the claimant complained of low back pain. The notes of that visit reflect that the claimant was being seen for examination of back and neck pain and left hand lacerations. Piper diagnosed lumbar strain and an open hand wound. She recommended that the claimant undergo physical therapy for his lumbar strain.

¶ 9 When the claimant returned to Salem on January 23, 2013, he complained of pain in his upper back and across his shoulders and low-back pain. Piper recorded an assessment of lumbar strain and scheduled an MRI of the claimant's lumbar spine.

¶ 10 On January 24, 2013, the claimant had the recommended MRI of his lumbar spine. The scan revealed: (1) preserved vertebral body heights, alignment and disc spaces; (2) no spinal stenosis or neuroforaminal narrowing; and (3) unremarkable intervertebral discs in the lumbar spine with a slight decreased signal at T12-L1 which could represent early dessication and very mild degenerative changes.

¶ 11 In her notes of the claimant's February 6, 2013 visit, Piper recorded musculoskeletal symptoms of neck pain, low-back pain, and weakness in his left ring finger. The claimant gave a history of neck stiffness and pain with increased activity and flexion; neck pain radiating to the left shoulder and upper back; persistent low-back pain, radiating to his left hip down to his left calf; and headaches. Piper recorded an impression of neck strain, lumbar strain, contusion of the hand with an intact skin surface, and an open wound to the hand. She referred the claimant to Dr. Brian Steinke at Orthopaedic Center of Southern Illinois (OCSI) for evaluation of his neck and low-back pain and Dr. Ahn for left hand swelling and weakness of the left ring finger. She also ordered an MRI of the claimant's cervical spine.

¶ 12 The claimant underwent the recommended MRI of his cervical spine on February 12, 2013. The scan was interpreted as revealing: (1) degenerative changes with disc protrusions/extrusion impinging on the anterior thecal space posterior to the C5-C6 level, showing some degree of hypertrophy contributing to a narrowed appearance of the spinal canal; (2) milder degenerative changes at C6-C7 to the left of the midline; and (3) slight narrowing of the right greater than the left neural foramen due to a disc osteophyte complex at C3-C4.

¶ 13 The claimant was first seen by Dr. Steinke on February 12, 2013. In the complaint history given by the claimant, he listed his chief complaint as lower lumbar and cervical pain. As of that visit, Dr. Steinke recorded an impression of low-back pain with a probable lumbar strain and

referred the claimant to Dr. Aiping Smith for back pain treatment.

¶ 14 The claimant saw Dr. Ahn at OCSI on February 13, 2013, complaining of stiffness in the fourth and fifth fingers of his left hand. The claimant also reported an inability to fully extend his fingers. Dr. Ahn diagnosed a left forearm foreign body and stiffness in left hand ring and little fingers at the MP joint, secondary to post-traumatic stiffness.

¶ 15 On February 25, 2013, the claimant was seen by Dr. Steinke. At that visit, the claimant complained of neck pain, worse on the left than on the right, radiating both into the occipital region and down between his scapula, with some radiation into his left posterior arm. The claimant gave a history of experiencing pain within two days of his work accident. Dr. Steinke referred the claimant for physical therapy and ordered the claimant off of work.

¶ 16 The claimant returned to Salem on March 6, 2013, complaining of neck pain, intermittent left arm pain, and headaches. The notes of that visit reflect that Piper diagnosed the claimant with a lumbar strain, a herniated cervical disc, and a contusion of the hand with intact skin surface.

¶ 17 On March 13, 2013, the claimant was seen by Dr. Beth Conrardy at OCSI. The claimant complained of low-back pain which seemed to be improving. Dr. Conrardy diagnosed minimal degenerative disc disease, left S1 joint pain, and low-back pain.

¶ 18 On April 26, 2013, the claimant was seen at Barnes Jewish Hospital and underwent a procedure to remove foreign bodies from his left forearm and repair lacerations of the tendon, left ring finger, and little finger at the MCP joints, and a debridement of the left dorsal hand wound.

¶ 19 On July 25, 2013, Dr. Smith saw the claimant on referral from Dr. Steinke. She testified that, as of that visit, she recommended pain medication, an S1 belt, a home exercise program,

and a left S1 joint injection to help alleviate the claimant's S1 joint pain. Dr. Smith stated that she believed the generator of the claimant's low-back pain was the S1 joint.

¶ 20 The claimant was next seen by Dr. Smith on March 13, 2013. He complained of low-back pain since his accident on December 20, 2012. Dr. Smith noted that the claimant's back pain was primarily on the left side of his low back. The claimant reported that he had undergone physical therapy which seemed to worsen his pain, but he did experience relief from S1 joint manipulations. Dr. Smith diagnosed minimal degenerative disc disease of the lumbar spine, left sacroiliac joint pain, and low-back pain. She advised the claimant to schedule return visits on an as-needed basis.

¶ 21 When the claimant was seen by Dr. Steinke on April 1, 2013, he again complained of neck pain radiating both into the occipital region and down between his scapula into his left posterior arm and occasionally into his left thumb and index finger. Dr. Steinke recommended that the claimant undergo a left-side C5-C6 transforaminal injection.

¶ 22 On April 8, 2013, the claimant was again seen by Dr. Conrardy. He reported experiencing pain in his neck and left upper extremity since his work accident on December 20, 2012. He complained of pain in the lower region of his cervical spine, radiating down his left arm posteriorly down to his thumb and index finger. Dr. Conrardy diagnosed cervical spondylosis, cervical degenerative disc disease, a displaced cervical disc, cervicobrachial syndrome, and unknown cardiac arrhythmia. She recommended that the claimant proceed with cervical epidural injections as recommended by Dr. Steinke.

¶ 23 The claimant had a cervical epidural steroid injection on June 24, 2013, and a translaminar epidural steroid injection on July 18, 2013.

¶ 24 When the claimant saw Dr. Smith on July 25, 2013, he reported that his pain had gotten

worse over the last month. Following her examination of the claimant on that day, Dr. Smith recorded an impression of left-sided low-back pain extending to the left posterior thigh; an essentially normal lumbar spine except for mild facet degenerative joint disease at multiple levels; that the claimant's pain could be due to S1 joint dysfunction, but facet syndrome could not be completely ruled out; a history of neck pain with C5-C6 disc protrusion; a history of GERD; and upper extremity injuries. Dr. Smith recommended that the claimant be fitted for an S1 joint belt, that he continue his home exercises, and that he receive S1 joint injections.

¶ 25 On August 5, 2013, the claimant had a second translaminar epidural steroid injection for a C5-C6 disc herniation with upper extremity radiculopathy.

¶ 26 The claimant was next seen by Dr. Smith on August 22, 2013, for neck pain and bilateral upper extremity pain. The claimant gave a history of worsening constant pain in the back of his neck; pain in the posterior of his thighs; pain in his dorsal forearm, constant on the left; intermittent pain in his right upper extremity; tingling in his fingers; and weakness in his upper extremities, bilaterally. Dr. Smith diagnosed paresthesia which could be due to a disk herniation at C5-C6; low-back pain which could be due to S1 joint dysfunction; facet syndrome superimposed with degenerative disc disease; hypertension; and GERD. Dr. Smith recommended that the claimant continue his home exercise program and undergo a new cervical spine MRI scan.

¶ 27 On August 26, 2013, and September 10, 2013, the claimant had left S1 joint injections as recommended by Dr. Smith.

¶ 28 On August 30, 2013, the claimant had an MRI scan of his of his cervical spine which revealed moderate right uncovertebral hypertrophy at C3-C4 contacting the right C4 nerve root; moderate central disc protrusion at C5-C6 causing mild central canal stenosis and contacting the

C6 nerve root; and a small left paracentral disc protrusion at C6-C7 contacting the C7 nerve root.

¶ 29 The claimant first saw Dr. Don Kovalsky, an orthopedic surgeon with a specialty in spinal surgery, on September 11, 2013. The claimant's Complaint History Form completed on that date states that his chief complaints were neck pain and left arm pain which began on December 20, 2012. The claimant complained of chronic left-sided neck pain which radiated down his shoulder arm and hand, and numbness and tingling in his left hand. Dr. Kovalsky noted that the claimant reported that, since his work accident of December 20, 2012, he has experienced neck and arm pain and has been off of work. Dr. Kovalsky testified that the claimant denied any prior injury, or treatment for any conditions, relating to his head, neck, or shoulder, although he did have a history of low-back problems, but not cervical problems. Dr. Kovalsky also noted that the claimant reported only minimal relief from his pain symptoms with physical therapy and injections. The claimant's Spurling's test was "equivocal." Cervical x-rays taken on that date revealed minor changes of the facets at C1-C2 and no significant disc space narrowing or osteophytes. Dr. Kovalsky's notes reflect that he reviewed the results of an MRI scan of the claimant's spine which had been taken on August 30, 2013. According to Dr. Kovalsky's notes, that scan detected a central disc herniation and osteophyte complex at C5-C6, with a mild foraminal narrowing bilaterally, and a small contained disc herniation at C6-C7 which was causing a minor effacement of the thecal sac on the left without severe neurological compression. Dr. Kovalsky's clinical diagnosis at that time was thoracic outlet syndrome, post-traumatic whiplash syndrome, and disc herniation at C5-C6 and C6-C7 with mild left cervical radiculopathy. He recommended that the claimant undergo physical therapy and continue to remain off of work. Dr. Kovalsky noted that, if the claimant experienced no improvement of his pain symptoms by December, he would consider scheduling the claimant for an anterior

discectomy and fusion at C5-C6 and C6-C7.

¶ 30 When the claimant saw Dr. Smith on September 26, 2013, he reported 60% improvement in his low-back pain following his S1 joint injection. Dr. Smith noted that there was a significant leakage of contrast dye suggesting a disruption of the S1 joint capsule. She recorded an impression of left-sided low-back pain, most likely due to S1 joint dysfunction; a history of neck pain with C5-C6 disc herniation; a history of GERD; and post-surgical status of the left-upper extremity. Dr. Smith noted that the claimant might benefit from a left S1 joint rhizotomy.

¶ 31 On October 1, 2013, the claimant had a physical therapy evaluation at SSM Health St. Mary's Hospital (St. Mary's); the referral being for neck sprain. He underwent physical therapy at St. Mary's from October 1, 2013, through January 14, 2014.

¶ 32 When he saw Dr. Kovalsky on October 23, 2013, the claimant reported a 10 to 15% improvement of his pain symptoms but that he was still experiencing mild pain at the occipital/cervical junction and pain at the cervical/thoracic junction. Dr. Kovalsky noted that the claimant complained of shooting pain into his left scapula and down into the upper part of his arm, arm pain with overhead activities and driving, stiffness in his left hand, and an inability to make a fist with his left hand. Dr. Kovalsky also noted that the claimant did not have severe pathology in his cervical spine; however, he did have mild to moderate spondylosis at C5-C6, what appeared to be a small left-sided disc osteophyte complex, early degenerative changes, and what appeared to be a small central-disc herniation C6-C7. Dr. Kovalsky noted a mildly positive Spurling's test on the left and a markedly positive Roos sign also on the left. He recommended that the claimant continue with physical therapy for brachial plexopathy in his neck. Dr. Kovalsky advised the claimant that there was no surgery for a brachial plexus injury. He was not of the opinion that the claimant's neck problems absolutely prohibited him from working, but the

problems with the claimant's hand and lower back were keeping him from working.

¶ 33 On November 1, 2013, the claimant underwent nerve conduction studies at The Washington University School of Medicine, Department of Neurological Neuromuscular Electrodiagnostic Laboratory. Those studies were interpreted as revealing evidence of a moderate left carpal tunnel syndrome. No evidence of ulnar neuropathy or left brachial plexopathy was detected.

¶ 34 Dr. Kovalsky's examination of the claimant on November 15, 2013, again revealed a mildly positive Spurling's test on the left. The claimant complained of worsening right-sided neck pain with numbness and tingling radiating down his arm. The claimant denied any falls, trauma or injuries since his last visit, and Dr. Kovalsky had no explanation for the claimant's increased neck and arm pain. As of that visit, Dr. Kovalsky diagnosed a severe disc herniation at C6-C7 on the left, central herniation with some spondylosis at C5-C6, and a brachial plexopathy in the claimant's neck, greater on the left side. Dr. Kovalsky recommended that the claimant remain off of work and return for a follow-up visit in eight weeks.

¶ 35 The claimant next saw Dr. Kovalsky on January 10, 2014. The claimant reported that physical therapy had helped relieve his symptoms but, he was still experiencing neck pain with some radiation into his shoulder blades and headaches. Dr. Kovalsky noted a diagnosis of whiplash related syndrome and spondylosis at C5-C6 with some foraminal narrowing bilaterally. It was also noted that the claimant had either a left brachial plexopathy or post-traumatic brachial plexus stretching and probably left carpal tunnel syndrome. The claimant was advised to return for a follow-up visit in 6 weeks, and if he was still experiencing neck pain, Dr. Kovalsky would consider scheduling the claimant for a cervical discectomy and fusion at C5-C6.

¶ 36 At the request of Trucking, the claimant was examined on January 15, 2014, by Dr.

Russell Cantrell, a physician board-certified in rehabilitation medicine. In his report of that examination, Dr. Cantrell noted that the claimant gave a history of having been involved in a truck accident on December 20, 2012. The claimant told Dr. Cantrell that, prior to his work accident, he had no problems with his neck, lower back, or upper extremities. On examination, Dr. Cantrell found mild limitations to the claimant's cervical spine in both flexion and extension and mild limitations with bilateral bending along with neck tightness. In his report, Dr. Cantrell enumerated the claimant's medical records which he reviewed along with his x-rays, MRI scans, CT scan, and EMG report. Dr. Cantrell opined that, although he saw degenerative disc disease from C3-C4 through C6-C7, he found no evidence of a lateralizing disc herniation. He also opined that the claimant was not experiencing symptoms of cervical radiculopathy.

¶ 37 The claimant had an MRI of his shoulder on March 3, 2014, which revealed a high-grade partial interstitial and bursal surface tearing of the mid to posterior supraspinatus and anterior infraspinatus tendons; a mild AC joint arthrosis with a small subacromial spur; fibrillation and degenerative tearing of the posterosuperior labrum; and mild subacromial subdeltoid bursitis.

¶ 38 Dr. Kovalsky's notes of the claimant's March 7, 2014 visit state that the claimant had a mild brachial plexus stretching injury on the left, post-traumatic carpal tunnel syndrome, left shoulder pain, and left S1 joint dysfunction. Dr. Kovalsky also noted that the claimant had extensive tendon injuries which had been surgically repaired, and the claimant was doing well. The claimant reported significantly less neck pain but stated that he was still experiencing left shoulder pain with overhead activity, some tingling in his arm, and symptoms of carpal tunnel syndrome. The claimant also reported that the effects of the S1 injection were wearing off and he was having recurrent left buttock pain. Dr. Kovalsky recommended that the claimant receive another S1 injection and referred him to Dr. Ahn for treatment of a left shoulder rotator cuff tear

and a carpal tunnel release. In addition, Dr. Kovalsky recorded his impression that the claimant should remain off of work indefinitely.

¶ 39 Dr. Smith administered an S1 joint injection to the claimant on March 25, 2014. When the claimant saw Dr. Smith on April 4, 2014, he reported a 50% improvement in his pain following the March 25, 2014 injection, which lasted for several days, but he then felt a "pop" in his lower back. Dr. Smith noted a diagnosis of (1) left-sided low-back pain extending into the left posterior thigh, suggesting the S1 joint as the pain generator and a possible unstable S1 joint; (2) neck pain with C5-C6 disc herniation; (3) shoulder pain; (4) GERD; (5) early disc dessication and disc degeneration at T12-L1. She recommended that the claimant undergo physical therapy to see if the S1 joint could be stabilized. She also noted that the claimant might be a good candidate for an S1 joint rhizotomy.

¶ 40 The claimant was seen by Dr. Ahn on April 2, 2014. The doctor's notes of that visit state that the claimant reported that he was experiencing left shoulder pain since his work accident on December 20, 2012. The claimant had undergone an MR arthrogram which Dr. Ahn noted revealed a deep partial tear of the supraspinatus tendon. He also noted that the MRI of the claimant's shoulder revealed a degenerative tear of the posterior labrum. Dr. Ahn recorded a clinical impression of left shoulder rotator cuff tendinopathy/deep partial tear. He recommended that the claimant undergo a short course of conservative treatment.

¶ 41 On April 9, 2014, the claimant underwent a physical therapy shoulder evaluation at St. Mary's on referral for pain in the shoulder joint and rotator cuff sprain. He received physical therapy at St. Mary's from April 9, 2014, through April 28, 2014. During the course of his therapy, the claimant advised the therapist that his shoulder pain became worse with therapy to his cervical spine.

¶ 42 In his notes of the claimant's April 30, 2014, visit, Dr. Ahn noted that the claimant had received little pain relief from the cortisone injection and therapy which he had received. The claimant's shoulder therapy had exacerbated his neck symptoms. It was also noted that the claimant was experiencing moderate carpal tunnel symptoms. The claimant elected to have surgery to repair his rotator cuff tear.

¶ 43 On May 8, 2014, the claimant was next seen by Dr. Smith. He reported that he experienced a 50% improvement in his back pain with physical therapy. Dr. Smith noted that the claimant informed her that his S1 joint stabilized with physical manipulation but that the S1 joint appeared to pop out on the prior day as he was exercising his lumbar spine muscles. Dr. Smith's working diagnosis remained the same, and she noted that the claimant was awaiting authorization for an S1 joint rhizotomy procedure.

¶ 44 When the claimant was seen by Dr. Smith on May 27, 2014, he had a radiofrequency ablation of the left dorsal rami, S1, S2, and S3 lateral branches under fluoroscope guidance. And when the claimant was seen on July 3, 2014, he reported 3 to 4 weeks of improvement in his back pain symptoms. Dr. Smith noted her impression that the improvement in the claimant's back pain symptoms was due to the combination of physical therapy and S1 joint rhizotomy. It was her belief that the claimant's left buttock pain was most likely due to piriformis muscle spasms associated with S1 joint dysfunction. Her working diagnosis remained unchanged. Dr. Smith recommended continued physical therapy and a left piriformis muscle injection.

¶ 45 On July 9, 2014, the claimant again underwent a physical therapy shoulder evaluation at St. Mary's; this time on referral for pain in the shoulder joint and post rotator cuff repair. He received physical therapy at St. Mary's from July 29, 2014, through December 1, 2014.

¶ 46 On July 17, 2014, the claimant underwent left shoulder arthroscopy, supraspinous rotator

cuff repair, and a subacromial decompression. The surgery was performed at the Good Samaritan Surgery Center. The post-operative diagnosis was a left shoulder subacromial impingement/rotator cuff tear. The claimant treated post operatively with Dr. Ahn.

¶ 47 When Dr. Ahn saw the claimant on July 23, 2014, and September 30, 2014, he noted that he was progressing well and that his pain symptoms were improving.

¶ 48 When he visited Dr. Ahn on October 1, 2014, and October 29, 2014, the claimant reported that his shoulder pain was improving but he was experiencing neck pain. Dr. Ahn recommended that the claimant undergo physical therapy and placed him on light duty work restrictions.

¶ 49 In her notes of the claimant's November 6, 2014 visit, Dr. Smith recorded the claimant's continued complaints of mid-back pain. She recommended that the claimant continue his home exercise program and have an MRI of his thoracic spine.

¶ 50 On November 26, 2014, the claimant reported to Dr. Ahn that he was experiencing increased pain with heavy resistive activity. Dr. Ahn recommended that the claimant begin a work hardening program.

¶ 51 When the claimant saw Dr. Kovalsky on December 4, 2014, he complained of continuing neck pain, headaches, and radicular arm pain. According to the claimant, he had not experienced any improvement in his neck pain. On examination, the claimant had a positive Spurling's test bilaterally. Dr. Kovalsaky ordered a repeat MRI of the claimant's cervical spine.

¶ 52 The claimant had an MRI of his thoracic spine on December 22, 2014, as ordered by Dr. Smith. That scan revealed no evidence of fracture; irregular endplates with multilevel Schmorl's nodes; minimal left paracentral disc extrusion at T5-T6, minimal right paracentral disc extrusion at T10-T11, causing no nerve root impingement; and mild-multilevel degenerative joint disease.

¶ 53 Dr. Smith's records of the claimant's January 8, 2015 visit reflect that he was seen for left-sided mid-back pain. According to her records, the claimant stated that he experienced left-sided mid-back pain at the time of his work accident and that he reported that pain when he went to the emergency room. However, Dr. Smith's records reflect that this visit was the first time that the claimant was being worked up for left-sided mid-back pain. The claimant complained of numbness in the mid back and pain. As of that visit, Dr. Smith noted the claimant's history of: left-sided thoracolumbar pain with evidence of multilevel mild disc degeneration without focalized disc herniation in the left-sided thoracolumbar junction or neural impingement; minimal small disc herniations at T5-T6 and T10-T11 of unclear clinical significance; left S1 joint pain; neck pain; and left shoulder pain post rotator cuff surgery. Dr. Smith did not recommend any additional physical therapy for the claimant's mid back but did recommend a left-sided medial branch block at the thoracolumbar junction. And on February 17, 2015, she administered a left T11, T12, L1, and L2 medial branch block under fluoroscopic guidance.

¶ 54 On December 17, 2014, Dr. Ahn released the claimant from treatment for his shoulder. He noted, however, that the claimant would probably require work hardening after he completed treatment for his back condition.

¶ 55 When the claimant was seen by Dr. Smith on February 13, 2015, he complained of swelling after receiving the medial branch block. Dr. Smith noted extensive swelling on both sides of the claimant's back up to the shoulder blades and down to the sacrum. She found no evidence of post-injection complications and attributed the claimant's complaints of increased neck pain and tightness to muscle spasms. The claimant was instructed to continue his home exercises. On February 17, 2015, Dr. Smith administered a second medial branch block injection.

¶ 56 The claimant had an MRI of his cervical spine on February 26, 2015, as ordered by Dr.

Kovalsky, which revealed degenerative disc disease; spondylosis with bilateral foraminal narrowing at C5-C6, with some central stenosis; and a left central soft disc herniation in the neutral foramen, causing compression of the C7 nerve root.

¶ 57 The claimant saw Dr. Kovalsky again on March 11, 2015. The notes of that visit reflect that the claimant complained of continuing neck pain. Dr. Kovalsky recorded the results of the claimant's recent MRI and recommended that the claimant undergo an anterior cervical discectomy and fusion at C5-C6 and a total disc arthroplasty at C6-C7, but he recommended that the surgery be delayed until the claimant had recovered from his shoulder surgery.

¶ 58 The claimant was again examined by Dr. Cantrell at the request of Trucking on June 22, 2015. Dr. Cantrell reported that his review of the MRI of the claimant's thoracic spine revealed findings which were degenerative in nature and that he did not see any evidence of disc herniation or spinal cord compression. According to Dr. Cantrell, the claimant suffered from multilevel degenerative disc disease, particularly in the middle and lower thoracic spine. He noted disc space narrowing, disc desiccation, and Schmorl's node deformities at T5-T6 and T9-T1; all of which he found to be degenerative in nature. He opined that, although the claimant may have sustained a cervical strain as the result of his work accident, he had not developed an acute radiculopathy as a result of the accident. According to Dr. Cantrell, he found no evidence that the claimant would benefit from either the anterior cervical discectomy and fusion at C5-CX6 or a disc replacement at C6-C7, as recommended by Dr. Kovalsky. When deposed, Dr. Cantrell opined that the claimant's left S1 joint was strained as a result of his work-related accident, and he also sustained a sprain injury to his thoracic spine.

¶ 59 When the claimant saw Dr. Kovalsky on July 2, 2015, he continued to complain of radicular arm pain. Dr. Kovalsky noted a clinical impression of persistent left post-traumatic

carpal tunnel syndrome; cervical spondylosis; and disc herniations, with axial neck pain, cephalgia, and radiculopathy. He again recommended cervical surgery.

¶ 60 The claimant was seen by Dr. Ahn on January 11, 2016. The doctor's notes of that visit state that the claimant complained of numbness and tingling in the radial three digits of his left hand and reported that his symptoms began after his work-related accident. Dr. Ahn's clinical diagnosis was left carpal tunnel syndrome and probable very early cubital tunnel syndrome. The claimant was scheduled for surgery.

¶ 61 On January 16, 2016, the claimant underwent a left endoscopic carpal tunnel release performed by Dr. Ahn. Dr. Ahn treated the claimant post-operatively, and he noted on January 25, 2016, that the claimant was doing well and without complaints.

¶ 62 On February 22, 2016, the claimant was seen by Dr. Ahn for a reevaluation of his carpal tunnel release. As of that date, Dr. Ahn discharged the claimant from care.

¶ 63 The claimant saw Dr. Kovalsky on January 27, 2016, complaining of neck pain, headaches, and pain radiating down from his neck to his shoulder blade and down into his forearm and thumb. Dr. Kovalsky noted that, if the claimant did not have significant improvement within six to eight weeks after his carpal tunnel surgery, he should undergo a repeat cervical MRI and surgery should be considered.

¶ 64 In his notes of the claimant's March 11, 2016, visit, Dr. Kovalsky recorded that the claimant had injured his cervical spine, shoulder, left forearm, and left wrist in his work accident. He also recorded that the claimant was still complaining of neck pain, headaches, pain radiating down into his left shoulder blade, and numbness and tingling in his forearm and hand. Dr. Kovalsky's clinical impression was chronic neck pain; cephalgia and left cervical radiculopathy due to cervical spondylosis at C5-C6; and cervical spondylosis at C6-C7 with a work-related

herniated disc at that level with C7 radiculopathy. Dr. Kovalsky was of the opinion that the claimant is a candidate for a two-level anterior cervical discectomy, epidural decompression, and interior body fusion at C5-C6 and C6-C7.

¶ 65 Dr. Cantrell saw the claimant again on May 23, 2016, at the request of Trucking. At that time, the claimant was still complaining of symptoms in his hands and fingers and that, since his carpal tunnel surgery, he continued to experience left-sided neck pain. According to Dr. Cantrell, the Spurling's test which he performed on the claimant on that date was positive on the left.

¶ 66 When the claimant was seen by Dr. Kovalsky on June 15, 2016, he complained of periodic numbness, tingling, and pain in his thumb; numbness and tingling in two digits of his left hand; muscle atrophy in his forearm; pain in his shoulder, elbow, and neck; and headaches. On examination, the claimant had a positive Spurling's test on the left which reproduced pain radiating into his thumb and fingers on his left hand. He also had negative Roos and Adson's signs. According to Dr. Kovalsky's notes, the claimant had some questionable incidence of thoracic outlet syndrome. He recorded a diagnosis of left surgical radiculopathy and axial neck pain due to spondylosis at C5-C6, and a disc herniation at C6-C7. Dr. Kovalsky continued to recommend surgery. According to Dr. Kovalsky, the claimant's spondylosis anteceded his work-related accident, but it was exacerbated by the accident.

¶ 67 When deposed, Dr. Kovalsky opined that the claimant had whiplash syndrome or thoracic outlet syndrome, as there were no pathological or anatomical findings. He maintained his opinion that the claimant had a disc herniation, left cervical radiculopathy, neck pain, and headaches; all of which is consistent with whiplash syndrome or the disc pathology of spondylosis and disc herniation. He also opined that the claimant had thoracic outlet syndrome or posttraumatic brachial plexopathy. Dr. Kovalsky testified that the claimant continues to

experience neck pain, headaches, and left arm pain which was reproduced with physical examination. He stated that the claimant has had essentially the same symptoms for three years and has failed to obtain relief from conservative treatment. Dr. Kovalsky opined that the claimant sustained cervical spine injuries as a result of his work-related accident, and the claimant's need for cervical spine surgery and treatment for thoracic outlet syndrome were caused or aggravated by his work accident of December 20, 2012. He stated that the claimant's carpal tunnel syndrome was related to his work accident and that his thoracic outlet syndrome was the result of the deceleration injury. Dr. Kovalsky admitted that he never reviewed the emergency room records from St. Anthony's Hospital but assumed that the claimant's neck and arm pain started within a few days after the accident. He stated that, although arm pain might be delayed, axial pain would have started relatively quickly.

¶ 68 When Dr. Smith was deposed, she testified that the injury to the claimant's S1 joint could, or might have, been caused by his December 20, 2012 accident. According to Dr. Smith, if the claimant had pre-existing issues with his thoracic spine, his work-related accident could have aggravated the preexisting conditions. She stated that the treatment which she provided to the claimant and the rhizotomy to the claimant's thoracolumbar area were causally related to the injuries he sustained in the accident of December 20, 2012. Dr. Smith opined that the claimant has facet syndrome but acknowledged that the condition could be the result of degenerative disc disease, posture, or trauma.

¶ 69 When Dr. Cantrell was deposed on July 6, 2016, he again opined that the claimant did not develop acute radiculopathy as a result of his work accident. He did not believe that the claimant had cervical radiculopathy. He was also of the opinion that the claimant's lumbar spine did not require any further treatment, although the claimant should continue with an exercise program.

Dr. Cantrell opined that the claimant sustained a sprain to the S1 joint as a result of his work accident but did not require any work restrictions based on his lumbar spine or sacroiliac joint. Dr. Cantrell testified that the claimant did not require any further pain treatment or work restrictions based upon the his thoracic spine complaints. Nor did he believe that cervical surgery was reasonable or medically necessary. Dr. Cantrell found no evidence that the claimant's work accident aggravated his degenerative neck condition. He stated his belief that the claimant's hand and finger symptoms were indicative of myofascial pain rather than cervical radicular in nature. He noted that, prior to Dr. Ahn's carpal tunnel surgery, the claimant was complaining of numbness and tingling in the 4th and 5th fingers on his left hand; however, when he saw Dr. Kovalsky several months later, the claimant complained of numbness and tingling in the 1st and 2nd fingers. Dr. Cantrell explained that the migration of the symptoms is relevant because, if the symptoms were generated by the C6 and C7 nerve roots, they would have been fixed in distribution and would not have migrated. Dr. Cantrell was also of the opinion that the claimant does not need a cervical fusion.

¶ 70 The claimant testified that, as of the arbitration hearing, he was still experiencing pain, numbness, and tingling in his left hand along with grip strength problems, pain in his lower back, pain in his mid back, mid-back spasms radiating down his left side, and neck pain. He stated that, prior to his work accident, he had not experienced problems or symptoms with his neck, mid back, lower back, SI joint, left shoulder, left arm, or left hand.

¶ 71 Following the arbitration hearing held on July 14, 2016, pursuant to section 19(b) of the Act (820 ILCS 305/19(b) (West 2014)), the arbitrator issued a written decision on October 25, 2016, finding that the claimant proved that he sustained an injury arising out of and in the course of his employment with Trucking on December 20, 2012, and that his current condition of ill-

being, specifically of his thoracic spine and cervical spine conditions, is causally related to his employment. The arbitrator placed greater reliance upon the causation opinions of Drs. Kovalsky and Smith than the contrary opinion of Dr. Cantrell. The arbitrator awarded the claimant 185 4/7 weeks of temporary total disability (TTD) benefits pursuant to section 8(b) of the Act (820 ILCS 305/8(b) (West 2014)) and granted Trucking a credit of $48,666.46 for TTD benefits paid. The arbitrator also ordered Trucking to pay $64,025.63 for medical services rendered to the claimant and ordered Trucking to authorize the medical treatment recommended by the claimant's treating physician.

¶ 72 Trucking filed a petition for review of the arbitrator's decision before the Commission. On August 11, 2017, a majority of the commissioners issued a decision affirming and adopting the arbitrator's decision. The dissenting commissioner found that the claimant had not proven that his alleged cervical and thoracic conditions and his need for prospective treatment are causally related to his employment. The caption of the Commission's decision lists Premium Transportation/Earl Henderson Trucking as the respondent.

¶ 73 Premium Transportation/Earl Henderson Trucking/Custom Personnel (collectively referred to as Henderson) sought a judicial review of the Commission's decision in the circuit court of Marion County. On July 3, 2018, the circuit court confirmed the Commission's decision, and this appeal followed.

¶ 74 Henderson argues that the Commission's finding that the claimant's condition of cervical and thoracic spine ill-being is causally connected to his work accident of December 20, 2012, is against the manifest weight of the evidence. It contends that Dr. Kovalsky's causation opinion is based upon an "assumption" that the claimant's neck pain symptoms began within a few days of his work accident, which it asserts is not borne out by the medical records. Relying upon Dr.

Cantrell's opinions and his analysis of the diagnostic evidence, Henderson concludes that the Commission's finding of a causal connection between the claimant's accident of December 20, 2012, and his condition of cervical and thoracic spine ill-being is against the manifest weight of the evidence. We find no merit in the argument.

¶ 75 Whether a causal relationship exists between a claimant's employment and his condition of ill-being is a question of fact to be resolved by the Commission, and its resolution of the issue will not be disturbed on review unless it is against the manifest weight of the evidence. *Certi-Serve, Inc. v. Industrial Comm'n*, 101 Ill. 2d 236, 244 (1984). In resolving such issues, it is the function of the Commission to decide questions of fact, judge the credibility of witnesses, determine the weight to be accorded to their testimony, and resolve conflicting medical evidence. *O'Dette v. Industrial Comm'n*, 79 Ill. 2d 249, 253 (1980). Whether a reviewing court might reach the same conclusion is not the test of whether the Commission's determination of a question of fact is supported by the manifest weight of the evidence; rather, the appropriate test is "whether there is sufficient evidence in the record to support the Commission's decision." *Benson v. Industrial Comm'n*, 91 Ill. 2d 445, 450 (1982).

¶ 76 By adopting the arbitrator's decision, the Commission placed greater reliance upon the causation opinions of Drs. Kovalsky and Smith than the contrary opinion of Dr. Cantrell. Although Dr. Kovalsky testified that, in arriving at his causation opinion, he "assumed" that the claimant's neck pain symptoms began within a few days of his work accident and there is no reference in the medical records to the claimant having complained of neck pain until his visit to Salem on January 7, 2013, the claimant's medical records do reflect that he told Dr. Steinke that he began to experience neck pain within two days of his work accident, he told Dr. Conrardy that he experienced neck pain since his work accident, and he told Dr. Smith that he experienced left-

sided mid back pain at the time of his accident and reported that when he was in the emergency room. In addition, the Commission specifically noted Dr. Kovalsky's credentials as a board-certified orthopedic surgeon as compared to Dr. Cantrell's non-surgical credentials in physical medicine and rehabilitation.

¶ 77 Distilled to its finest, Henderson's argument is merely an invitation for this court to reweigh the evidence in the record, which is something we are not tasked to undertake. As noted earlier, it is the Commission's function to judge the credibility of witnesses, determine the weight to be accorded to their testimony, and resolve conflicting medical evidence. And based upon the record before us, we cannot say that the Commission's resolution of those issues is against the manifest weight of the evidence.

¶ 78 For the reasons stated, we affirm the judgment of the circuit court of Marion County which confirmed the Commission's decision awarding the claimant benefits under the Act and remand this matter to the Commission for further proceedings.

¶ 79 Affirmed and remanded.