2017 IL App (5th) 160218WC-U

Workers' Compensation
Commission Division
Order Filed: June 30, 2017

No. 5-16-0218WC

IN THE

APPELLATE COURT OF ILLINOIS

FIFTH DISTRICT

WILLIAM UNTHANK,	)	Appeal from the
	)	Circuit Court of
Appellant,	)	White County.
	)	
v.	)	No. 14-MR-21
	)	
THE ILLINOIS WORKERS' COMPENSATION	)	
COMMISSION *et al.*,	)	Honorable
	)	Thomas J. Dinn,
(David Stanley Mine Consultants, Appellee).	)	Judge, presiding.

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

ORDER

¶ 1 *Held:* The decision of the Illinois Workers' Compensation Commission declining to award the claimant permanent total disability benefits pursuant to the Workers' Compensation Act (820 ILCS 305/1 *et seq.* (West 2006)) is not against the manifest weight of the evidence.

¶ 2 The claimant, William Unthank, appeals from an order of the circuit court which confirmed a decision of the Illinois Workers' Compensation Commission (Commission) declining to award him permanent total disability (PTD) benefits pursuant to the Workers'

Compensation Act (Act) (820 ILCS 305/1 *et seq.* (West 2006)). For the reasons which follow, we affirm.

¶ 3 The following factual recitation is taken from the evidence adduced at the arbitration hearing.

¶ 4 On June 12, 2006, the claimant, a coal miner, was working as a member of a "belt crew" at the Patiki Mine. He was employed by David Stanley Mine Consultants (David Stanley), a subcontractor. The claimant's duties on that date required him to set up belts moving coal, lifting buckets weighing 100 pounds or more, and performing other tasks which required pushing, pulling and bending. According to the claimant, as he attempted to climb over a belt, he lost his balance, fell, and landed on a belt roller, striking the right side of his low back. He testified that he was able to get up on his own power, but did not perform any further work during his shift.

¶ 5 After his work shift ended, the claimant sought medical care at the Harrisburg Medical Center emergency room. He complained of a severe, dull pain in his low back, radiating into his right leg. X-rays were taken of the claimant's lumbar spine which revealed mild degenerative boney changes and no acute boney abnormality. Following an examination, the claimant was diagnosed as suffering from an acute myofascial strain, low back pain, and a lumbar contusion. He was prescribed medication and released with a recommendation that he see Dr. Kimball Ewell, a family physician.

¶ 6 On June 15, 2006, the claimant sought treatment from Dr. Ewell. He complained of severe low back pain, radiating into his right leg and hip. Dr. Ewell diagnosed a lumbosacral strain, prescribed medication for pain, and authorized the claimant to remain off of work.

¶ 7 The claimant next saw Dr. Ewell on June 21, 2006. On that visit, the claimant complained of pain in his low back and a burning sensation in his right leg and hip. Dr. Ewell

diagnosed sciatica of the low back, authorized the claimant to remain off of work, and ordered an MRI scan of the claimant's lumbar spine. In addition, Dr. Ewell referred the claimant to Dr. Charles Hester, a chiropractor, for therapy.

¶ 8 The claimant was treated by Dr. Hester from June 26, 2006, through August 9, 2006. During that period, the claimant complained of low back pain radiating into his right leg and muscle spasms. Dr. Hester treated the claimant with stretching exercises, massages, heat, and electrical therapy.

¶ 9 The MRI scan of the claimant's lumbar spine, which Dr. Ewell ordered, was taken on July 11, 2006, at Saline Valley Radiology. The radiologist's report of that scan states that there was no evidence of a disc bulge, a disc herniation, spinal stenosis, or compression of the neural structures.

¶ 10 When the claimant saw Dr. Ewell on July 26, 2006, he complained of a burning sensation in his right leg and hip. In his notes of that visit, Dr. Ewell recorded that the claimant's MRI scan was negative. As of that visit, Dr. Ewell continued in his diagnosis of back strain with sciatica.

¶ 11 In Dr. Hester's notes of the claimant's visit on August 9, 2006, he recorded that the claimant continued to complain of low back pain radiating into his right leg. Dr. Hester noted that the claimant's pain subsided with treatment and recommended that the claimant continue with physical therapy, ultrasound treatments and spinal adjustments. The claimant did not return to Dr. Hester for any further treatment.

¶ 12 The claimant next saw Dr. Ewell on August 24, 2006, and complained of sciatic pain radiating down his right leg. He reported that he was no longer seeing Dr. Hester as the chiropractic treatments made his pain worse. Dr. Ewell recommended that the claimant undergo a CT myelogram.

¶ 13 The claimant underwent the recommended CT myelogram on August 30, 2006, at Harrisburg Medical Center. According to the radiologist's report, the procedure revealed old healed fractures of the right transverse processes at L2, L3 and L4 with vertebral segments; a minimal anterior disc bulge at L4-L5; mild spondylosis; and atherosclerosis.

¶ 14 Dr. Ewell's notes of a visit on September 21, 2006, state that the claimant was still experiencing pain in the right lumbosacral area, localized in his right flank. He noted that the CT myelogram report reflected the presence of fractures of the transverse processes. Dr. Ewell did not believe that the claimant was a surgical candidate. He continued to authorize the claimant to remain off of work and recommended additional physical therapy at Harrisburg Medical Center.

¶ 15 At the request of David Stanley, the claimant was examined on September 27, 2006, by Dr. Don Kovalsky, an orthopedic surgeon. The claimant reported that he slipped and fell on his right low back and flank. He complained of pain in his low back, radiating into his right buttocks and leg. On examination, Dr. Kovalsky found the claimant's physical movements to be normal. However, he noted the presence of tenderness in the claimant's right-sided mid-lumbar region over the paralumbar muscles, tenderness over the L2 and L5 region on the right, and moderate right-sided lumbar spasm from the upper lumbar region. Based upon his examination of the claimant, Dr. Kovalsky recorded a clinical impression of healing transverse process fractures at L2, L3 and L4 on the right side, secondary to blunt trauma. He did not believe that the claimant could return to regular work at that time and recommended physical therapy with a transition to work hardening. Dr. Kovalsky was of the belief that it would take three to four months for the claimant's symptoms to resolve.

¶ 16 The claimant began physical therapy at Harrisburg Medical Center on October 5, 2006. However, when he next saw Dr. Ewell on November 14, 2006, the claimant reported that he

stopped going to physical therapy due to pain. Dr. Ewell referred the claimant to Dr. Kee Park, a neurosurgeon.

¶ 17 The claimant presented to Dr. Park on December 13, 2006, complaining of pain in his low back radiating into his right leg. Dr. Park's records of that visit reflect that, on examination, he found that the claimant had: normal motor strength, gait and station, and muscle tone with no atrophy or fasciculations; intact sensation throughout; and present and equal deep tendon reflexes. Dr. Park also reviewed the claimant's CT scan images and noted that they showed right-sided transverse process fractures at L2, L3 and L4 which had already fused. He found no evidence of disc herniation or nerve root compression. Dr. Park authorized the claimant to remain off of work until he could review the claimant's MRI scan. Subsequently, Dr. Park reviewed that scan and, in an office note dated January 3, 2007, stated that the MRI scan was essentially normal. Dr. Park found that, as of that date, the claimant could return to full-duty work.

¶ 18 The claimant was next seen by Dr. Ewell on January 10, 2007. As of that visit, he complained of burning pain in the back of his legs and hip on his right side. Dr. Ewell recommended that the claimant participate in work hardening.

¶ 19 The claimant underwent work hardening at Harrisburg Medical Center from January 15, 2007, through February 7, 2007. However, when he saw Dr. Ewell on February 13, 2007, he reported that the work hardening was not helping his symptoms. Dr. Ewell referred the claimant to Dr. Gurpeet Padda for pain management.

¶ 20 The claimant saw Dr. Padda on March 1, 2007. Following his examination of the claimant, Dr. Padda diagnosed lumbosacral spondylosis without myelopathy. Dr. Padda noted that the claimant had likely exacerbated an old spinal injury and developed lumbosacral

spondylosis. Dr. Padda administered facet joint injections at three levels. According to Dr. Padda's records, the claimant reported immediate reduction in his symptoms. However, the claimant testified that the injections made his pain worse.

¶ 21 Dr. Ewell's records of a visit by the claimant on March 13, 2007, state that the claimant reported that the injections administered by Dr. Padda provided no help. Dr. Ewell referred the claimant to Dr. Kirk Price at the Neck and Back Clinic, and the claimant was treated by Dr. Price on six occasions in March 2007.

¶ 22 The claimant continued to treat with Dr. Ewell. On September 5, 2007, he saw Dr. Ewell, complaining of stiffness. Dr. Ewell continued to authorize the claimant to remain off of work, a status which the doctor maintained throughout the remainder of 2007.

¶ 23 On May 7, 2008, the claimant was again examined by Dr. Kovalsky at the request of David Stanley. The claimant continued to complain of right-sided back pain and reported that the treatment which he received had not reduced his symptoms. Dr. Kovalsky reported normal findings on clinical examination of the claimant. He reviewed spinal x-rays which were taken in his office on that date and found evidence of minimal disc degeneration with slight facet arthrosis at L4-L5, bilaterally. According to his report, Dr. Kovalsky was of a belief that the claimant's transverse process fractures had healed. However, he recommended a CT scan to rule out occult pathology and determine whether the transverse process fractures had, in fact, healed. Dr. Kovalsky's clinical impression was persistent right back pain. He restricted the claimant to light-duty work with a 30 pound lifting restriction and no repetitive bending, lifting, or twisting.

¶ 24 The claimant continued under the care of Dr. Ewell throughout the remainder of 2008. Dr. Ewell ordered additional CT and MRI scans which were performed on November 10 and 11, 2008. These scans revealed no acute findings and demonstrated healed right transverse process

fractures. The scans were unremarkable with the exception of evidence of some minimal posterior diffuse disc bulging at L4-L5 and L5-S1, without spinal stenosis or compression of the neural structures.

¶ 25 The claimant was again examined by Dr. Kovalsky on January 21, 2009. Dr. Kovalsky reviewed the claimant's CT and MRI scans taken in November 2008. The doctor found that the scans were unremarkable and revealed that the claimant's transverse process fractures had healed. He found no evidence of non-union abnormalities, disc herniations, spinal stenosis, or ongoing pathology. Dr. Kovalsky noted that he found no evidence of any ongoing true and anatomical pathology in the claimant's lumbar spine which would account for his reported symptoms. He reported that the claimant could perform light-duty work. However, due to the fact that the claimant had not worked for a significant period of time, Dr. Kovalsky recommended that the claimant undergo a two to three month period of work hardening.

¶ 26 The claimant began a work hardening program at Farrell Hospital on May 4, 2009. He attended four sessions, cancelled two appointments, and failed to appear at two other scheduled sessions. One of the physical therapists noted that, on June 19, 2009, he informed the claimant that he was expected to give his full effort to the program. According to the note, the claimant stated that his doctor had made a mistake in ordering work hardening and accused the facility of "working for comp." The claimant was discharged from the program on that date.

¶ 27 The claimant continued to treat with Dr. Ewell in May, June and July 2009. He was again examined by Dr. Kovalsky on September 23, 2009. Dr. Kovalsky reported that the claimant continued to complain of right-sided lumbar muscle spasms with persistent pain, radiating into his legs. He noted that his examination of the claimant was unremarkable and recorded an impression that the claimant was exaggerating his symptoms. Dr. Kovalsky

recommended that the claimant have a functional capacity evaluation (FCE) which he expected would show evidence of symptom magnification.

¶ 28 At the recommendation of his attorney, the claimant had an FCE at Integrated Health on October 2, 2009. Based upon the evaluation, the claimant was found to be capable of performing light-duty work with a maximum 20 pound lifting restriction. No symptom exaggeration or magnification was noted.

¶ 29 Dr. Kovalsky subsequently viewed surveillance tapes of the claimant taken on June 9, 2009. In a second report, also dated September 23, 2009, Dr. Kovalsky noted that the tape showed the claimant performing actions such as power washing a building, climbing a ladder, bending and lifting, which should have caused him severe pain, yet the claimant was clearly not in pain and showed no signs of obvious distress. Based upon his review of the tape, Dr. Kovalsky found that the claimant was exaggerating his symptomology and that he was capable of working at a much greater level than was reflected in his FCE. Dr. Kovalsky questioned the validity of the October FCE and suggested that it may not have been encompassing enough. He recommended that the claimant have an additional FCE. Dr. Kovalsky noted that the claimant incurred a minor injury that should have disabled him for approximately six to eight months and that he did not believe that the claimant was nearly as disabled as he claimed.

¶ 30 As recommended by Dr. Kovalsky, the claimant had a second FCE which took place on March 31, 2010, at Southern Orthopedics Associates. Although the report of that evaluation stated that the claimant was limited to lifting 40 pounds and carrying 35 pounds, the individual who administered the tests questioned its reliability and accuracy due to the claimant's varying levels of physical effort.

¶ 31 At the direction of his attorney, the claimant was evaluated on September 20, 2010, by Jack Strader, a vocational rehabilitation expert. In his report of that evaluation, Strader stated that he reviewed the claimant's medical records, obtained a work history, and administered a variety of tests. He opined that the claimant was unemployable based upon his injuries, limited work capacity, and academic abilities. Strader was deposed and testified consistently with his written report. He stated that the claimant is learning disabled in reading, spelling and mathematics and is incapable of completing a job application without assistance. He opined that, based upon the claimant's pain level and need for medication, his limited work capability, and academic ability, the claimant is not a viable candidate for employment in any capacity. On cross-examination, Strader admitted that the claimant is capable of establishing and running his own business. He also admitted that, in arriving at his opinions, he relied upon the claimant's medical records and complaints of pain.

¶ 32 The claimant was examined for the last time by Dr. Kovalsky on September 22, 2010. In his report of that examination, Dr. Kovalsky noted that the clinical findings of his examination were normal. He also noted positive Waddell's signs and that the claimant's complaints of pain were disproportionate to his physical findings. Dr. Kovalsky recorded opinions that the claimant had reached maximum medical improvement (MMI), no further treatment or medication was indicated, and the claimant could return to full-duty work without restrictions. When deposed, Dr. Kovalsky reaffirmed those opinions.

¶ 33 At the direction of his attorney, the claimant was examined by Dr. David Volarich on June 8, 2011. Following his review of the claimant's medical records and his physical examination of the claimant, Dr. Volarich diagnosed lumbar right leg radicular syndrome consistent with discogenic pain, most likely emanating from L4-L5 and L5-S1 disc bulges; and

healed right-sided transverse process fractures at L2, L3 and L4. It was Dr. Volarich's opinion that the claimant's work accident of June 12, 2006, was the proximate cause of his lumbar right leg radicular syndrome and the transverse process fractures at L2, L3 and L4 for which he was treated. When deposed, Dr. Volarich confirmed his opinions and additionally opined that the claimant could return to work, but only with restrictions of no bending, twisting, lifting, pushing, pulling, carrying or climbing. He also recommended that the claimant not handle weight in excess of 15 or 20 pounds, that he avoid lifting weight over his head or away from his body, or carry any weight for long distances or over uneven terrain. He also advised that the claimant avoid remaining in a fixed position for more than 30 minutes in either a sitting or standing position. According to Dr. Volarich, the claimant would require ongoing care for his pain syndrome, consisting of medication and physical therapy. However, on cross-examination, he agreed that he detected no muscle spasms when he examined the claimant. He also testified that the claimant informed him that, since his work accident, he had been unable to do yard work or drive his "mud truck."

¶ 34 The claimant continued under the care of Dr. Ewell throughout 2010, 2011, 2012 and 2013. Prior to the arbitration hearing the claimant last saw Dr. Ewell on August 28, 2013. During the course of his treatment of the claimant, Dr. Ewell's working diagnosis remained unchanged. He continued treating the claimant with medication and continued to authorize the claimant to remain off of work. When deposed, Dr. Ewell stated that his treatment of the claimant since 2006 had essentially remained the same; namely, palliative care consisting of analgesics, muscle relaxants and anti-inflammatories in varying doses. He testified that the claimant's transverse process fractures were fully healed and had been so since 2006. He admitted that the claimant did not have a herniated disc in his lumbar spine or a surgical

explanation for his complaints of sciatica. Dr. Ewell stated that he is a family practitioner and is not board certified. He also admitted that he does not specialize in orthopedics.

¶ 35 During the arbitration hearing, the claimant testified that he has continued to treat with Dr. Ewell who has continuously authorized him to remain off of work. According to the claimant, he suffers pain at a level of 6 on a scale of 10 and spends most of his day lying on a couch. He stated that he no longer rides a motorcycle; is no longer able to lift weights, play sports, or ride bikes with his children; and no longer uses his weight-lifting machines. The claimant testified that he cannot stand or bend without experiencing pain and that he has been required to hire individuals to do work around his house due to the pain he experiences when attempting those activities. He denied performing any activity since his work accident which exceeded his restrictions. On cross-examination, however, the claimant admitted that he had engaged in power washing a two-story building. He stated that his pain increases when he rides in a car. However, he admitted that, since his accident, he has participated in "mudding" events which consist of attempting to drive a truck with large tires and raised suspension through 100 feet of mud as fast as possible until the truck eventually comes to a stop. According to the claimant, he competes in four or five mudding events each season and has been participating in those events from 2008 through 2011.

¶ 36 The claimant testified that he has not worked since his accident on June 12, 2006, and has not applied for work; although he had tried mowing, washing windows, and washing houses. According to the claimant, he does not feel capable of working based upon his physical capabilities and lack of training and skills. He testified that he has an eighth-grade education and has difficulty reading. He stated that he has primarily worked as a laborer or in construction. The claimant admitted, however, that he had once operated his own carpentry business.

¶ 37 Following the arbitration hearing, the arbitrator issued a decision, finding that, on June 12, 2006, the claimant sustained fractures of the right transverse processes of L2, L3 and L4, and a low back strain/sprain which arose out of and in the course of his employment with David Stanley. The arbitrator awarded the claimant 232 5/7 weeks of temporary total disability benefits for the periods commencing on June 13, 2006, through January 4, 2007, and January 10, 2007, through December 6, 2010; ordered David Stanley to pay the claimant's medical expenses for the period from June 12, 2006, through December 6, 2010, but not thereafter; and awarded the claimant 75 weeks of permanent partial disability benefits for 15% loss of the person as a whole pursuant to section 8(d)2 of the Act (820 ILCS 305/8(d)2 (West 2012)). The arbitrator specifically found that the evidence of record did not support an award of PTD benefits.

¶ 38 The claimant sought a review of the arbitrator's decision before the Commission. In a unanimous decision dated September 9, 2014, the Commission affirmed and adopted the decision of the arbitrator.

¶ 39 The claimant filed a petition for judicial review of the Commission's September 9, 2014, decision in the circuit court of White County. The circuit court entered an order on May 6, 2016, confirming the decision of the Commission. This appeal followed.

¶ 40 As his only assignment of error, the claimant argues that the Commission's finding that he is not permanently and totally disabled is against the manifest weight of the evidence. He contends that his medical records, the testimony of Dr. Ewell, Dr. Volarich, and Strader, along with his work history and education, establish that he is "unable to make some contribution to the work force sufficient to justify the payment of wages." The claimant asserts that he met his burden of establishing that he falls within the odd-lot category, and David Stanley failed to introduce evidence of suitable work that was regularly and continuously available to him. David

Stanley argues that the medical records in the record, coupled with the opinions of Dr. Kovalsky, support the Commission's finding that, "[a]t best" the claimant sustained a low back strain/sprain in addition to fractured transverse processes as a result of his work-related accident and is able to return to work without restrictions.

¶ 41 The extent or permanency of an injured employee's disability is a question of fact to be resolved by the Commission, and its resolution of the issue will not be disturbed on review unless it is against the manifest weight of the evidence. *E.R. Moore Co. v. Industrial Comm'n*, 71 Ill. 2d 353, 361 (1978). In resolving such issues, it is the function of the Commission to judge the credibility of witnesses and resolve conflicting medical evidence. *O'Dette v. Industrial Comm'n*, 79 Ill. 2d 249, 253 (1980). For a finding of fact to be contrary to the manifest weight of the evidence, an opposite conclusion must be clearly apparent. *Caterpillar, Inc. v. Industrial Comm'n*, 228 Ill. App. 3d 288, 291 (1992). Whether a reviewing court might reach the same conclusion is not the test of whether the Commission's determination of a question of fact is supported by the manifest weight of the evidence. Rather, the appropriate test is whether there is sufficient evidence in the record to support the Commission's determination. *Benson v. Industrial Comm'n*, 91 Ill. 2d 445, 450 (1982).

¶ 42 In this case, the Commission found the opinions of Dr. Kovalsky on the issue of the nature and extent of the claimant's injuries and his ability to return to full-duty work to be more persuasive and credible than the opinions of Dr. Volarich, Dr. Ewell and Strader. We find more than sufficient evidence in the record to support the Commission's finding in this regard.

¶ 43 Dr. Kovalsky opined that, as a result of his work-related accident, the claimant sustained only a minor injury which should only have disabled him for six to eight months. Dr. Kovalsky found that, as of September 22, 2010, the claimant had reached MMI, he required no further

treatment or medication, and could return to full-duty work without restrictions. In contrast, Dr. Volarich opined that the claimant could only return to work with extensive restrictions and that he would require ongoing care for his pain syndrome. On the issue of the nature and extent of the claimant's injuries, we believe that the record supports Dr. Kovalsky's opinions. The diagnostic testing of the claimant conducted on July 11, 2006, August 30, 2006, November 10, 2008, and November 11, 2008, each found that the claimant's transverse process fractures had healed. The MRI conducted on July 11, 2006, revealed no evidence of a disc herniation or bulge, and the CT scans of August 30, 2006, and November 11, 2008, detected only minimal anterior disc bulging without nerve root compression. Even Dr. Ewell noted that the November 2008 scans revealed no acute findings and demonstrated that the transverse process fractures were healed. In addition, Dr. Kovalsky's unremarkable findings on examination of the claimant are consistent with Dr. Park's findings when he examined the claimant on December 13, 2006.

¶ 44 On the issue of the claimant's ability to return to full-duty work, the Commission again relied upon the opinion of Dr. Kovalsky who found that the claimant was at MMI and capable of returning to full-duty work as of September 22, 2010. In contrast, Dr. Volarich and Strader opined that the claimant is unemployable due, in part, to his persistent pain. However, the Commission found that the claimant's complaints of ongoing symptomology lacked credibility and were discredited by the activities which he is seen performing on the June 9, 2009, surveillance video and his admitted participation in mudding events from 2008 through 2011.

¶ 45 If an individual is capable of gainful employment without seriously endangering his health, he is not permanently and totally disabled. *Jefferson Electric Co. v. Industrial Comm'n*, 64 Ill. 2d 85, 92-93 (1976). In this case, the Commission credited Dr. Kovalsky's opinion that the claimant is capable of full-duty work from a medical standpoint. Based upon the record

before us, we are unable to find that the Commission's determination in this regard is against the manifest weight of the evidence.

¶ 46 Nevertheless, the claimant contends that the Commission erred in failing to award him PTD benefits on an "odd-lot" theory. We disagree.

¶ 47 An injured employee need not be reduced to total incapacity to be entitled to PTD benefits. *Ceco Corp. v. Industrial Comm'n*, 95 Ill. 2d 278, 286 (1983). If the employee's disability is limited in nature so that he is not obviously unemployable, the burden is upon the employee to prove by a preponderance of the evidence that he fits into the "odd-lot" category; that is, although not altogether incapacitated from working, he is so handicapped that he is not regularly employable in any well-known branch of the labor market. *Valley Mould & Iron Co. v. Industrial Comm'n*, 84 Ill. 2d 538, 546-47 (1981). A claimant can satisfy his burden of proving that he falls into the odd-lot category by either (1) showing diligent but unsuccessful attempts to find work, or (2) showing that because of his age, skills, training, and work history, he will not be regularly employed in a well-known branch of the labor market. *Westin Hotel v. Industrial Comm'n*, 372 Ill. App. 3d 527, 544 (2007). Whether a claimant has met his burden of proving that he falls into an odd-lot category is a question of fact to be determined by the Commission, and its resolution of the question will not be disturbed on review unless it is against the manifest weight of the evidence. *Id.*

¶ 48 The claimant in this case admitted that he has not worked since his accident on June 12, 2006, and that he has not applied for work since that date. He rests the argument that he satisfied his burden of proving that he falls into an odd-lot category on the opinion of Strader. However, the Commission found that Strader's opinion was without probative value because it is based

upon medical opinions and the claimant's claims of an inability to work which were found to be unpersuasive and not credible.

¶ 49 For the reason already stated, the Commission determined that the claimant's complaints of ongoing symptomology lacked credibility. An expert's opinion is only as valid as the information upon which it is based. Strader's opinion that the claimant is not a viable candidate for employment in any capacity is based, in significant part, upon the claimant's complaints of persistent pain. Once it was determined that the claimant's complaints of ongoing symptomology lacked credibility, the credibility and probative value of Strader's opinion were also called into question. As noted earlier, it was the Commission's function to judge Strader's credibility and the weight to be accorded his opinions. *O'Dette*, 79 Ill. 2d at 253. The Commission determined that his opinions lacked probative value for the reasons stated, and we are unable to conclude that its determination in this regard is against the manifest weight of the evidence.

¶ 50 Based upon the foregoing analysis, we conclude that the Commission's finding that the claimant is not permanently and totally disabled is not against the manifest weight of the evidence based either on a claim of physical disability or an odd-lot theory. We, therefore, affirm the judgment of the circuit court which confirmed the decision of the Commission.

¶ 51 Affirmed.