2019 IL App (5th) 180491WC-U

Order filed May 14, 2019

IN THE
APPELLATE COURT OF ILLINOIS
FIFTH DISTRICT
WORKERS' COMPENSATION COMMISSION DIVISION

JEFF BAKER,	)	Appeal from the Circuit Court
	)	of the First Judicial Circuit,
	)	Williamson County, Illinois
	)	
Appellant,	)	
	)	
v.	)	Appeal No. 5-18-0491WC
	)	Circuit No. 18-MR-66
	)	
THE ILLINOIS WORKERS'	)	Honorable
COMPENSATION COMMISSION, *et al.*	)	Carey C. Gill,
(Minova USA, Inc., Appellee).	)	Judge Presiding.

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

ORDER

¶ 1 *Held*: By finding no causal connection between the workplace accident and the petitioner's cervical condition, the Illinois Workers' Compensation Commission did not make a finding that was against the manifest weight of the evidence.

¶ 2 The circuit court of Williamson County confirmed a decision by the Illinois Workers' Compensation Commission (Commission) to deny workers' compensation benefits to

petitioner, Jeff Baker, for a disc herniation in the neck, which he claimed was a result of his falling off a platform while working for respondent, Minova USA, Inc. (Minova). Baker appeals.

¶ 3 Because the Commission's decision is not against the manifest weight of the evidence, we affirm the judgment.

¶ 4 I. BACKGROUND

¶ 5 A. Two Claims for Workers' Compensation, Narrowed Down Ultimately to One Claim for a Cervical Condition Allegedly Resulting From a Fall at Work

¶ 6 Baker filed two claims for workers' compensation. He filed the first claim on May 12, 2009 (case No. 09-WC-20490); it was for injuries he sustained on April 27, 2009, when he fell at work. He filed the second claim on September 1, 2010 (case No. 10-WC-033530); it was for a repetitive type of injury to his neck and hands. The second claim was based on a medical examination report that Dr. Jason A. Browdy wrote on July 14, 2010.

¶ 7 1. *The First Decision by the Commission and the Circuit Court's Reversal of the Decision*

¶ 8 On July 13, 2011, a section 19(b) hearing was held on Baker's two workers' compensation claims. See 820 ILCS 305/19(b) (West 2010).

¶ 9 On September 6, 2011, the arbitrator issued a decision.

¶ 10 The arbitrator concluded that Baker had failed to prove that, as of July 14, 2010, his employment had caused a repetitive type of injury to his neck and hands. Thus, according to the arbitrator, case No. 10-WC-033530 was unproven.

¶ 11 The arbitrator concluded, however, that Baker had proved his other claim: that by falling at work on April 27, 2009, he sustained injuries in an accident that arose out of and in the course of his employment. Thus, according to the arbitrator, case No. 09-WC-20490 was proven.

¶ 12 Specifically, the arbitrator found that Baker had suffered the following injuries from his fall at work: a fracture of his left ankle, De Quervain syndrome in both wrists, and an abnormality of the radial tunnel in his right arm. (It should be noted that none of these injuries that the arbitrator found was an injury to the neck.) The arbitrator awarded Baker 74 3/7 weeks of temporary total disability benefits for the period of April 30, 2009, through October 4, 2010, at the rate of $486.29 per week (see *id.* § 8(b)) and $1440 for medical expenses (see *id.* § 8(a)).

¶ 13 But the arbitrator's decision in case No. 09-WC-20490 was not entirely favorable to Baker. The arbitrator decided that Baker had reached maximum medical improvement as of October 4, 2010, and that radial tunnel surgery would be unnecessary, even though one of Baker's treating physicians, Dr. Steven D. Young, had recommended such surgery. Therefore, the arbitrator refused to order Minova to pay for radial tunnel surgery—or for any further medical treatment.

¶ 14 Baker appealed to the Commission. On May 14, 2012, the Commission affirmed and adopted the arbitrator's decision.

¶ 15 Baker then sought judicial review. On October 25, 2012, after hearing oral arguments, the circuit court concluded that the Commission's decision was against the manifest weight of the evidence. The court regarded it as logically inconsistent to find, on the one hand, that the right radial tunnel condition was causally related to Baker's employment and to find, on the other hand, that Baker had reached maximum medical improvement, considering that several doctors had recommended, at the very least, additional diagnostic testing for that condition. It made no sense to the court to deny further prescribed medical treatment for a condition, right radial tunnel compression, that according to the Commission's own finding had arisen out of and in the course of Baker's employment. Therefore, the court reversed the Commission's decision

and remanded the case with directions to reinstate the temporary total disability benefits and to authorize coverage of the further medical treatment that Baker's treating physicians, Dr. Young and Dr. Richard L. Morgan, had recommended.

¶ 16 Accordingly, on September 23, 2014, on remand, the Commission modified in part and vacated in part its decision. The Commission ordered Minova to pay temporary total disability benefits for the period of October 4, 2010, through July 13, 2011, in addition to the temporary total disability benefits the Commission previously awarded. Also, given the circuit court's reasoning that Baker must not have reached maximum medical improvement as of yet (judging by the opinions of his treating physicians, Dr. Morgan and Dr. Young), the Commission ordered Minova to pay for the further medical treatment that those physicians had recommended.

¶ 17 On July 31, 2014, in response to a new report by Dr. Young, Minova ceased paying temporary total disability benefits to Baker.

¶ 18 2. *The Second Decision by the Commission and the Circuit Court's Affirmance of That Decision*

¶ 19 On February 23, 2017, there was a second section 19(b) hearing, the purpose of which was to adjudicate a claim by Baker that a recently diagnosed cervical condition was a result of the workplace accident of April 27, 2009. (As we soon will discuss, this diagnosis was by someone other than the treating physicians, Dr. Morgan and Dr. Young.) In this second section 19(b) hearing, "the parties agreed" (to quote from Baker's brief) "that *** the current issues were dealing with case [No.] 09[-]WC[-]20490 only." Because of the new cervical diagnosis, Baker requested the reinstatement of temporary total disability benefits, payment of medical bills, coverage of prospective medical treatment, and penalties.

¶ 20 In a decision on August 14, 2017, the arbitrator set down the following findings or conclusions. First, although it was undisputed that Baker sustained injuries to his wrists and left

ankle in his fall on April 27, 2009, he had failed to prove that his cervical condition was causally related to the fall. Second, Minova did not have to pay for ongoing medical treatment, including the cervical surgery that Dr. David J. Fletcher and Dr. Michael A. Chioffe had recommended. Third, Baker reached maximum medical improvement on January 7, 2014 (the date of a section 12 examination by Dr. David M. Brown (see 820 ILCS 305/12 (West 2014))), and, thus, Baker was entitled to no further temporary total disability benefits after that date. Fourth, Minova should receive a credit in the amount of $14,102.41 for temporary total disability benefits it had paid to Baker for the period of January 7 to July 28, 2014.

¶ 21 Baker appealed to the Commission, which on February 22, 2018, affirmed and adopted the arbitrator's decision.

¶ 22 Baker again sought judicial review. This time, on September 28, 2018, the circuit court confirmed the Commission's decision, finding it was not against the manifest weight of the evidence.

¶ 23 This appeal followed.

¶ 24 B. The Fall at Work

¶ 25 Baker's job at Minova was to make roof plates for coal mines, using a press. Each roof plate weighed 800 to 850 pounds, and the press was a large machine. On April 27, 2009, Baker climbed up onto a platform to make some necessary adjustment to the press. The platform, which had a grate floor covered by a grease-resistant mat, had been moved a little bit away from the press, and the mat extended over the open space between the platform and the press. At this spot, the mat buckled under Baker's left foot. As his left leg went down through the mat, he flung his hands out in front of him, trying to catch hold of something so that he would not fall onto the press. His right elbow struck the press, and his left ankle struck a section of angle iron.

He landed on his hands. He never struck his head; nor did anything fall on his head. He was 36 years old at the time of the accident.

¶ 26 C. Treatment of the Wrists and Arms

¶ 27 Immediately after the fall, Baker complained to Dr. Morgan not only of pain in his left ankle (which, as it turned out, was fractured) but also of pain in his hands and wrists. Eventually, the left ankle healed. But the pain in his hands and wrists persisted.

¶ 28 On December 9, 2009, after Baker had received little or no relief from physical therapy and from steroid injections into his wrists, Dr. Morgan performed De Quervain surgery on the right wrist. On February 24, 2010, he performed De Quervain surgery on the left wrist. Both surgeries were releases of the first dorsal interosseous compartment.

¶ 29 The pain, numbness, and tingling in Baker's hands did not go away. Concluding that the De Quervain surgeries had done Baker no good, Dr. Morgan referred him to Dr. Steven Young to be evaluated for possible radial tunnel syndrome.

¶ 30 As for Dr. Morgan, he was at an impasse; he could not figure out exactly what ailed Baker. Apparently, Baker still had symptoms and limitations, as suggested by a functional capacity evaluation administered at Dr. Morgan's request on September 17, 2010:

> "[O]verall test findings, in combination with clinical observations, indicate [that] Mr. Baker is not able to perform the tasks required for him to return to work. He does not have any limitations related to the ankle fracture, and demonstrates the ability to stand and walk as required by his job; however, he does not have the lifting strength required to complete his job duties due to limitations from both hands, wrist/hands ***."

The hope was that Dr. Morgan's partner, Dr. Young, would be able to dispel the mystery.

¶ 31 Baker saw Dr. Young on January 13, 2011. He complained to Dr. Young that, for the past couple of years, he had been suffering from bilateral upper extremity pain. Dr. Young did a physical examination and opined that Baker possibly had radial tunnel syndrome. After all, Baker was complaining of pain directly over the radial tunnel (which, it should be noted, is located in the upper forearm, near the elbow, not in the wrists or hands).

¶ 32 On May 15, 2013, Dr. Young performed surgery on Baker's right forearm: a right radial tunnel decompression. (In the rather long interim between the radial tunnel diagnosis and the surgery, the Commission decided that the diagnosed De Quervain syndrome and radial tunnel condition were work-related. After that question had been resolved by litigation, the radial tunnel surgery had to be postponed until Baker overcame an antibiotic-resistant infection.)

¶ 33 In a follow-up appointment on July 18, 2013, Baker told Dr. Young that, despite the radial-tunnel decompression surgery, he still was having pain in his right elbow or proximal forearm, over the radial tunnel.

¶ 34 On August 19, 2013, a nurse at Southern Illinois Orthopedic Center, where Dr. Morgan and Dr. Young worked, wrote a note that Baker was complaining of severe pain in both arms and that the pain extended from his elbows to his hands. Baker told the nurse that both arms felt swollen and tight and that the pain was so severe he did not think he could do any more work conditioning—which, accordingly, Dr. Young put on hold.

¶ 35 Until the right arm was doing better, Dr. Young was unwilling to perform radial tunnel decompression surgery on the left arm. Instead, on September 24, 2013, he had Baker undergo an electromyogram (EMG) to find out whether he had any compressive neuropathy.

¶ 36 The EMG, Dr. Young reported, was completely negative. It showed no median neuropathy at the wrist, no peripheral neuropathy, and no cervical radiculopathy in the upper

limbs. Nor, in the EMG, was there any evidence of radial neuropathy on the right. Although the left ulnar nerve had a decreased velocity above the elbow, the decrease was too small to qualify as ulnar neuropathy at the elbow.

¶ 37 In a follow-up appointment on September 26, 2013, Dr. Young told Baker he now did not believe that Baker had any nerve compression. Unsure what else to do, he referred Baker to Dr. Paul Juergens, a pain management specialist.

¶ 38 On October 16, 2013, Dr. Juergens examined Baker. He found that Baker had a normal range of motion of the cervical spine, and he noted that an EMG and nerve conduction study of September 24, 2013, showed no cervical radiculopathy. Puzzled as to why Baker was having numbness and tingling in his hands, Dr. Juergens prescribed Gabapentin and a compound cream to see if they would relieve Baker's symptoms. He told Baker to return in a month.

¶ 39 In a further examination, on December 10, 2013, Dr. Juergens again found no evidence of cervical radiculopathy in Baker's upper extremities. Dr. Juergens believed that Baker's symptoms possibly arose from a mixture of epicondylitis (injured tendons in the elbow) and radial nerve entrapment. He recommended that Baker undergo an ultrasound-guided steroid injection in and around the radial nerve.

¶ 40 On January 7, 2014, at Minova's request, Baker underwent a section 12 examination by Dr. Brown, a hand surgeon. In his report, Dr. Brown noted that, upon physical examination, Baker had diffuse tenderness over the left forearm—pain that was not localized to the radial tunnel or any specific area of the forearm. In Dr. Brown's opinion, this symptom was not explainable by a diagnosis of radial tunnel syndrome. He did not recommend any further medical treatment.

¶ 41 In another follow-up appointment, on February 25, 2014, Dr. Juergens found that Baker still had full range of motion of the cervical spine and a normal neurological examination of the cervical spine.

¶ 42 On March 12, 2014, Baker underwent the procedure that Dr. Juergens had recommended, a steroid injection into the extensor tendon sheath of the right wrist.

¶ 43 After that injection, Baker had no further appointments with Dr. Juergens, and he received no further medical recommendations, prescriptions, or treatment for his arms, wrists, and hands.

¶ 44 On June 10, 2014, Dr. Young wrote a narrative report, in which he stated that he now "certainly [did] not believe that the fall that [Baker] had would have caused bilateral radial tunnel syndrome" (contrary to an opinion Dr. Young provided earlier).

¶ 45 On July 31, 2014, in response to Dr. Young's report, Minova stopped paying temporary total disability benefits to Baker.

¶ 46 On February 17, 2015, at Minova's request, Baker underwent another section 12 examination by Dr. Brown. In his report of this examination, Dr. Brown agreed with Dr. Young that the fall of April 27, 2009, could not have caused radial tunnel syndrome, especially considering that the symptoms in Baker's forearms did not manifest themselves until almost a year and a half after his fall at work. Dr. Brown did not think that Baker needed any further medical treatment. If Baker were his patient, Dr. Brown would not recommend any further diagnostic testing, either. Instead, he would advise Baker that the best thing for him to do would be to resume his normal activities. As far as Dr. Brown could see, there was no pathological or anatomical reason why Baker should be limited in his physical activities or restricted from working.

¶ 47 D. The New Diagnosis: a Cervical Problem

¶ 48 1. *Dr. Patrick K. Stewart*

¶ 49 On September 5, 2015, at the request of his attorney, Baker went to see another hand surgeon, Dr. Patrick K. Stewart. Baker had been complaining of pain in his left forearm. Dr. Stewart reviewed Baker's medical records and administered some diagnostic tests, including a grip test and a Semmes-Weinstein test, which was designed to detect neuropathies. The results of those tests made no anatomic sense to Dr. Stewart; he inferred that Baker was magnifying his symptoms. Because the surgery Dr. Young had performed seemed to have done nothing for Baker's symptoms, Dr. Stewart was skeptical that Baker ever had radial tunnel syndrome in the first place.

¶ 50 Dr. Stewart noted, however, that Baker's neck appeared to be stiff. On the basis of that subjective complaint, Dr. Stewart recommended that Baker undergo a cervical evaluation. For purposes of workers' compensation, though, Dr. Stewart regarded Baker as being at maximum medical improvement and did not think that an evaluation of the cervical spine would have anything to do with the workplace accident of April 27, 2009.

¶ 51 2. *Dr. David J. Fletcher*

¶ 52 On May 11, 2016, at his attorney's request, Baker saw a physician specializing in occupational medicine, Dr. David J. Fletcher.

¶ 53 On May 18, 2016, Dr. Fletcher had Baker undergo another functional capacity evaluation. Dr. Fletcher testified: "The bottom line in the consistency of both instruments is that he's physically unable to safely go back to his former level employment as a plate press operator in the coal industry at the present time."

¶ 54 In addition, Dr. Fletcher had Baker undergo another EMG. It showed no

peripheral nerve entrapment.

¶ 55 Dr. Fletcher also X-rayed Baker's hands. The X-rays were unremarkable.

¶ 56 Because of those negative diagnostic tests, Dr. Fletcher "did not believe that [Baker] had any pathology that was coming from his hands or wrists that would explain his current subjective symptoms" of pain, numbness, and tingling. Dr. Fletcher "was certain that Mr. Baker did not have radial tunnel syndrome in his left upper extremity as a source of his subjective complaints."

¶ 57 Therefore, on May 24, 2016, Dr. Fletcher had Baker undergo cervical magnetic resonance imaging (MRI) to explore the possibility that Baker had a neck problem that was radiating into his hands. Comparing that MRI to an earlier MRI, Dr. Fletcher concluded that Baker had foraminal nerve root irritation from a disc herniation at C5-C6. He believed that Baker could benefit from cervical fusion at that level.

¶ 58 Dr. Fletcher testified that Baker had degenerative changes in his cervical spine—osteophytes and bone spurs—which probably preexisted the 2009 injury. Nevertheless, Dr. Fletcher opined that the "axial load injury" that Baker suffered in the slip and fall had combined with these preexisting degenerative changes to cause some soft-tissue protrusion, putting pressure on the C6 nerve and radiating pain and weakness into the arms. Dr. Fletcher believed that Baker's case had been misdiagnosed and mismanaged and that a neck injury had been his problem all along. The lack of prior neck pain was not unusual, Dr. Fletcher explained. Instead of manifesting itself by neck pain, the disc herniation at C5-C6 could have manifested itself solely by pain in the hands and arms—misinterpreted, for all those years, as pathology in the hands and arms themselves.

¶ 59 As Dr. Fletcher admitted, though, C6 radiculopathy secondary to C5-C6 disc

pathology could occur in the natural course of aging, without trauma. As a matter of fact, Baker had degenerative changes and disc bulging at other levels of his cervical spine. Dr. Fletcher agreed, for example, that the bulge in the disc at C4-C5 and its posterolateral spurs had nothing to do with Baker's falling at work in April 2009. Dr. Fletcher also agreed that the findings in Baker's MRI of May 24, 2016, were not uncommon for someone of his age and weight and that about half the population would have similar anatomical findings.

¶ 60 3. *Dr. Michael A. Chioffe*

¶ 61 On June 22, 2016, at Dr. Fletcher's recommendation, Baker saw Dr. Michael A. Chioffe, an orthopedic surgeon. Dr. Chioffe noted that the cervical MRI of May 24, 2016, showed a moderate broad-based posterior disc osteophyte complex with mild to moderate neuroforaminal impingement. Although the cervical spine X-rays of June 22, 2016, were within normal limits, Dr. Chioffe recommended, on the basis of the MRI and Baker's symptoms, that Baker undergo an anterior cervical discectomy and fusion.

¶ 62 A couple of days later, Baker told Dr. Chioffe he wanted to go ahead with the fusion surgery. Minova, however, refused to pay for it.

¶ 63 On July 19, 2016, a medical assistant, Azucena Vargas, e-mailed Dr. Chioffe that she had telephoned Baker to schedule his cervical fusion and that, by her understanding, the surgery would be paid for by private insurance. Dr. Chioffe replied: "That is fine. I do not believe this is a work comp issue[.] I discussed with him personal insurance. His injury was many years ago."

¶ 64 4. *Dr. Thomas K. Lee*

¶ 65 On December 1, 2016, at Minova's request, Baker underwent a section 12 examination by Dr. Thomas K. Lee, a board-certified orthopedic surgeon who specialized in

spine surgery. Lee testified that he performed approximately 200 spine surgeries a year and that about half of those surgeries were on the cervical spine.

¶ 66 In reviewing Baker's medical records, Dr. Lee took particular note that when examining Baker on October 16, 2013, Dr. Juergens found he had a normal and painless range of motion in his cervical spine, including extension. The same was true in a physical examination in the succeeding year. Thus, as late as four or five years after falling at work, Baker had normal range of motion without pain. By contrast, in 2016, when Dr. Fletcher, Dr. Chioffe, and Dr. Lee physically examined Baker, he had neck pain with range of motion.

¶ 67 Dr. Lee diagnosed Baker as presently having cervical spondylosis at C5-C6 without myelopathy, that is, without any disease of the spinal cord. Spondylosis, Dr. Lee explained, was another name for arthritis and could occur normally, with aging; it could occur with or without trauma. He opined that Baker's cervical spondylosis was merely from aging, not from a workplace accident that happened years ago. In reviewing a stack of medical records over five inches thick from Baker's primary care doctor alone, Dr. Lee noted that Baker was followed extensively, sometimes for several times a month, for a long list of medical and orthopedic complaints—even complaints pertaining to the lumbar spine and the leg—and that there was no mention of any problem with the neck until six years after Baker's fall at work. On October 16, 2013, for instance, Baker had a normal cervical range of motion. Also, multiple evaluations showed normal upper extremity reflexes from the time of the workplace injury until June 2016.

¶ 68 Now, by contrast, Baker had cervical tenderness, markedly reduced cervical extension, and asymmetrically diminished upper extremity reflexes, all of which indicated a more recently emerging neurological problem. Dr. Lee agreed with Dr. Fletcher that impingement at the C5-C6 level could manifest itself by radiculopathy into the left and right

upper extremities—and that Baker probably had such radiculopathy. To Dr. Lee, though, it seemed highly unlikely that a disguised or missed cervical disc pathology from 2009 would yield normal findings specific to the cervical spine for several years and that in 2016 Baker would display new mechanical and neurologic symptoms causally related to his fall in 2009. If Baker had injured his neck years ago, in April 2009, Dr. Lee would have expected to see a more chronic picture by now. It seemed far more likely to Dr. Lee that the spondylosis in Baker's neck was just normal wear and tear from aging.

¶ 69 Dr. Lee noted that around 2015, when Baker began running and "trying to get healthy," he began having headaches in the back of his head. Dr. Lee testified: "[Such symptoms can be associated with] cervical spondylosis, degenerative changes of wear and tear over time, *** and so I think it's just the process of time and aging and gravity on our spines and the normal wear and tear of tissues." It was just a matter of getting older, and, medically, there was nothing to be done.

¶ 70 In sum, Dr. Lee concluded that Baker's cervical spine was at maximum medical improvement, Baker had sustained no permanent partial disability, and the workplace accident of April 2009 had inflicted no damage to his cervical spine that necessitated any restrictions.

¶ 71 E. The Beating That Baker Received in October 2010

¶ 72 Baker testified that on October 1, 2010, a group of six men knocked him down, jumped on him, and beat him. According to records from West Frankfort Family Practice, he was kicked in the head and, in the words of the doctor, "beaten badly." The doctor ordered a CT (computed tomography) scan and an X-ray of Baker's head and neck. Three days later, Baker had two black eyes from the battery, and the doctor noted he still had a lot of swelling to the

head and face. On October 7, 2010, Baker returned for a follow-up examination because he still had bruising over his eyes.

¶ 73 F. Why the Arbitrator Believed Dr. Lee Over Dr. Fletcher

¶ 74 In her decision of August 14, 2017, the arbitrator found Dr. Lee to be more credible than Dr. Fletcher. She gave five reasons for this credibility determination.

¶ 75 First, Dr. Lee's credentials as a board-certified orthopedic surgeon specializing in spine surgery made him "[em]inently more qualified" than Dr. Fletcher, an occupational medicine physician, to opine whether Baker's fall at work had caused his cervical problem.

¶ 76 Second, Dr. Lee had reviewed Baker's primary care records, including a note to the effect that Baker began having headaches in 2015 after beginning a strenuous regimen of physical exercise. Not only did Dr. Fletcher fail to address the possible effect of this exercise program, but it was unclear he even reviewed the primary care records.

¶ 77 Third, Dr. Fletcher seemed to ignore an obvious problem with his theory of causation: that in 2013 Baker had a normal cervical examination and it was not until seven years after Baker's accident at work that any doctor diagnosed a cervical condition. "Notably, this was after [Baker] had been beaten badly in an altercation with six men[,] who kicked his head, necessitating diagnostic studies for the cervical spine, and after he had begun a strenuous exercise program that resulted in headaches and leg pain."

¶ 78 Fourth, even though Dr. Fletcher had referred Baker to Dr. Chioffe, an orthopedic spine surgeon—someone who, one would think, would be especially qualified to address the issue of causation—Baker never offered in evidence a causation opinion by Dr. Chioffe. To the arbitrator, that omission was telling. And even more telling was the e-mail in which Dr. Chioffe

opined, in so many words, that Baker's cervical condition had nothing to do with his accident at work.

¶ 79 Fifth, Dr. Fletcher "ignore[d] the indisputable evidence in this case that it was not until a year and a half after the accident that [Baker] had complaints in his forearms, a symptom that Dr. Fletcher attributed to the cervical condition." Dr. Fletcher testified—incorrectly—that Baker's symptoms had been consistent all along. Actually, it was not until the end of 2010 that Baker began complaining of pain in his forearms, a fact that Dr. Morgan, Dr. Lee, Dr. Brown, and Dr. Stewart all noted.

¶ 80 II. ANALYSIS

¶ 81 In his brief, Baker writes: "The only physician who accurately diagnosed [Baker's] condition *** was Dr. Fletcher." Baker further writes: "It has now been concluded that [Baker] suffers from a cervical condition creating the hand and arm symptoms caused by his work injury on April 27, 2009." Therefore, Baker appears to accept Fletcher's opinion that he really never had De Quervain syndrome or radial tunnel syndrome (contrary to the Commission's first decision in this case) and that, all along, he had been afflicted with radiculopathy from a bulging disc at C5-C6.

¶ 82 The issue, then, is whether the Commission *had* to believe Dr. Fletcher's opinion that Baker's fall at work on April 27, 2009, caused this cervical condition. By finding no causal connection between Baker's fall at work on April 27, 2009, and his newly diagnosed cervical condition, did the Commission make a finding that was against the manifest weight of the evidence? See *Westin Hotel v. Industrial Comm'n*, 372 Ill. App. 3d 527, 538 (2007). Or, to phrase the question differently, is it "clearly apparent," from the evidence in the record, that the Commission should have found a causal connection? *Id.* at 539.

¶ 83 For three reasons, the answer is no.

¶ 84 First, believing Dr. Lee over Dr. Fletcher is a reasonably defensible determination of credibility. Arguably, Dr. Lee's qualifications were more specifically relevant to the issue of what had caused the disc herniation at C5-C6. Whereas Dr. Fletcher was a physician specializing in occupational medicine, Dr. Lee was a board-certified orthopedic surgeon who specialized in spine surgery and who performed approximately 200 spine surgeries a year, about half of which surgeries were on the cervical spine.

¶ 85 Second, a reasonable trier of fact could take the view that if, as Baker now claims, he injured his neck when falling at work on April 27, 2009, and if the pain, numbness, and tingling in his upper extremities had been, all along, radiculopathy from the alleged neck injury, the radiculopathy would have showed up a lot earlier in the diagnostic examinations he underwent over the years. For a long time, there was no sign of radiculopathy. In September 2013, for instance, Dr. Young administered an EMG, which showed no cervical radiculopathy. Likewise, in December 2013, Dr. Juergens tested Baker for cervical radiculopathy and found none.

¶ 86 Third, even the spine surgeon to which Dr. Fletcher referred Baker stated: "I do not believe this is a work comp issue." Thus, in Dr. Chioffe's opinion, the workplace accident of April 27, 2009, did not cause Baker's cervical condition.

¶ 87 Baker quotes from *Schroeder v. Illinois Workers' Compensation Comm'n*, 2017 IL App (4th) 160192WC, ¶ 25: "[A] chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury." (Internal quotation marks omitted.) But the critical word in that quoted sentence is

"may." The Commission does not *have* to find a causal nexus in *every* case in which a condition of ill-being chronologically followed an accident in the workplace. Chronological sequence does not always demand an inference of causation. Just because someone develops arthritis in the spine after falling in the workplace, it does not necessarily follow that the arthritis had anything to do with accident. People get arthritis without having suffered any physical trauma. In the normal course of aging, spines wear down, and discs bulge.

¶ 88 Because the weight of the evidence does not clearly require acceptance of Baker's theory of workplace causation, the same weight of the evidence does not clearly require the reinstatement of temporary total disability benefits. See *Holocker v. Illinois Workers' Compensation Comm'n*, 2017 IL App (3d) 160363WC, ¶ 35 ("Whether a claimant is entitled to [temporary total disability] benefits and for how long are questions of fact to be determined by the Commission, and a reviewing court will not disturb the Commission's determination of these issues unless they are contrary to the manifest weight of the evidence."). To be entitled to temporary total disability benefits, Baker had to prove that his cervical condition was "a work-related injury" that temporarily and totally incapacitated him from working. *Id.* ¶ 34. For the reasons we have explained, a reasonable trier of fact could be unconvinced that the cervical condition was a work-related injury and, consequently, could reject the claim for temporary total disability benefits. See *id.*

¶ 89 The same logic applies to medical expenses. "Under section 8(a) of the Act [(820 ILCS 305/8(a) (West 1996))], the claimant is entitled to recover reasonable medical expenses *that are causally related to the accident* and that are determined to be required to diagnose, relieve, or cure the effects of claimant's injury." (Emphasis added.) *F&B Manufacturing Co. v. Industrial Comm'n*, 325 Ill. App. 3d 527, 534 (2001). Because Baker's cervical condition was

causally unrelated to the accident (as the Commission reasonably found), he was not entitled to recover the medical expenses of treating that condition. See 820 ILCS 305/8(a) (West 2016); *F&B Manufacturing*, 325 Ill. App. 3d at 534.

¶ 90 III. CONCLUSION

¶ 91 For the foregoing reasons, we affirm the circuit court's judgment, which confirmed the Commission's decision.

¶ 92 Affirmed.