

2014 IL App (5th) 130484WC-U
No. 5-13-0484WC
Order filed September 22, 2014

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

JULIE DANIELS,)	Appeal from the Circuit Court
)	of Fayette County.
Appellant,)	
)	
v.)	No. 13-MR-7
)	
THE ILLINOIS WORKERS')	
COMPENSATION COMMISSION, <i>et al.</i> ,)	Honorable
)	James L. Roberts,
(Aldi, Inc., Appellee).)	Judge, Presiding.

JUSTICE HUDSON delivered the judgment of the court.
Presiding Justice Holdridge and Justices Hoffman, Harris, and Stewart concurred in the judgment.

ORDER

¶ 1 *Held:* (1) The Commission's finding that the condition of claimant's low back is not causally related to her work accident is not against the manifest weight of the evidence; (2) the Commission's decision to award respondent a credit for overpayment of temporary total disability benefits in the amount of \$8,596.56 is not against the manifest weight of the evidence; but (3) case would be remanded to the Commission for further proceedings to enter findings regarding payment of medical expenses related to claimant's cervical condition.

¶ 2 Claimant, Julie Daniels, filed an application for adjustment of claim pursuant to the Workers' Compensation Act (Act) (820 ILCS 305/1 *et seq.* (West 2006)) alleging various injuries to her person as a result of an accident on August 10, 2006, while in the employ of respondent, Aldi, Inc. The matter proceeded to arbitration pursuant to section 19(b) of the Act (820 ILCS 305/19(b) (West 2006)). The arbitrator found that claimant sustained an accidental injury arising out of and in the course of her employment on August 10, 2006. However, the arbitrator concluded that claimant failed to sustain her burden of establishing a causal relationship between her low-back complaints and the accident. The arbitrator therefore determined that respondent had paid all reasonable and necessary medical expenses and denied claimant's request for future medical benefits related to her low-back condition. The arbitrator also awarded respondent a credit of \$20,874 for overpayment of temporary total disability (TTD) benefits. Thereafter, claimant sought review before the Illinois Workers' Compensation Commission (Commission). The Commission reduced the amount of the credit due respondent to \$8,596.56, but otherwise affirmed and adopted the decision of the arbitrator and remanded the matter for further proceedings pursuant to *Thomas v. Industrial Comm'n*, 78 Ill. 2d 327 (1980). Claimant then sought judicial review of the Commission's decision in the circuit court of Fayette County. The circuit court confirmed the decision of the Commission.

¶ 3 On appeal, claimant raises three issues. First, she argues that the Commission's finding that the condition of her lumbar spine is not causally related to her work accident is against the manifest weight of the evidence. Second, she contends that the Commission erred in crediting respondent for the overpayment of TTD benefits. Third, she argues that the Commission erred in denying payment for certain medical expenses. For the reasons set forth below, we affirm in part, vacate in part, and remand the matter for further proceedings.

¶ 4

I. BACKGROUND

¶ 5 The following factual recitation is taken from the evidence presented at the arbitration hearing held on November 30, 2011. Claimant was employed by respondent as a shift manager. At the arbitration hearing, claimant testified that on August 10, 2006, she hurt her back, felt a pop in her chest, and experienced immediate pain after lifting a box of cantaloupes weighing between 40 and 50 pounds. Claimant testified that she initially sat down on the floor because of the pain. She then arose, walked across the store to the office, and called the manager. The next thing claimant recalled was waking up while lying on the floor with the manager standing over her. Claimant testified that when she awoke, it was difficult for her to breathe due to back and chest pain. An ambulance transported claimant to Fayette County Hospital.

¶ 6 The hospital records reflect that upon her arrival, claimant reported chest pain with radiation to the left shoulder with movement. An EKG and CT scans of the head and chest were essentially normal. Claimant was diagnosed with a pectoralis strain. Upon discharge, claimant was prescribed pain medication and instructed to follow up with her primary-care physician.

¶ 7 On August 11, 2006, claimant presented to the office of Dr. David Oligschlaeger, where she was seen by physician's assistant Gary Hayden. At that time, claimant complained of discomfort primarily in the center of the chest, right parasternal area, and left high anterior chest with no radiation. Hayden noted mild swelling over the upper and mid sternum and manubrial angle as well as extreme pain with palpation of the right second and fourth ribs over the costochondral junction. Hayden's assessment was costochondritis and syncope. Claimant was given pain medication and instructed not to work until further notice. Claimant saw Hayden on August 16, August 23, and September 6, 2006, with continued complaints of chest pain, and she was eventually referred to Dr. Timothy Gray of the Bonutti Clinic for a second opinion.

¶ 8 Claimant saw Dr. Gray on September 13, 2006. At that time, claimant completed an intake form in which she specified that the location of her pain was the upper right chest. Upon examination, Dr. Gray noted tenderness along the right proximal border of the sternum, but claimant's back and lower extremities were nontender and allowed full motion. Dr. Gray diagnosed costochondritis and a sternal injury. He prescribed medication for pain and inflammation and instructed claimant to remain off work until further notice. On November 1, 2006, claimant was seen at the Bonutti Clinic by Dr. Karl Rudert. At that time, claimant complained of severe pain over the second and third ribs and a portion of the fourth rib. Dr. Rudert diagnosed costochondral separation of the second and third ribs on the right with chronic costochondral pain or T2 syndrome. Dr. Rudert recommended a Lidoderm patch to numb the area giving it time to heal. When claimant next saw Dr. Rudert on November 13, 2006, she reported that the patches were not working. At that time, Dr. Rudert referred claimant to Dr. Rachel Feinberg and instructed claimant to remain off work.

¶ 9 On November 20, 2006, claimant presented to the emergency room at St. Anthony's Memorial Hospital. Claimant reported that her right second rib "popped out" and she was experiencing chest pain. Claimant denied any back pain at the time. Claimant was administered a pain reliever and discharged. On November 27, 2006, claimant saw Dr. Manjeshwar Prabhu for a second opinion. At that time, claimant complained of pain across the anterior part of the chest around the region of the sternum following an accident at work in August 2006. Dr. Prabhu interpreted an X ray as showing fractures of the first, second, and possibly third ribs on the right side. He noted, however, that claimant's pain does not correspond to the site of the rib fractures. Dr. Prabhu diagnosed a rib fracture and possibly sterna fracture secondary to trauma at work.

¶ 10 On November 29, 2006, claimant saw Dr. Feinberg. Claimant told Dr. Feinberg that she was injured at work in August 2006 when she picked up a heavy box and felt a “pop” in her chest. Claimant reported excruciating pain in her anterior chest and noted that when she moves, her ribs pop in and out. Dr. Feinberg noted significant restriction in claimant’s left iliopsoas muscle, which contributes to thoracic spine dysfunction. She recommended an iliopsoas compartment block to decrease claimant’s pain and stabilize her ribs, followed by trigger-point injections to facilitate repositioning of the ribs. Dr. Feinberg noted that once the ribs are aligned and spinal biomechanics are stabilized, claimant will progress to core strengthening. Dr. Feinberg authorized claimant off work until January 15, 2007, when she would be re-evaluated.

¶ 11 On January 17, 2007, Dr. Feinberg administered a left iliopsoas compartment block and a dorsal median nerve root block at T9. A dorsal median nerve root block at T7 and a thoracic facet injection were performed on January 25, 2007, followed by another dorsal median nerve root block at T7 on February 1, 2007. While treating with Dr. Feinberg, claimant was also undergoing physical therapy with a focus on the re-alignment and stabilization of claimant’s rib cage as well as mobilization of the thoracic spine. On February 8, 2007, claimant met with Dr. Feinberg and reported that her ribs were popping out more frequently, causing excruciating pain. Dr. Feinberg told claimant that the hypermobility of her ribs would require surgical intervention. She discontinued physical therapy and referred claimant to Dr. David Caplin, a plastic surgeon experienced in extensive revision of complicated chest wounds.

¶ 12 Claimant saw Dr. David Caplin on February 23, 2007. Claimant told Dr. Caplin that she was lifting a 40-pound box at work when she had a sudden onset of right parasternal pain so severe that she passed out and struck her head. Claimant told Dr. Caplin that she has pain all the time and that her ribs pop out on the right side and have to be manipulated back in place. Dr.

Caplin noted that Dr. Feinberg had treated claimant for back problems as sequelae of the work injury. After examining claimant, Dr. Caplin diagnosed chronic post-traumatic chondritis in the right parasternal area. Dr. Caplin felt that stabilization procedures for this region would be extremely difficult and unpredictable, and he wanted to speak to an interventional radiologist to get a better sense of whether there is a more accurate way to image the area. Claimant met with Dr. Caplin and Dr. Feinberg on May 10, 2007, to discuss her plan of care. Dr. Caplin indicated that he was not aware of any documented procedure for the treatment of displaced ribs, although he thought that partial removal of the rib was a possibility. Dr. Caplin referred claimant to Dr. G. Alexander Patterson for surgical intervention.

¶ 13 Claimant saw Dr. Patterson on June 27, 2007. She described the onset of pain and clicking in the anterior chest wall overlying the right second and third costal sterna junction after lifting something at work. Dr. Patterson noted that since that time, claimant has had persistent discomfort and periodic dislocation of the second and third costal cartilage as it joins the sternum. Dr. Patterson diagnosed costochondritis with rib separation. He proposed stabilizing claimant's chest wall or resecting the ends of the costal cartilage to prevent their dislocation on the sternum. On August 16, 2007, claimant underwent a partial excision of the right second and third costal cartilage with mesh reconstruction. Dr. Patterson continued to follow claimant and noted that she was doing well following her chest surgery.

¶ 14 On October 10, 2007, claimant returned to Dr. Feinberg's office. Dr. Feinberg noted that, overall, claimant had had a good outcome from her chest surgery, but was reporting "significant" pain in her chest and mid-back. Dr. Feinberg recommended extensive myofascial release with no manual therapy done to the anterior chest. Claimant again saw Dr. Feinberg on October 30, 2007. At that time, Dr. Feinberg noted that claimant's "low back pain, neck and chest pain"

were steadily improving. Claimant was treated with sacral decompression and extensive myofascial release to the legs. Dr. Feinberg instructed claimant to increase her aerobic activity and felt that claimant was progressing well and recommended continued physical therapy. By November 15, 2007, Dr. Feinberg noted that after a few more sessions of treatment, claimant would “graduate maximally medically improved.”

¶ 15 On November 29, 2007, claimant again saw Dr. Feinberg. At that time, claimant reported that her chest pain is no longer as intense, although she does experience some burning, and Dr. Feinberg indicated that claimant was approaching the end of her physical therapy treatment. Claimant posed several questions regarding her future. In response, Dr. Feinberg informed claimant that she would never be able to go back to any type of overhead work and that she would be unable to lift with her arms extended or with any type of rotation or twist. Dr. Feinberg believed that claimant was a good candidate for retraining and thought that she could do some computer work or other sedentary work.

¶ 16 When claimant saw Dr. Feinberg on December 6, 2007, she reported that her neck was doing better and her back was “getting there.” On December 18, 2007, Dr. Feinberg discharged claimant from physical therapy. In addition, she imposed a 10-pound lifting restriction and reiterated that claimant would not be able to return to her job or do any type of overhead lifting. Dr. Feinberg also opined that claimant would be a very good candidate for retraining and recommended six to eight weeks of physical therapy each year to allow claimant to maintain some stabilization and progressive strengthening. Claimant saw Dr. Patterson on January 11, 2008. At that time, Dr. Patterson noted that claimant was doing quite well with only some residual numbness over the right anterior chest. Dr. Patterson authorized claimant to return to work and advised her to return on an as-needed basis.

¶ 17 On March 26, 2008, claimant presented to Dr. Oligschlaeger's office, where she again saw Hayden. At that time, claimant had complaints of pain in the right anterior chest just lateral to the sternum. Hayden noted a small circular area under claimant's right breast at the sight of the incision from her surgery in August 2007. Hayden diagnosed chest wall musculoskeletal pain and prescribed pain medication. On April 15, 2008, claimant saw Dr. Feinberg after her surgical scar popped open. Dr. Feinberg referred claimant to Dr. Patterson, where she was seen on April 30, 2008. Dr. Patterson noted that the mesh graft inserted in claimant's chest appeared to be in good condition and was not infected. Claimant returned to Dr. Patterson's office on July 21, 2008, and reported longstanding postoperative discomfort and parasthesia. Dr. Patterson noted that a CT scan showed that the mesh inserted in claimant's chest appeared to be in good position, and he released claimant from his care. On August 7, 2008, Dr. Feinberg recommended that claimant be treated closer to home with periodic massage therapy to avoid fixation of the spine.

¶ 18 On October 3, 2008, claimant consulted chiropractor Jamileh Naddaf. Prior to her examination, claimant completed an intake form in which she reported back, neck, and chest pain with an onset date of August 10, 2006, after lifting a box at work. On an accompanying diagram, claimant marked the upper back, neck, and right upper chest as the affected areas. However, claimant gave Naddaf a verbal history of her work accident and subsequent treatment, reporting tenderness, oozing, and pulling pain in the chest as well as frequent headaches and pain in the neck, mid-back at the bra line, lower back, and right shoulder. Claimant further related that she reported multiple areas of pain to every doctor she had seen, but they focused on her chest complaints. According to claimant, the pain at the bra line and in her neck had been present since the date of injury. Naddaf diagnosed cervical, thoracic, and lumbar myofascitis

and neuropathy and recommended a course of treatment three times a week for four weeks. Naddaf also ordered X rays of the cervical, thoracic, and lumbar spine and the right shoulder. The radiologist interpreted the X ray of claimant's lumbar spine as negative, but Naddaf disagreed with the radiologist's reading.

¶ 19 Following her initial consultation, claimant began treating regularly with Naddaf. Over the months that followed, claimant reported varying degrees of pain in her low back and neck. When claimant saw Naddaf on December 29, 2008, she stated that she was not doing well. She reported severe myospasms and the inability to sleep due to severe pain, but noted that her low-back pain was not as noticeable.

¶ 20 On January 5, 2009, claimant underwent MRIs of the right shoulder and cervical spine. The MRI of the right shoulder showed a possible tear of the labrum. The MRI of the cervical spine revealed mild disc/spur complexes at C4-C5, C5-C6, and C5-C7, most significant at C5-C6 where bilateral foraminal encroachment was noted. Meanwhile, claimant continued to treat regularly with Naddaf throughout January 2009 with complaints of persistent pain in her right shoulder and neck. Based on the results of the MRIs, Naddaf discussed a referral to a specialist for both the cervical spine and right shoulder.

¶ 21 On January 22, 2009, claimant returned to the Bonutti Clinic, where she again saw Dr. Rudert. Claimant completed a patient questionnaire in which she indicated that her chief complaints involved neck pain, back pain, numbness in the leg, and pain, numbness, and weakness in the arm as a result of a work accident on August 10, 2006. After examining claimant and reviewing the MRIs taken in January 2009, Dr. Rudert diagnosed a C5-C6 degenerative disc. Dr. Rudert recommended an EMG/NCV of the upper extremity to exclude any other pathology. Dr. Rudert opined that claimant could have easily had a neck and shoulder

problem when he originally saw her, but noted that her treatment concentrated on her chest complaints and that there were no complaints involving the neck or the shoulder at that time. Dr. Rudert further opined that claimant's complaints could be related to her lifting injury. He continued to recommend that claimant remain off work.

¶ 22 Claimant saw Dr. Terrence Pencek on February 10, 2009. In a pre-appointment questionnaire, claimant indicated that she was injured on August 10, 2006, when she was lifting a box weighing between 40 and 50 pounds and felt a pop in the right side of her chest and immediate pain. Claimant further wrote that she then fainted and hit her head and that after "coming to" she had head and neck pain as well as right shoulder and back pain. Dr. Pencek took a verbal history from claimant in which she reported her symptoms as posterior neck pain, tingling in the right arm, frequent headaches, and "heavy" legs at night. Following an examination and a review of the MRI of claimant's cervical spine, Dr. Pencek recommended a discography at C4-C5, C5-C6, and C6-C7 and an MRI of the thoracic spine. The discography and MRI of the thoracic spine were taken on March 11, 2009. A pain questionnaire completed by claimant in conjunction with these studies indicates pain from the neck to the mid-back. The discography revealed concordantly painful discs at C4-C5 and C5-C6. The MRI of the thoracic spine was negative. Claimant followed up with Dr. Pencek on March 26, 2009, with complaints of pain in the neck and upper back, as well as numbness and tingling in both hands, but mostly on the right. Dr. Pencek recommended a C4-C5, C5-C6 anterior cervical discectomy and fusion. The operation was performed by Dr. Pencek on June 10, 2009.

¶ 23 Claimant saw Dr. Pencek post-operatively on June 22, 2009. At that time, claimant denied any weakness or numbness in her arms and related that she "feels healed." Dr. Pencek instituted a five-pound lifting restriction and instructed claimant to increase her exercise through

walking. Claimant returned to Dr. Pencek's office on July 21, 2009. She reported some pain in the right jaw and muscle tightness in the back of the neck, but otherwise told Dr. Pencek that her pain was "100 times better," that she had no arm pain, and that she was "fixed." Dr. Pencek ordered physical therapy which claimant began on July 28, 2009. At that time, claimant's principal concerns were mid- to upper-back tightness and general cervical tension as well as generalized weakness throughout the neck and upper back.

¶ 24 Claimant returned to Dr. Pencek's office on September 15, 2009. At that time, claimant reported pain in the mid-thoracic region, but noted that her neck and arm pain were gone. Claimant also reported tingling in her right leg. Dr. Pencek opined that claimant may have a lumbar radiculopathy. He recommended four more weeks of physical therapy. On October 6, 2009, claimant underwent an MRI of the lumbar spine. On November 3, 2009, Dr. Pencek noted that the MRI was "unremarkable" and that there were no disc herniations or compression of nerve roots. Dr. Pencek continued claimant's physical therapy for four more weeks and prescribed pain medication. In addition, on November 24, 2009, claimant underwent an EMG/NCV study of her lower limbs. The EMG/NCV was normal without evidence indicative of lumbar or sacral radiculopathic process.

¶ 25 Claimant saw Dr. Pencek on December 15, 2009, with complaints of low-back pain and tingling down both legs, mainly in the mid-thoracic region at T6. Dr. Pencek prescribed Lidoderm patches and felt that claimant would benefit from trigger-point injections. In addition, Dr. Pencek told claimant that he had exhausted all possible ideas for her pain management and that she will not require follow-up care in his office, but he ordered more physical therapy.

¶ 26 Claimant had an initial evaluation for the physical therapy ordered by Dr. Pencek on December 18, 2009. At that time, claimant complained of an extreme increase in lower

extremity pain, numbness, and tingling on November 14, 2009, that continued for two weeks. The therapist noted that claimant's problems included thoracic pain; numbness and tingling in the bilateral lower extremity; neuromuscular spasms in thoracic areas; tenderness to palpation of low-back landmarks; and weakness of the quads, hip flexors, and trunk stabilizers. The therapist assessed thoracic pain with lower extremity radiculopathy and weakness. She developed a four-week therapy program to address these problems. In the meantime, claimant met with a vocational counselor on January 4, 2010. The vocational counselor recommended a transferrable-skills analysis.

¶ 27 On February 3, 2010, claimant presented to Dr. Brian Ogan of the Illinois Spine and Pain Center with complaints of mid-thoracic pain and mid-lower lumbar pain radiating to the bilateral buttocks, thighs, and calves. Claimant reported that the thoracic and lumbar complaints are distinct and began following a work-related injury in 2006. Upon examination, Dr. Ogan noted that claimant demonstrated a full range of motion of the lumbar spine without pain reproduction and she was fully neurologically intact in the lower extremities. Dr. Ogan diagnosed chronic thoracic and lumbar pain with bilateral lower-extremity radiating pain status post industrial-related injury in 2006. Dr. Ogan wanted to review an MRI of claimant's lumbar spine, but noted that he had no "clear explanation" of the etiology of her symptoms.

¶ 28 On March 16, 2010, claimant was again evaluated by Dr. Ogan. Claimant reported that since her initial visit, her pain had increased in intensity and frequency without a specific initiating event. Claimant reported that at the time of the work injury, she noted a tingling sensation in the low back and bilateral lower extremities which has progressed to a deep aching pain with increased intensity and frequency. Dr. Ogan ordered an MRI of the lumbar spine. The MRI was performed on March 31, 2010, and demonstrated minimal degenerative changes of the

lower lumbar facet joints with no significant disc protrusion or spinal or foraminal stenosis present. On May 19, 2010, claimant saw Hayden with complaints of low-back pain radiating to the buttocks, thighs, and calves bilaterally. Claimant reported that the pain began in August 2006, when she fell at work. Hayden diagnosed low-back pain and referred claimant to chiropractor Naddaf.

¶ 29 Claimant presented to Naddaf on May 27, 2010. At that time, claimant complained of chest pain, neck pain, and pain radiating to both legs which is worsened with extension. Claimant reported that the pain initially occurred after a work-related injury in August 2006. Claimant also stated that she has had pain in the lower back, buttocks, and bilateral legs “for months after her neck surgery” in June 2009. Following an examination, Naddaf diagnosed post-surgical cervicalgia, lumbar radiculopathy with sciatic involvement, and cervical, thoracic, and lumbar myofascitis. Naddaf recommended a course of treatment three times a week for four weeks. During Naddaf’s treatment, claimant repeatedly complained of severe low-back pain, so Naddaf ordered an MRI of the lumbar spine. The MRI was taken on June 10, 2010, and was significant for L4-L5 facet arthrosis with small synovial cyst. Naddaf advised claimant to consult an orthopaedic surgeon for evaluation of the cyst.

¶ 30 On July 15, 2010, claimant saw Dr. Pencek, with complaints of low-back pain radiating to the buttocks, hips, and legs bilaterally. During the visit, claimant told Dr. Pencek that she complained of low-back pain when he first saw her in relation to her cervical problem, but he responded that he would treat one problem at a time. Dr. Pencek reviewed an MRI from October 2009, noting that all discs appeared to be healthy. Dr. Pencek ordered a lumbar discogram and a new MRI. The discogram and MRI were performed on August 5, 2010. The discogram produced pain at L3-L4 and L4-L5, but not at the control disc, L5-S1. The MRI of the lumbar

spine was negative. Claimant followed up with Dr. Pencek on August 20, 2010. After reviewing the discogram, Dr. Pencek recommended an L3-L4, L4-L5 interbody fusion and posterolateral fusion. While awaiting approval for back surgery, claimant presented to the emergency room with complaints of low-back pain and she continued to see her primary-care physician and Dr. Pencek with complaints of low-back pain.

¶ 31 At the arbitration hearing, claimant testified that she still experiences pain in her low back with bilateral radiation to the lower extremities, which affects her activities of daily life. Claimant testified that she would like to undergo the surgery recommended by Dr. Pencek. On cross-examination, claimant acknowledged that her initial treatment records do not reference a low-back injury or low-back pain. She also acknowledged other progress notes which reference back complaints involving only “general” back symptoms and not low-back symptoms.

¶ 32 Dr. Pencek, a board-certified orthopaedic surgeon, testified by evidence deposition in September 2009 and March 2011. Dr. Pencek related that he first recorded complaints of low-back pain from claimant at her first office visit on February 10, 2009, when claimant stated that her legs felt “heavy” at night. Dr. Pencek testified that he opted to treat claimant first for her cervical condition because “it seemed to be a more obvious complaint at her first office visit.” He also cited the fact that claimant complained of thoracic pain, which can be referred from the cervical spine. He related that, for practical reasons, the neck is treated first in individuals with both cervical and lumbar complaints because “we don’t want [the patient] on the operating table in a prone position injuring [his or her] cervical spinal cord while we’re working in the lumbar region.” Dr. Pencek further testified that when he saw claimant on September 15, 2009, she described tingling in her right leg. Dr. Pencek opined that the tingling may be a lumbar

radiculopathy. At that time, Dr. Pencek sent claimant for an MRI of the lumbar spine, but the film was negative for any disc herniations.

¶ 33 Claimant returned to Dr. Pencek's office on July 15, 2010, reporting pain in her low back, both buttocks, both legs, and both hips. Dr. Pencek conducted a general examination and a neurological examination, both of which were normal. An MRI of the lumbar spine showed a synovial cyst, and a discogram reproduced pain at both L3-L4 and L4-L5. Based on the test results, Dr. Pencek diagnosed internal disc disruption and discogenic pain and recommended an L3-L4 and L4-L5 interbody fusion with a posterolateral fusion. Dr. Pencek opined that the work accident of August 10, 2006, could have caused all the problems claimant described based upon the mechanism of the injury. Nevertheless, he allowed that he could not exclude some other reason for claimant's symptoms. He further stated that, although he believed in the honesty of claimant, if her veracity were shown to be "suspect," it might alter his opinion.

¶ 34 On cross-examination, Dr. Pencek testified that, other than chiropractor Naddaf, he did not have any medical records for claimant prior to the first time he examined her. Dr. Pencek testified that an office note of July 15, 2010, references complaints of low-back pain. Specifically, the office note states that claimant said that she complained of low-back pain on her first visit, but that Dr. Pencek stated that he would take care of one problem at a time. Nevertheless, Dr. Pencek agreed that claimant did not reference any low-back pain in her pre-appointment questionnaire and that he did not have any independent recollection of her discussing low-back pain when on February 10, 2009, when she first came to see him. Dr. Pencek further testified that diagnostic films of claimant's lumbar spine prior to November 2009 showed no abnormalities. Further, while the September 15, 2009, office note references tingling

in claimant's right leg, Dr. Pencek admitted that the office note mostly discussed her thoracic spine with no reference to the low back.

¶ 35 Dr. Pencek further testified on cross-examination that although claimant had subjective complaints of pain during the discogram, the study did not show any leaking fluid. Thus, Dr. Pencek acknowledged, the discogram was positive based on claimant's subjective pain complaints. Further, a CT lumbar diagnostic study taken after the discogram was negative for an annular tear at L3-L4, L4-L5, or L5-S1. Regarding the causation of claimant's pain, Dr. Pencek stated that he would "be a fool" not to think that there could be a source of her pain other than the accident in August 2006. He acknowledged that her accident history does not reference an immediate injury or trauma to her low back. He stated that if the facts turn out to be different in terms of whether claimant actually experienced a twist to her low back or trauma to her low back, it would cause him to change his causation opinion.

¶ 36 Dr. Frank Petkovich, a board-certified orthopaedic surgeon, conducted an independent medical evaluation of claimant on May 12, 2011, at respondent's request. Dr. Petkovich testified by evidence deposition taken on June 27, 2011. Claimant told Dr. Petkovich that on August 10, 2006, she was lifting a box of cantaloupes at work when she felt a sudden pain in her upper chest in the area of her sternum. She further related that she called for help but that she fell backwards and struck her head. Claimant eventually underwent chest and neck surgery.

¶ 37 Dr. Petkovich testified that at some point, claimant mentioned low-back pain. Dr. Petkovich reviewed MRIs of claimant's thoracic and lumbar spine taken on March 11, 2009. Dr. Petkovich testified that the films were negative for any abnormalities. Claimant underwent another MRI of the lumbar spine on March 31, 2010, which was also normal. An MRI of the lumbar spine taken on June 10, 2010, was interpreted as showing a possible synovial cyst at L4-

L5, but was otherwise normal. Dr. Petkovich reviewed the June 10, 2010, film and did not find evidence of a synovial cyst. An MRI of the lumbosacral spine taken on August 5, 2010, was normal without any evidence of disc abnormalities such as a disc herniation or nerve-root compression.

¶ 38 Dr. Petkovich noted that a discogram of L3-L4, L4-L5, and L5-S1 was performed on August 9, 2010. Dr. Petkovich explained that a discogram involves injecting dye into the disc, the goal of which is to add pressure to a contained area to check for leakage. Dr. Petkovich interpreted the discogram as normal, noting that the dye injected into the disc was well contained without any evidence of leakage. Dr. Petkovich acknowledged that the discogram report noted that claimant did have some pain. According to Dr. Petkovich, however, a discogram is a painful study and an increased amount of pain indicates the containment and the stability of the disc, further enforcing the absence of any leakage.

¶ 39 Dr. Petkovich also performed a physical examination of claimant. Regarding claimant's lumbar spine, Dr. Petkovich noted that although claimant stated there was tenderness to palpation in the paraspinous lumbar area, he was unable to palpate any muscle spasm. Dr. Petkovich testified that when he asked claimant directly about her range of motion, she was more limited than on distraction testing. Dr. Petkovich noted full mobility of claimant's lumbosacral spine during distraction testing. As such, he opined that claimant was exaggerating her symptoms. He also noted that neurologically, claimant's lower extremities were intact, meaning that there was no evidence that claimant had any nerve-root impingement. Dr. Petkovich also noted that straight-leg raising was unremarkable on both sides. Thus, from a neurological standpoint, Dr. Petkovich did not see any evidence of any type of nerve-root impingement being caused by any disc in her lower back. Further, on the discogram and the other diagnostic studies,

there was no evidence of disc herniation, annular tears, or anything that was abnormal to claimant's lumbar spine.

¶ 40 With respect to the lumbar condition, Dr. Petkovich opined that, from the information available to him, claimant "may have" sustained a thoracic and lumbar strain at the time of the August 10, 2006, accident. Dr. Petkovich stated that his response was qualified because claimant failed to mention her lumbar spine when she initially saw Dr. Pencek and Dr. Oligschlaeger. Moreover, Dr. Petkovich did not see any comment that claimant had made to Dr. Rudert or Dr. Gray and she did not give Dr. Petkovich a history of initially injuring her low back at the time of the August 10, 2006, accident. In any event, Dr. Petkovich opined that any strain which she may have experienced had completely resolved by the time he examined her. In this regard, Dr. Petkovich noted that although claimant had subjective complaints of pain in her low back, she had a totally normal and unremarkable physical examination of her thoracic and lumbar spine and the radiographic studies were normal. Dr. Petkovich added that, regardless of cause, he did not believe that surgical intervention was necessary to treat claimant's low back, given that any injury sustained had completely resolved by the time he saw her.

¶ 41 On cross-examination, Dr. Petkovich testified that the pain that claimant experienced during the discogram was the result of the procedure itself and had nothing to do with the damage to the actual disc. Dr. Petkovich agreed that the discogram was done at three levels—L3-L4, L4-L5, and L5-S1—and that claimant did not report any pain at L5-S1. According to Dr. Petkovich, however, a discogram is a painful study and it is difficult for the patient to differentiate between the disc level and the pain. Dr. Petkovich testified that, in his opinion, there are no objective physical findings or radiographic findings to indicate why claimant would have subjective complaints of low-back pain.

¶ 42 Based on the foregoing evidence, the arbitrator found that claimant sustained an accident on August 10, 2006, arising out of and in the course of her employment with respondent. However, the arbitrator also found that claimant failed to establish a causal connection between her low-back condition and the work accident. In reaching this conclusion, the arbitrator reasoned that, prior to her July 2010 visit with Dr. Pencek, claimant never gave a history of injuring her low back in the work accident or complained of low-back pain to any of her medical providers. The arbitrator also noted that claimant's testimony that she related complaints involving her low back soon after the injury occurred was "thoroughly refuted" by her admissions on cross-examination and by the medical records submitted into evidence. The arbitrator acknowledged that claimant did report thoracic back complaints, but pointed out that the thoracic area is not the same as the lumbar area. Moreover, given claimant's injury to her right second and third ribs, the arbitrator believed it was "natural" to complain of pain in her chest and thoracic area. In light of the arbitrator's finding on causation, he denied future medical benefits, including the low-back surgery proposed by Dr. Pencek. The arbitrator also tacitly concluded that a causal relationship exists between her work accident and her neck and chest problems and determined that respondent had paid all reasonable and necessary medical expenses related to those conditions. Finally, the arbitrator awarded a credit of \$20,874 to respondent for overpayment of TTD benefits.¹

¶ 43 Claimant appealed the matter to the Commission. The Commission reduced the credit to respondent for overpayment of TTD benefits, citing two grounds. First, the Commission

¹It is unclear from the arbitrator's decision how he calculated the overpayment of TTD benefits.

determined that claimant had been paid TTD at a rate below the statutory minimum of \$260 per week. Second, the Commission determined that claimant was entitled to TTD benefits from August 10, 2006 (the date of the accident), through December 15, 2009 (the date Dr. Pencek discharged claimant from care for her cervical condition), a total of 174-6/7 weeks. Noting that respondent had paid TTD benefits totaling \$54,059.38, the Commission reduced the overpayment credit to \$8,596.56 (\$54,059.38 minus (\$260 x 174-6/7)). On all other matters, the Commission affirmed and adopted the decision of the arbitrator. The Commission remanded the matter to the arbitrator for further proceedings pursuant to *Thomas*, 78 Ill. 2d 327. On judicial review, the circuit court of Fayette County confirmed the decision of the Commission in all respects. This appeal by claimant ensued.

¶ 44

II. ANALYSIS

¶ 45

A. Causation

¶ 46 On appeal, claimant challenges the Commission's finding that the condition of her lumbar spine is not causally related to her industrial accident. In a proceeding under the Act, the employee has the burden of proving by a preponderance of the evidence all of the elements of his or her claim. *O'Dette v. Industrial Comm'n*, 79 Ill. 2d 249, 253 (1980). Among other things, the employee must establish that his or her condition of ill-being is causally connected to a work-related injury. *Elgin Board of Education School District U-46 v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 943, 948-49 (2011). Causation presents an issue of fact. *Bernardoni v. Industrial Comm'n*, 362 Ill. App. 3d 582, 597 (2005); *Caterpillar, Inc. v. Industrial Comm'n*, 228 Ill. App. 3d 288, 293 (1992). In resolving factual matters, it is within the province of the Commission to assess the credibility of the witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the

evidence. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 206 (2003); *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 674 (2009). Thus, a reviewing court may not substitute its judgment for that of the Commission on such issues merely because other inferences from the evidence may be drawn. *Berry v. Industrial Comm'n*, 99 Ill. 2d 401, 407 (1984). We review the Commission's factual determinations under the manifest-weight-of-the-evidence standard. *Orsini v. Industrial Comm'n*, 117 Ill. 2d 38, 44 (1987). A decision is against the manifest weight of the evidence only if an opposite conclusion is clearly apparent. *Mlynarczyk v. Illinois Workers' Compensation Comm'n*, 2013 IL App (3d) 120411WC, ¶ 17.

¶ 47 With respect to the issue of causation, the Commission affirmed and adopted the findings of the arbitrator. The arbitrator, relying on the testimony of the witnesses and the medical records, determined that claimant failed to establish a causal relationship between her low-back condition and the work accident of August 10, 2006. Notably, the arbitrator found that the first history of claimant injuring her low back as a result of the work accident was in July 2010 when she sought additional treatment from Dr. Pencek. The arbitrator acknowledged that claimant did report thoracic back complaints prior to that time, but pointed out that the thoracic area is not the same as the lumbar area. The arbitrator also acknowledged claimant's testimony that she did complain of pain in her low back soon after the work accident, but noted that claimant's testimony was "thoroughly refuted" by the medical evidence and her admissions to the contrary on cross-examination.

¶ 48 Claimant argues that the Commission's finding that her low-back condition is not causally related to her work accident is against the manifest weight of the evidence. According to claimant, the record "clearly reflects" that she complained of an injury to her low back and low-back pain prior to returning to Dr. Pencek in July 2010. In support of this contention,

claimant recounts her testimony at the arbitration hearing that she reported back pain at Fayette County Hospital on the day of the accident and to Dr. Oligschlaeger's office the following day. Claimant also contends that the medical records establish that she made multiple complaints of low-back pain and related symptoms to medical personnel prior to July 2010.

¶ 49 Applying the deferential standard applicable to our review of this issue, we cannot say that the Commission's decision is against the manifest weight of the evidence. Significantly, claimant's testimony that she made multiple complaints of low-back pain and related symptoms to medical personnel proximate to the time of the accident is not borne out by the contemporaneous medical records. The records from Fayette County Hospital do not reference any low-back pain, any injury to the low-back as a result of the work accident, or any treatment for low-back symptoms. Rather, they show that when claimant presented to the emergency room shortly after the accident, she reported chest pain with radiation to the left shoulder upon movement. Similarly, when claimant presented to Dr. Oligschlaeger's office the day after the accident, she complained of discomfort primarily in the center of the chest, right parasternal area, and left high anterior chest with no radiation. Again, the records from Dr. Oligschlaeger's office contain no reference to low-back pain, an injury to the low back as a result of the work accident, or any treatment for low-back symptoms. In fact, when claimant returned to Dr. Gray a month after the accident, she did not report any low-back pain or a low-back injury as a result of the work accident. Indeed, Dr. Gray noted that claimant's back and lower extremities were nontender and allowed full motion. Further, she denied back pain when she sought treatment at the emergency room at St. Anthony's Hospital in November 2006. Finally, the medical records do not reflect that claimant reported any low-back pain or a low-back injury as a result of the

work accident when she initially treated with Dr. Rudert, Dr. Prabhu, Dr. Feinberg, Dr. Caplin, or Dr. Patterson.

¶ 50 In an effort to establish that she made multiple complaints of low-back pain and related symptoms to medical personnel prior to July 2010, claimant cites various medical records. In particular, claimant directs us to the treatment records of chiropractor Naddaf, Dr. Ogan, Dr. Pencek, and physician's assistant Hayden from Dr. Oligschlaeger's office. While these records do reference low-back complaints by claimant prior to July 2010, they do not compel reversal of the Commission's causation finding.

¶ 51 Initially, claimant refers us to chiropractor Naddaf's office note of October 3, 2008, which references a history of "pain in the neck, mid-back at the bra-line, lower back, and right shoulder." However, this complaint occurred more than two years after the accident. More important, Naddaf does not relate the low-back pain to the work accident. The office note states that the pain at claimant's bra line and in her neck has been present since the date of the injury, but does not reference an onset date for the low-back pain. In fact, Naddaf's progress note from May 27, 2010, suggests that claimant's low-back pain began after her June 2009 neck surgery. We also point out that a pain diagram claimant completed in October 2008 prior to seeing Naddaf is inconsistent with the verbal history Naddaf took from claimant. The pain diagram describes pain only in the upper back, neck, and chest following the August 2006 work accident. It does not refer to any low-back pain, much less the onset of low-back pain following the work accident.

¶ 52 Claimant also directs us to Dr. Pencek's note of September 15, 2009, when she reported tingling in her right leg. However, Dr. Pencek attributed this symptom to a lumbar radiculopathy, not the work accident. Indeed, during his deposition testimony, Dr. Pencek

admitted that claimant did not reference a history of an injury to her low back or indicate that she had low-back pain in the pre-appointment questionnaire she completed. Moreover, Dr. Pencek testified that he did not have any independent recollection of her discussing low-back pain. Although Dr. Pencek ordered an MRI of claimant's lumbar spine in October 2009, the film was interpreted as "unremarkable" with no evidence of any disc herniation or nerve-root compression, and, on December 15, 2009, Dr. Pencek released claimant from his care, noting that she "will not require follow up with our office."

¶ 53 When claimant saw Dr. Ogan early in 2010, she presented with complaints of mid-lower lumbar pain with radiation following the work accident in August 2006. Similarly, a May 19, 2010, office note from Dr. Oligschlaeger's office also references low-back pain with radiation to the lower extremities which claimant related to the August 2006 accident. However, these histories conflict with the contemporaneous medical records, which are devoid of any low-back complaints subsequent to the work accident or any radiation to the lower extremities. Accordingly, given the absences of a history of low-back complaints contemporaneous to the work accident as well as the inconsistencies in the medical records regarding the onset of low-back pain, the Commission could have reasonably determined that the medical records cited by claimant do not support a finding of causation between claimant's low-back pain and her work accident.

¶ 54 Claimant also contends that Dr. Pencek offered a practical reason for not mentioning a low-back injury or low-back pain. Notably, Dr. Pencek stated that when a patient presents with both cervical and lumbar complaints, he will treat the cervical condition first so as to protect the cervical spinal cord from injury during treatment for the lumbar region. While this might explain *how* Dr. Pencek would treat a patient experiencing both cervical and lumbar complaints, it does

nothing to explain *why* Dr. Pencek's office notes are devoid of any reference to low-back pain when he initially treated her. Moreover, on December 15, 2009, following treatment for her cervical condition, Dr. Pencek stated that claimant "will not require follow up with our office." Thus, the course of treatment prescribed in this case by Dr. Pencek is inconsistent with the plan of sequential treatment he describes.

¶ 55 Claimant also insists that the Dr. Pencek's deposition testimony supports a finding that her low-back complaints are related to her accident at work and that the Commission erred in rejecting it. We disagree. To the extent that the medical testimony might be construed as conflicting, it is well established that the resolution of such conflicts falls within the province of the Commission, so its finding will not be reversed on appeal unless contrary to the manifest weight of the evidence. *Sisbro, Inc.*, 207 Ill. 2d at 206. The Commission was presented with two conflicting medical opinions. Dr. Pencek's testimony supported a finding of causation between claimant's low-back complaints and the work accident while Dr. Petkovich's does not. However, Dr. Pencek's opinion testimony was highly qualified. Dr. Pencek stated that he could not exclude a reason other than the work accident as the cause of claimant's low-back injury. He testified that given the lapse in time between claimant's work accident and her treatment for low-back symptoms, he would "be a fool" not to think that there could be another source of her low-back complaints. Moreover, it was Dr. Pencek's opinion that the deciding factor in determining the cause of claimant's low-back complaints was the veracity of the patient. As the record demonstrates, claimant's credibility is questionable given the inconsistent histories she provided regarding her low-back complaints.

¶ 56 Claimant also insists that Dr. Petkovich's deposition testimony supports a finding of causation. She notes that Dr. Petkovich testified that claimant may have sustained a thoracic and

lumbar strain at the time of her work injury. Claimant, however, ignores Dr. Petkovich's additional testimony that, even if claimant had a low-back injury as a result of the work accident, it constituted a strain which had completely resolved and did not need any surgical intervention. Moreover, as Dr. Petkovich noted, he was unable to state with any certainty whether claimant sustained a low-back injury as a result of the work accident because her medical records are devoid of any such history. As noted above, our review of the record supports this latter finding.

¶ 57 In short, given the conflicting evidence regarding claimant's low-back complaints and the highly qualified medical opinion offered by claimant's expert medical witness, we cannot say that a conclusion opposite that of the Commission is clearly apparent. Accordingly, we find that the Commission's determination that claimant failed to sustain her burden of proving a causal connection between her low-back condition and her work accident is not against the manifest weight of the evidence.

¶ 58 B. TTD Overpayment Credit

¶ 59 Next, claimant challenges the Commission's award to respondent of a credit in the amount of \$8,596.56 for the overpayment of TTD benefits. A claimant is entitled to TTD benefits from the date of the injury until he or she reaches maximum medical improvement (MMI). *Freeman United Coal Mining Co. v. Industrial Comm'n*, 318 Ill. App. 3d 170, 177 (2000). A claimant reaches maximum medical improvement when his or her condition stabilizes. *Freeman United Coal Mining Co.*, 318 Ill. App. 3d at 175-76. A condition stabilizes when it improves as far as the character of the injury will permit. *Land & Lakes Co. v. Industrial Comm'n*, 359 Ill. App. 3d 582, 594 (2005). Among the factors to consider in determining whether a claimant has reached MMI are a release to return to work (with restrictions or otherwise), as well as medical testimony or evidence concerning claimant's injury, the extent

thereof, the prognosis, and whether the injury has stabilized. *Kawa v. Illinois Workers' Compensation Comm'n*, 2013 IL App (1st) 120469WC, ¶ 103 (quoting *Freeman United Coal Mining Co.*, 318 Ill. App. 3d at 178). This presents a factual question, which we will not disturb unless it is against the manifest weight of the evidence. See *Kawa*, 2013 IL App (1st) 120469WC, ¶ 105. As noted earlier, a decision is contrary to the manifest weight of the evidence only if an opposite conclusion is clearly apparent. *Mlynarczyk*, 2013 IL App (3d) 120411WC, ¶ 17.

¶ 60 Claimant cites two reasons in support of her claim that the Commission erred in awarding defendant a credit for overpayment of TTD benefits. First, claimant argues that because the current condition of her low back is causally related to her work accident, she is entitled to ongoing TTD benefits, therefore eliminating any credit due respondent. Having previously rejected claimant's causation argument, we decline to overturn the credit on this basis.

¶ 61 Alternatively, claimant alleges that the finding that she owes respondent a credit for overpayment of TTD benefits should be reversed because she has not reached maximum medical improvement (MMI) from her chest and neck conditions. According to claimant, no doctor has released her to work without restrictions or indicated that her chest and neck conditions have stabilized. We disagree.

¶ 62 The Commission determined that claimant reached MMI from her chest and neck conditions by December 15, 2009. The record amply supports this finding. Claimant underwent surgery on August 16, 2007, consisting of a partial excision of the right second and third costal cartilage with mesh reconstruction. By January 11, 2008, Dr. Patterson noted that claimant was doing well with only some residual numbness over the right anterior chest. At that time, Dr. Patterson authorized claimant to return to work and advised her to return to his office on an as-

needed basis. Claimant returned to Dr. Patterson on July 21, 2008, reporting longstanding postoperative discomfort and paresthesia. However, Dr. Patterson noted that a CT scan showed that the mesh inserted in claimant's chest appeared in good position, and he again released claimant from his care.

¶ 63 On June 10, 2009, Dr. Pencek performed a C4-C5 and C5-C6 anterior cervical discectomy and fusion on claimant. Two weeks after surgery, claimant told Dr. Pencek that she felt "healed" and was not experiencing any weakness or numbness in her arms. A month after the operation, claimant reported some pain in the right jaw and muscle tightness in the back of the neck, but otherwise told Dr. Pencek that she experiences no arm pain and that she was "100 times better." Claimant continued to treat with Dr. Pencek for several months after the operation, noting that she had no neck or arm pain. By December 15, 2009, Dr. Pencek informed claimant that he had exhausted all possible ideas for pain management and that she would not be required to follow up with his office.

¶ 64 Based on the foregoing evidence, the Commission could have reasonably concluded that claimant reached MMI improvement from her chest and neck conditions by December 15, 2009. The evidence shows that claimant's chest condition stabilized and she had been released to return to work by January 11, 2008. Similarly, the evidence shows that claimant's neck condition had been stabilized by December 15, 2009, when Dr. Pencek advised claimant that he had exhausted all possible ideas for pain management and that she would not be required to follow up with his office. The Commission's finding is therefore not against the manifest weight of the evidence.

¶ 65 C. Medical Expenses

¶ 66 Finally, claimant argues that the Commission's finding that respondent has paid all reasonable and necessary medical expenses was against the manifest weight of the evidence.

According to claimant, respondent is responsible for a multitude of bills related to her cervical injury involving treatment prior to December 15, 2009, the date of MMI. Claimant also requests payment for all of the bills incurred for her low-back injury and for prescriptions related to both her neck and back injuries. Respondent maintains that the Commission's finding that it has paid all reasonable and necessary medical expenses is not against the manifest weight of the evidence because many of the medical bills were not certified, they are inaccurate, and they do not differentiate between alleged work-related treatment and treatment that is not work-related.

¶ 67 Initially, we deny claimant's request for medical expenses related to her low-back condition based on our earlier finding affirming the Commission's decision that she failed to establish that condition is causally related to her work accident. Turning to claimant's request for additional medical expenses related to her cervical injury, we find that we are unable to properly review the Commission's decision. The arbitrator and the Commission are charged with making findings of fact and law. *Skzubel v. Illinois Workers' Compensation Comm'n*, 401 Ill. App. 3d 263, 269 (2010); *J.S. Masonry, Inc. v. Industrial Comm'n*, 369 Ill. App. 3d 591, 598 (2006); *Swift & Co. v. Industrial Comm'n*, 150 Ill. App. 3d 216, 220 (1986). These findings need not be stated in any particular language and, if possible, may be implied from the Commission's decision. *Skzubel*, 401 Ill. App. 3d at 269; *J.S. Masonry, Inc.*, 369 Ill. App. 3d at 598; *Illinois Bell Telephone Co. v. Industrial Comm'n*, 265 Ill. App. 3d 681, 686 (1994); *Swift & Co.*, 150 Ill. App. 3d at 221. The rationale for requiring the arbitrator and the Commission to make findings of fact and law is to allow the reviewing court to adequately review the Commission's decision. See *Skzubel*, 401 Ill. App. 3d at 269 (citing *Reinhardt v. Board of Education of Alton Community Unit School District No. 11*, 61 Ill. 2d 101, 103 (1975)).

¶ 68 In this case, the parties agreed at the arbitration hearing that one of the issues in dispute was medical expenses. The record shows that when claimant sought to introduce the medical bills at the arbitration hearing, respondent objected on the basis that some of the bills were not certified. The arbitrator noted respondent's objections, but then stated that he would allow the evidence to go in. Yet, when the arbitrator rendered his decision, he summarily concluded that respondent had paid all reasonable and necessary medical expenses. The Commission affirmed and adopted the arbitrator's finding without any comment. While the Commission may have denied the medical expenses at issue based on the reasons suggested by respondent, we are unable to discern any basis for inadmissibility based on the record before us. Thus, we are compelled to vacate the Commission's finding on the issue of medical expenses and remand the cause to the Commission to make appropriate findings on this issue.

¶ 69 Upon remand, the Commission shall determine which medical bills, if any, were properly certified or received in response to a Commission subpoena. See 820 ILCS 305/16 (West 2010) (providing that (1) bills kept by a treating healthcare provider, certified as true and correct, shall be admissible without any further proof as evidence of the medical and surgical matters stated therein and (2) there is a rebuttable presumption that any bills received in response to a Commission subpoena are certified to be true and correct). The Commission shall then determine which medical expenses attributable to claimant's cervical condition remain unpaid. The Commission shall order respondent to pay those unpaid expenses for bills that it determines are properly admitted in accordance with the provisions of section 16 of the Act or that were the subject of any other independent basis for payment, such as a stipulation among the parties.

¶ 70

III. CONCLUSION

¶ 71 For the reasons set forth above, we affirm that portion of the judgment of the circuit court of Fayette County, which confirmed the Commission's decision with respect to causation and overpayment of TTD expenses. We vacate that portion of the trial court's decision confirming the Commission's finding that respondent has paid all reasonable and necessary medical expenses. We also vacate that portion of the Commission's decision finding that respondent has paid all reasonable and necessary medical expenses. We remand the matter to the Commission for further proceedings consistent with this order. Upon remand, the Commission shall make appropriate findings regarding the award of medical expenses.

¶ 72 Affirmed in part, vacated in part, and remanded with directions.