2022 IL App (4th) 210490WC-U
Nos. 4-21-0490WC & 4-21-0491 cons.
Order filed June 24, 2022

FILED
June 24, 2022
Carla Bender
4th District Appellate
Court, IL

NOTICE: This order was filed under Supreme Court Rule 23(b) and is not precedent except in the limited circumstances allowed under Rule 23(e)(l).

IN THE

APPELLATE COURT OF ILLINOIS

FOURTH DISTRICT

WORKERS' COMPENSATION COMMISSION DIVISION

DANVILLE MASS TRANSIT, a Department of the City of Danville, Illinois,	)	Appeal from the Circuit Court of Vermilion County.
Appellant,	)	
v.	)	Nos. 19 MR 592 21 MR 107
THE ILLINOIS WORKERS' COMPENSATION COMMISSION, *et al*.	)	Honorable Karen E. Wall,
(Jean A. Bates-Martin, Appellee).	)	Judge, Presiding.

JUSTICE HUDSON delivered the judgment of the court.

Presiding Justice Holdridge and Justices Hoffman, Cavanagh, and Barberis concurred in the judgment.

ORDER

¶ 1 *Held*: (1) The Illinois Workers' Compensation Commission's finding that claimant's condition of ill-being as it relates to the cervical spine is causally related to her work accident of June 15, 2016, was not against the manifest weight of the evidence; and (2) the Illinois Workers' Compensation Commission's findings that claimant was entitled to reasonable and necessary medical expenses, temporary total disability benefits, and prospective medical care related to her cervical spine condition were not against the manifest weight of the evidence. Affirmed.

¶ 2 Claimant, Jean A. Bates-Martin, filed an application for adjustment of claim pursuant to the Workers' Compensation Act (Act) (820 ILCS 305/1 *et seq*. (West 2016)) seeking benefits from respondent, Danville Mass Transit, a Department of the City of Danville, Illinois. Relevant to this appeal, the arbitrator found that claimant's condition of ill-being as it relates to her cervical spine was causally related to her work accident. The arbitrator further determined that all medical services provided to claimant for her cervical spine condition were reasonable and necessary to cure or relieve the effects of the injury she sustained as a result of the work accident. The arbitrator awarded claimant 122-2/7 weeks of temporary total disability (TTD) benefits. The arbitrator also awarded prospective medical care in the form of additional medication, but denied claimant's request for a repeat cervical injection. A majority of the Illinois Workers' Compensation Commission (Commission) modified the decision of the arbitrator and ordered respondent to authorize prospective medical care in the form of a repeat cervical injection. The Commission otherwise affirmed and adopted the arbitrator's decision and remanded the matter for further proceedings pursuant to *Thomas v. Industrial Comm'n*, 78 Ill. 2d 327 (1980). On judicial review, the circuit court of Vermilion County confirmed in part and set aside in part the decision of the Commission. Relevant here, the court confirmed the Commission's finding that claimant's cervical condition is causally related to her work accident, but increased the period of TTD. Respondent now appeals. Respondent argues that the Commission's finding that claimant established a causal connection between her work accident and the condition of ill-being as it relates to her cervical spine was against the manifest weight of the evidence. Respondent further argues that given this lack of causation, the Commission's findings that claimant was entitled to reasonable and

necessary medical expenses, TTD benefits, and prospective medical care related to her cervical spine condition were against the manifest weight of the evidence.[1] We affirm.

¶ 3 I. BACKGROUND

¶ 4 On August 11, 2016, claimant filed an application for adjustment of claim seeking benefits from respondent. In her application, claimant alleged that she sustained injuries to her left arm and shoulder as a result of a slip-and-fall accident at work on June 15, 2016. Claimant subsequently amended her application for adjustment of claim to include additional injuries to her neck and lumbar spine. An arbitration hearing on claimant's application for adjustment of claim was held on February 15, 2019, before arbitrator Maureen Pulia. At the arbitration hearing, respondent agreed that claimant suffered a compensable work-related accident to her left shoulder on June 15, 2016. Relevant to this appeal, however, respondent disputed causal connection, medical expenses, TTD benefits, and prospective medical care as it related to claimant's alleged injury to her cervical spine. The following factual recitation is taken from the evidence adduced at the arbitration hearing.

¶ 5 At the time of the injury, claimant was employed by respondent as a city bus driver. Before beginning her route each day, claimant would inspect her bus. Claimant testified that on June 15, 2016, she performed an initial inspection of the outside of her bus and then entered the vehicle. Once inside, claimant noticed that her external driver's side mirror needed to be adjusted. As

[1] Only respondent filed a notice of appeal from the trial court's ruling. The appeal was inadvertently docketed twice under two different docket numbers, 4-21-0490WC and 4-21-0491WC. Upon the motion of respondent, we consolidated the two cases for the purposes of decision.

claimant descended the bus's stairs to adjust the mirror, she slipped. Claimant grabbed the rail on the bus door with her left hand, but her feet came out from underneath her. Claimant let go of the rail and struck her back, at about her bra line, on the bottom step of the bus and landed on the ground on the left side of her buttock. Claimant did not hit her head or neck. Claimant got up on her own, but stated that it was hard to walk. Claimant testified that about 20 minutes after the fall, her left arm started to hurt. About another 1½ to 2 hours later, while claimant was driving the bus, she noticed that when she grabbed the steering wheel, she had pain in the palm of her hand and her left thumb would not move. Claimant subsequently began to experience stiffness and numbness in her neck and pain in her buttocks. Claimant was worried about her ability to grab the steering wheel with her left arm. She reported the accident to respondent and was directed to the occupational medicine clinic at Carle Health (Carle).

¶ 6 At Carle, claimant was examined by Steven Jacobs, a physician's assistant. Claimant presented with complaints of pain in the left hand, thumb, wrist, and shoulder. She also complained of left forearm pain with burning in the elbow region and mid-thoracic back pain at the T10 level. Claimant denied any neck pain or issues with any other body part. Upon examination, Jacobs noted that claimant's neck, although tight, had full range of motion. Light provocative touching of the cervical, lumbar, and thoracic areas over the bony spinous processes elicited no tenderness. Jacobs diagnosed a left upper extremity FOOSH (fall on outstretched hand) injury. Claimant was prescribed range-of-motion exercises and placed in a thumb spica splint and a sling. She was released to right-hand work only with mostly sitting and an ability to get up every 20 to 30 minutes.

¶ 7 Claimant followed up with Jacobs on June 21, 2016. At that time, claimant's primary complaints were shoulder pain, left arm numbness, trapezius strain radiating towards the neck, and left-sided upper back pain. Upon examination, Jacobs noted that claimant had full range of motion

cervically without any radicular symptoms. There was no tenderness to palpation over the bony spinous processes of the cervical area, but the trapezius area on the left had increased hypertonicity of the muscle and was sore to the touch. Jacobs's diagnosis was "[m]ultiple injuries secondary to a fall." He instructed claimant to not drive a bus, to avoid overhead work, and to do mostly right-hand work. In addition, Jacobs imposed a two-pound lifting restriction for her left hand and prescribed physical therapy for her left shoulder. On June 28, 2016, claimant began physical therapy. The initial therapy evaluation noted that claimant's complaints included variable and intermittent pain of the lateral cervical spine to the upper and middle trapezius which at times goes from the axilla to the medial arm.

¶ 8 While undergoing therapy, claimant continued to follow up with Jacobs. On July 6, 2016, Jacobs reported that claimant's neck had "improved vastly." Claimant had minor complaints with full flexion of the neck, but nothing with rotation or extension, and she denied any radicular symptoms. Upon examination, light provocative touching over the bony spinous processes of the cervical and thoracic areas elicited no tenderness. Cervically, claimant exhibited "really good range of motion" with only minor problems putting the chin to the chest. Jacobs continued claimant's work restrictions. At a follow-up visit on July 21, 2016, Jacobs noted that most of claimant's problems involved the left shoulder girdle area and that there had not been any neck issues. Claimant again demonstrated "excellent range of motion" cervically "without any radicular symptoms" and exhibited no tenderness over the cervical or thoracic areas with light provocative touching over the bony spinous processes. Jacobs continued the previously imposed work restrictions.

¶ 9 Claimant returned to Jacobs on July 25, 2016. Although claimant reported that she felt "a lot better," she still had pain in the left shoulder and some discomfort in the neck and thoracic

spine. Jacobs sent claimant for X rays of her cervical and thoracic areas. The X ray of the cervical spine demonstrated C3-C4 moderate to severe left foraminal stenosis and additional mild cervical degenerative changes. The X ray of the thoracic spine revealed no acute fracture or malalignment and minimal lower thoracic levoconvex curvature. Upon examination, Jacobs noted that, cervically, claimant was moving her neck well. Spurling's sign was negative. An MRI of the left shoulder showed a partial tear of the intra-articular long head biceps tendon and a probable extension to the biceps anchor where there could be degeneration or a component of a superior labral anterior to posterior (SLAP) tear.

¶ 10 On August 1, 2016, claimant returned to Jacobs for evaluation of her left shoulder pain. Jacobs noted that claimant also had complaints of headaches and neck pain. With regard to the latter, Jacobs noted that radiological studies of the neck showed some arthritic changes and foraminal stenosis. Upon examination, claimant had good range of motion cervically with a negative Spurling's sign. Jacob made various diagnoses, including cervical discomfort with known arthritic changes. He referred claimant to an orthopedic physician for her shoulder and continued her work restrictions. Claimant worked light duty from June 16, 2016 (the day after the accident), through August 2, 2016, when her employment ceased.

¶ 11 On August 25, 2016, claimant consulted Dr. Robert Gurtler, an orthopedic physician. Dr. Gurtler noted that claimant presented with two problems. First, she had articular surface damage in the left shoulder and a biceps issue in the left shoulder that caused some shoulder pain. Second, she had burning pain in the back of her arm and shoulder to her elbow as well as pain down into her thumb and index finger. Dr. Gurtler was of the opinion that these latter symptoms were not from her shoulder, but rather were caused by foraminal stenosis at C4-C5. He recommended a cervical MRI and a referral to neurosurgery. He also noted that arthroscopic surgery of the shoulder

may be required in the future.

¶ 12 On August 29, 2016, claimant followed up with Jacobs. Claimant's complaints included left shoulder pain and neck pain with radiation to the elbow. Claimant reported tightness in the neck region and difficulty rotating her neck without pain. Jacobs's diagnoses included cervical strain with possible internal derangement, left shoulder pain with a tear of the intra-articular long head biceps tendon and a possible SLAP tear, thoracic back pain, and low back pain. He thought the upper extremity pain was possibly related to the neck.

¶ 13 On August 30, 2016, claimant underwent an MRI of the cervical spine. The impression was C3-C4 severe left foraminal stenosis and C4-C5 moderate left foraminal stenosis. No central spinal canal stenosis was noted. On September 1, 2016, claimant followed up with Jacobs. Claimant reported pain in the interscapular area, the base of the neck, and in the midpoint of the thoracic spine. She also reported soreness down her arm and her left thumb. Jacobs assessed cervical foraminal stenosis per the MRI and thoracic pain. Noting that claimant's neck issues had become more prevalent as time passed, Jacobs referred claimant to the spine center and continued her off work.

¶ 14 On September 8, 2016, claimant presented to Dr. Samatha Tipirneni, a spine center physician, for her complaints of neck pain. Claimant reported that most of her pain was between the left intra-shoulder blade area in the thoracic area. She also complained of left posterior neck pain radiating to the left upper extremity. Upon examination, Dr. Tipirneni opined that claimant over-amplified symptoms involving her cervical, thoracic, and lumbar spine. Dr. Tipirneni noted three of five positive Waddell's signs and that even a light touch and rotation reproduced pain. Dr. Tipirneni also noted that claimant had tenderness along the left trapezius that reproduces her pain. Active range of cervical flexion, extension, and rotation was not very painful. Spurling's sign was

negative. Dr. Tipirneni interpreted the July 2016 X rays of the cervical spine as showing preexisting degenerative disease that was "mainly wear and tear arthritis" and "not anything acute from her injury." Dr. Tipirneni interpreted the August 2016 MRI of the cervical spine as showing C3-C4 severe left foraminal stenosis and C4-C5 moderate left foraminal stenosis. Dr. Tipirneni's impression was myofascial pain syndrome, cervical sprain, lumbar sprain/strain, preexisting cervical degenerative disc disease, preexisting cervical spinal stenosis, cervical radiculopathy, and obesity. Dr. Tipirneni felt the majority of claimant's problems were thoracic, mainly muscular in origin. Dr. Tipirneni recommended physical therapy and a left sided C4-C5 transforaminal injection.

¶ 15 On September 20, 2016, claimant presented to Dr. Zeeshan Ahmad for the cervical injection recommended by Dr. Tipirneni. Upon examination, Dr. Ahmad noted pain in the left shoulder which worsened with overhead activities or reaching objects. Left shoulder passive abduction and external rotation reproduced pain. Cervical rotation was limited on the left, but did not reproduce pain. Dr. Ahmad diagnosed shoulder capsulitis and shoulder arthritis. He opined that claimant needed a shoulder injection "based on strong clinical evidence" rather than an injection to the cervical spine. Claimant agreed with the plan and Dr. Ahmad administered an injection to the left shoulder. Claimant testified that the injection "took the edge off" her neck, shoulder, back, and arm pain, but the relief lasted only a couple of weeks.

¶ 16 On October 4, 2016, claimant followed up with Dr. Tipirneni. Claimant reported left posterior neck pain and left shoulder pain. Dr. Tipirneni noted that when claimant saw Dr. Ahmad, he felt her symptoms were more shoulder related than neck related. As a result, he administered a left intra-articular shoulder injection. Claimant reported 40% improvement from the shoulder injection and stated that the symptoms from her elbow down to her fingers got better. Dr. Tipirneni

opined that the symptom relief reported by claimant was just a placebo effect since claimant did not receive a neck injection. Dr. Tipirneni's impression was ongoing left shoulder pain, cervical strain/sprain, thoracic sprain, preexisting cervical degenerative disc disease, preexisting cervical spinal stenosis, and obesity. Dr. Tipirneni believed that claimant's complaints were more related to the shoulder, and she referred claimant back to Dr. Gurtler. Nevertheless, she recommended additional physical therapy for the thoracic region and neck area. Further, she opined that claimant would be at maximum medical improvement (MMI) for the thoracic and cervical areas after physical therapy. Dr. Tipirneni did not recommend any type of permanent restrictions and released claimant from her care.

¶ 17 On October 6, 2016, claimant returned to Jacobs. Claimant reported that she was still having problems with her left shoulder, but therapy was helping her cervical and thoracic spine. Claimant indicated that the pain that was going past the elbow was abating. Upon examination, Jacobs noted good range of motion in flexion, extension, and rotation of the neck. No tenderness was noted over the bony spinous processes of the cervical or thoracic area, but claimant demonstrated increased hypertonicity in the muscles of the cervical and thoracic areas on palpation. Spurling's sign was negative. Jacobs assessed multiple issues, including shoulder impingement and myofascial pain in the cervical and thoracic areas that had improved. Jacobs referred claimant back to Dr. Gurtler for her shoulder issues. He also recommended that she continue therapy of the cervical and thoracic area, and he continued claimant's off-work status.

¶ 18 On October 25, 2016, claimant returned to Dr. Gurtler. Dr. Gurtler repeated his earlier conclusion that claimant had "more than one problem," a cervical problem and a shoulder problem. Citing the findings on the July 2016 X rays, Dr. Gurtler opined that the left foraminal stenosis is the source of claimant's severe pain, particularly the pain in the scapula region. Dr. Gurtler agreed

to proceed with left shoulder surgery. He noted, however, that whatever is done to address her shoulder pain will not address the pain in the scapular area. The surgery was performed on February 3, 2017.

¶ 19 On March 21, 2017, claimant presented for a section 12 examination (see 820 ILCS 305/12 (West 2016)) by Dr. Matthew Ross. In addition to examining claimant, Dr. Ross conducted a record review and authored a report of his findings. Claimant told Dr. Ross that her injuries arose following a slip-and-fall accident at work on June 15, 2016. Claimant reported pain in her left trapezius area, over the left scapula, and in the left armpit area. She stated that the pain radiates into the medial aspect of her left upper arm. She also related that her left thumb, index finger, and middle finger hurt. Claimant reported some stiffness in her neck, but denied any significant neck pain. Claimant denied any previous trouble with her neck or back. Upon examination, claimant's neck was supple with full range of motion. Tenderness was noted over the left trapezius muscle, left scapula, left rhomboid, and left shoulder girdle. Dr. Ross noted that a cervical spine X ray dated June 25, 2016, showed early degenerative changes at the C4-C5 and C5-C6 levels and foraminal stenosis at C3-C4. An MRI of the cervical spine dated August 30, 2016, showed mild anterolisthesis of C4 on C5, significant foraminal stenosis on the left side at C3-C4, moderate foraminal stenosis at C4-C5, and a minimal left disc protrusion without impingement on the nerve elements at C5-C6.

¶ 20 Dr. Ross opined that claimant sustained an injury to her left shoulder on June 15, 2016, which had been appropriately treated by Dr. Gurtler. With regard to the cervical spine, Dr. Ross noted that claimant clearly had preexisting cervical foraminal stenosis at the C3-C4 and C4-C5 levels, but there was no evidence that she had been symptomatic from this pathology prior to the work accident. He stated that it was difficult to ascertain clinically whether a component of her

residual pain was due to a C4 radiculopathy from her C3-C4 foraminal stenosis. He noted that while the dermatomal territory of the C4 nerve roots overlaps her current area of trapezius and shoulder pain, neither the C4 nor C5 nerve roots would cause paresthesia and numbness of the left thumb, index finger, and middle finger. He stated that this would be the territory of either the C6 or C7 nerve roots or the median nerve. Dr. Ross suspected that claimant's hand paresthesia was probably due to a median neuropathy, possibly at the wrist. Dr. Ross recommended additional diagnostic testing consisting of a left C4 selective nerve-root block in conjunction with a cervical epidural steroid injection. The purpose of the block is to identify whether the C3-C4 foraminal stenosis is in fact symptomatic. If it is, the steroid component of the injection should provide some benefit. If not, claimant could conceivably require a posterior foraminotomy at that level. Dr. Ross also recommended an EMG/NCV study of the left arm to assess whether she has median nerve compromise. Dr. Ross opined that claimant had not yet reached MMI and that she was not functionally capable of returning to her job as a bus driver.

¶ 21 On May 11, 2017, Dr. Gurtler placed claimant at MMI for her left shoulder. He recommended that she follow up with a spine specialist for her cervical issues.

¶ 22 On June 6, 2017, claimant presented to Dr. Ahmad for a left C3-C4 transforaminal selective nerve root injection, as recommended by Dr. Ross. On June 27, 2017, claimant returned to Dr. Ahmad for a follow-up visit. Claimant told Dr. Ahmad that she was "definitely better" following the injection. Claimant was able to raise her left arm without much pain. She also reported that the pain she had in her left elbow had been reduced to a mild ache. Dr. Ahmad referred claimant back to Dr. Ross for further treatment. At the arbitration hearing, claimant confirmed that she did experience some relief from the cervical injection. However, it was short lived and her cervical and left upper extremity pain returned to its pre-injection levels.

¶ 23 On August 7, 2017, Dr. Ross drafted an addendum report after reviewing additional medical records, including the report of Dr. Ahmad dated June 27, 2017. Dr. Ross noted that the EMG/NCV he ordered documented mild left carpal tunnel syndrome. No cervical radiculopathy was noted. Dr. Ross also noted that Dr. Gurtler declared claimant at MMI for her left shoulder and believed that any remaining pain was originating from her cervical spine. Although claimant underwent a left C3-C4 transforaminal selective nerve-root injection with Dr. Ahmad, there was no record whether claimant experienced immediate or significant pain improvement when the C4 nerve was anesthetized. Dr. Ahmad did observe, however, that claimant was "definitely better" at an appointment postdating the injection. Dr. Ross believed that the improvement noted by Dr. Ahmad was probably due to the steroid effect of the injection. Dr. Ross opined that "it is likely that at least a component of [claimant's] symptoms are from her cervical spine." Dr. Ross felt that a repeat block and steroid injection would be needed if claimant's improvement plateaued at an unacceptable level or if her pain recurs. Dr. Ross "strongly advise[d]" that Dr. Ahmad and claimant record her early response to the nerve-root block, as this would confirm or disprove whether claimant has a C4 radiculopathy. Dr. Ross opined that claimant's cervical symptoms are causally related to the injury of June 15, 2016. In this regard, Dr. Ross noted that claimant denied symptoms involving the cervical spine prior to the work accident and he had not been presented with any medical records that call into question claimant's veracity on the matter. Regarding further treatment recommendations for claimant, Dr. Ross stated that he was unaware of claimant's current condition. According to Dr. Ahmad, claimant's symptoms were significantly improved. If true, Dr. Ross thought it would be appropriate for claimant to undergo a functional capacity evaluation (FCE) to determine whether she was capable of performing her job duties. If claimant fails the FCE, additional treatment could be warranted, including a repeat selective nerve-root block and

epidural cortisone injection. Dr. Ross stated that until these issues are resolved, claimant has not reached MMI.

¶ 24 On November 22, 2017, claimant presented to Dr. Arundhati Biswas for her neck and back pain. Dr. Biswas observed that claimant experienced some improvement following left shoulder surgery and cervical injections, but her pain had not completely resolved. Dr. Biswas noted that a cervical spine MRI done in 2016 showed some degenerative changes. He requested a new cervical MRI to determine if there was any progression of claimant's degenerative disc disease. Dr. Biswas also prescribed gabapentin and amitriptyline for nerve pain and indicated that another set of cervical injections may be helpful. On December 28, 2017, claimant underwent the MRI recommended by Dr. Biswas. The impression was C3-C4 severe left foraminal stenosis and C4-C5 moderate left foraminal stenosis. No central spinal canal stenosis was noted.

¶ 25 On February 1, 2018, Dr. Tipirneni administered a cervical C7-T1 interlaminar epidural steroid injection to claimant. At the time of the injection, claimant's chief complaints were neck pain and arm symptoms. Claimant testified that after this injection she had relief for about 2½ weeks, but it was not the same relief as she had after the injection in June 2017. Following the injection, claimant followed up with Dr. Biswas. Dr. Biswas recommended physical therapy for improvement of claimant's shoulder movements on the left side and Robaxin for muscle relaxation. Claimant underwent additional physical therapy for her cervical radiculopathy from March 6, 2018, through April 5, 2018.

¶ 26 On May 30, 2018, Dr. Singh performed a section 12 examination (see 820 ILCS 305/12 (West 2016)) and record review. In his report of the examination, Dr. Singh detailed that claimant reported that her symptoms began on June 15, 2016, after she slipped and fell while adjusting the mirror on her bus. Claimant complained of pain in the neck, midback, and low back. Claimant also

reported bilateral radiating dysesthesia of the arms and legs. Claimant denied any prior injuries to her neck or low back prior to the date of accident. Claimant told Dr. Singh that her pain was "sudden and constant in nature," her symptoms were getting worse, and that her discomfort occurs predominantly at night. Dr. Singh noted that MRIs of the cervical spine taken on August 30, 2016, and December 28, 2017, revealed slight loss of disc signal intensity at C3-C4 and moderate to severe C3-C4 and C4-C5 foraminal narrowing on the left side. Dr. Singh diagnosed cervical muscular strain and degenerative disc disease at C3-C4 and C4-C5. He opined that claimant sustained a soft-tissue muscular strain to her cervical spine which had resolved. However, he did not believe her C3-C4 foraminal narrowing was symptomatic, explaining "[t]his would result in trapezial pain and not arm pain. There is no correlating arm distribution of pain for the C4 nerve root, which would be involved in this situation. Furthermore, the EMG further confirms the fact that there is no cervical radiculopathy involved." Dr. Singh was not sure why recommendations were made for selective nerve-root injections into the C3-C4 space "as claimant never manifested trapezial discomfort, which would correlate with the C4 pathology." For the same reasons, Dr. Singh did not believe that claimant sustained an aggravation of her underlying degenerative condition as a result of the work accident. Dr. Sigh noted that claimant's prognosis was guarded and opined that she could return to full-duty work without restriction. Additionally, Dr. Singh opined that claimant did not need any additional treatment and had reached MMI. Following Dr. Singh's examination, respondent terminated claimant's workers' compensation benefits.[2]

[2] Claimant also presented for a section 12 examination with Dr. Gary Misamore. Claimant offered Dr. Misamore's report (and a subsequent addendum) into evidence during the depositions of Drs. Ross and Singh. Respondent objected on the basis of hearsay. The arbitrator sustained

¶ 27 On November 30, 2018, claimant returned to Dr. Biswas. At that time, claimant reported that her neck and back pain interfered with her activities of daily living. Dr. Biswas recommended repeat MRIs of the lumbar and cervical spines to determine if there were any changes. He also prescribed a Medrol dosepak, proton pump inhibitors (PPI), Robaxin, and amitriptyline to see if these medications help her symptoms. On December 21, 2018, claimant underwent a repeat MRI of the cervical spine. Although the examination was limited due to claimant's motion, the impression was multilevel degenerative changes of the cervical spine, similar to the prior MRI on December 28, 2017.

¶ 28 At the arbitration hearing, claimant testified that she continues to have headaches and pain in her neck, left shoulder blade, down her arm, and in her armpit down to her fingertips. Claimant also reported intermittent numbness and tingling, which was worse at night. Claimant testified that she has never been without any neck, left shoulder, or left arm pain. For her pain, claimant takes Tylenol, naproxen, and methocarbamol (Robaxin). Pain at best is 4 out of 10. Claimant is unable to tie any specific activity to her pain. Claimant testified that her activities since seeing Dr. Ross include cooking and cleaning the house and taking care of her three foster children, ages one, two, and three. She stated that she does not lift the two- and three-year-old children. Claimant wants the injections recommended by Dr. Ross and any surgery that is recommended.

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respondent's hearsay objections and Dr. Misamore's reports were not admitted. The Commission tacitly affirmed the arbitrator's ruling. However, the trial court set aside the Commission's decision with respect to the admissibility of Dr. Misamore's reports and admitted them pursuant to Illinois Rule of Evidence 703 (eff. Jan. 1, 2011) (pertaining to the bases of opinion testimony by experts). Respondent does not challenge the trial court's ruling on this matter in this appeal.

¶ 29 Respondent offered into evidence the job description for the City of Danville bus driver. The physical demands of the position involve constant (over 50%) sitting and driving a vehicle, occasional (10-25%) walking, standing, turning, and operating light/heavy equipment, and minimal (less than 10%) climbing, kneeling, bending, reaching, pushing, pulling, lifting, and carrying. The weight limits for pushing, pulling, lifting, lowering, and carrying were light to moderate (10-25 pounds).

¶ 30 Also admitted into evidence were the evidence depositions of Dr. Singh and Dr. Ross. Dr. Singh is board certified in orthopedic medicine with a subspecialty in spine surgery. Dr. Singh testified that claimant had a normal neurological examination. He noted that claimant had full strength, normal reflexes in her arms and legs, normal sensation in her arms and legs, and full range of motion of the cervical and lumbar spine. Dr. Singh also testified that claimant had degenerative disc disease at C3-C4 and C4-C5 that had been aggravated by the initial fall. He opined, however, that claimant had no clinical manifestations of a cervical radiculopathy, no deficits in her clinical evaluation from the C4-C5 distribution that would correlate with findings on the MRIs, no sensory loss, no reflex changes, and no strength loss. He further noted an EMG diagnostically failed to reveal any evidence of radiculopathy, which was consistent with claimant's clinical examination. Dr. Singh recommended against any further treatment.

¶ 31 Dr. Singh further testified that he did not agree with Dr. Ross's opinion that claimant's foraminal narrowing of the cervical spine was symptomatic. He testified that it was "anatomically impossible" for the left upper extremity complaints to be attributed to an aggravation of degenerative disc disease at the C3-C5 levels. He testified the nerve root would not provide sensation to the arm. For those reasons, Dr. Singh was unable to attribute claimant's subjective complaints to any anatomic findings. Dr. Singh instead attributed claimant's left trapezial pain to

a soft-tissue sprain, and stated that any symptoms related thereto had resolved by the time of his examination.

¶ 32 At his deposition, Dr. Ross testified that he has been a board-certified neurosurgeon since 1995. Dr. Ross opined that claimant's cervical symptoms were caused, at least in part, by the injuries sustained in the June 15, 2016, fall at work. As a result of his examination on March 21, 2017, Dr. Ross recommended that claimant undergo additional testing to determine whether claimant's condition was coming from the neck. Specifically, he recommended a left C4 selective nerve-root block, *i.e.*, an epidural steroid injection. Dr. Ross explained that the C4 nerve root supplies healing to the area of the upper shoulder about which claimant was complaining. The recommended procedure would determine whether the C4 nerve root is involved in claimant's symptoms. If the C4 nerve is the source of her symptoms, she would be a surgical candidate. Dr. Ross also recommended an EMG/NCV of the left arm to determine if she had carpal tunnel syndrome. Dr. Ross testified that claimant had not reached MMI as of the date of his examination on March 21, 2017, and she was not capable of returning to her position as a bus driver.

¶ 33 Dr. Ross further testified that he prepared an addendum report after claimant underwent additional studies, including a C3-C4 selective nerve-root injection. Dr. Ross testified that the nerve-root injection was inconclusive because there was no record of claimant's response "other than a delayed *** description that she was better." He explained that the nerve-root injection consists of two components, a local anesthetic and cortisone. The local anesthetic is diagnostic in nature in that it alleviates the pain by putting the nerve to sleep, but only for several hours. The cortisone component has no diagnostic benefit. Rather, it is therapeutic as it builds up gradually. Thus, he explained, in diagnosing whether a particular nerve is responsible for pain, it is the information gleaned from the first several hours after the treatment (from the local anesthetic) that

is important. This information was absent in claimant's case. Even with the limited value in the reporting from the first C3-C4 injection, Dr. Ross was of the opinion that since the cortisone injection into claimant's neck made her better, some of her symptoms were coming from her neck. He stated that it was possible to see improvement in her symptomatology without a second block at C3-C4 or surgery to correct that disc if the swelling of the affected nerve diminishes. Dr. Ross testified that claimant was not yet at MMI.

¶ 34 On cross-examination, Dr. Ross acknowledged that on the date of his physical examination of claimant (March 21, 2017), the mobility of claimant's cervical spine was normal. He noted, however, that claimant was tender over the left trapezius muscle, the left scapula, the left rhomboid, and the left shoulder girdle (upper back muscles). Dr. Ross testified that these symptoms could be related to the cervical spine or the shoulder. For this reason, he advised diagnostic testing (a C4 block) to determine the source of claimant's symptoms. Dr. Ross further testified that as of the date of his August 2017 addendum report, he did not have an opinion as to whether claimant could return to work as a bus driver as it pertains to her cervical spine because he did not know how much better claimant was after the injection. For that reason, he recommended an FCE to determine if she was capable of performing the duties of her position as a bus driver. Dr. Ross was of the opinion that as of August 2, 2017, assuming claimant was as good or better then when he saw her, which is what the records indicate, claimant could certainly lift between 10 and 25 pounds.

¶ 35 Based on the foregoing record, the arbitrator determined that claimant's current condition of ill-being as it related to her cervical spine is causally related to the injury of June 15, 2016. In reaching this conclusion, the arbitrator noted that claimant had no problems with her neck area prior to the injury. However, since the injury, she has had ongoing problems with her neck area that were temporarily improved after she underwent injections. The arbitrator also noted that

claimant's "treating physicians" opined that there is a causal connection between claimant's cervical spine and her injury on June 15, 2016. Additionally, the arbitrator observed that Dr. Singh testified at his deposition that claimant had a degenerative disc disease diagnosis at C3-C4 and C4-C5 that was "aggravated" by the work accident. Having found that claimant's condition of ill-being as it related to her cervical spine was casually related to the work accident, the arbitrator concluded that all medical services that were provided to claimant for her cervical spine from the date of the accident through February 15, 2019 (the date of the arbitration hearing), were reasonable and necessary to cure or relieve claimant from the effects of the injury she sustained on June 15, 2016. The arbitrator noted that, with respect to her cervical spine, claimant requested prospective medical care in the form of a repeat C3-C4 injection. The arbitrator denied claimant's request, finding that there was no current recommendation for any further treatment for claimant's cervical spine in the medical records. However, the arbitrator authorized a Medrol dosepak, PPI, Robaxin, and amitriptyline based on Dr. Biswas's recommendation of November 30, 2018. Finally, the arbitrator awarded claimant 122-2/7 weeks of TTD benefits, representing the period from August 2, 2016 (when claimant stopped working), through December 5, 2018 (the date of Dr. Ross's deposition). The arbitrator noted that at his deposition, Dr. Ross determined that claimant "was as good or better than she was on 8/2/17, and therefore could certainly lift between 10-25 pounds, which is the maximum weight claimant is required to lift pursuant to the job description for a bus driver for [respondent]," but there was no indication that claimant ever attempted to return to work.

¶ 36 A majority of the Commission ordered respondent to authorize prospective medical care in the form of a repeat injection at C3-C4 pursuant to the recommendation of Dr. Ross, but otherwise affirmed and adopted the decision of the arbitrator. The Commission remanded the

matter for further proceedings pursuant to *Thomas*, 78 Ill. 2d 327.[3] On judicial review, the circuit court of Vermilion County confirmed in part and set aside in part the decision of the Commission. Relevant here, the court confirmed the Commission's finding that claimant's cervical condition is causally related to the work accident of June 15, 2016. However, the trial court disagreed that claimant was entitled to TTD benefits only until December 5, 2018. Instead, the trial court awarded TTD benefits through February 15, 2019 (the date of the arbitration hearing), on the basis that claimant had not reached MMI by that time. This appeal by respondent ensued.

¶ 37 II. ANALYSIS

¶ 38 On appeal, respondent raises two issues. First, it argues that the Commission's finding that claimant established a causal connection between her work accident and the condition of ill-being as it relates to her cervical spine was against the manifest weight of the evidence. Second, it argues that given this lack of causal connection, claimant was not entitled to medical expenses, TTD benefits, or prospective medical care as they relate to the cervical spine.

¶ 39 A. Causation

¶ 40 Respondent argues that the Commission's finding that claimant established a causal connection between her work accident and the condition of ill-being as it relates to her cervical spine was against the manifest weight of the evidence. According to respondent, the Commission

[3] Commissioner Coppoletti specially concurred in part and dissented in part. She concurred with the majority in all aspects of its decision "other than its order to compel Respondent to authorize medical treatment." Instead, Commissioner Coppoletti would have ordered respondent "to provide and pay for the awarded medical expenses and/or treatment."

took a "narrow view of the evidence" and ignored a multitude of objective findings supporting an opposite conclusion.

¶ 41 The purpose of the Act is to protect an employee from any risk or hazard which is peculiar to the nature of the work he or she is employed to do. *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 674 (2009). To recover compensation under the Act, an employee must prove by a preponderance of the evidence all elements of his or her claim, including a causal connection between the work accident and the injury for which he or she seeks benefits. *Boyd Electric v. Dee*, 356 Ill. App. 3d 851, 860 (2005). In cases involving a preexisting condition, recovery will depend on the employee's ability to establish that a work-related accidental injury aggravated or accelerated the preexisting condition such that the employee's current condition of ill-being can be said to be causally connected to the work accident. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 204-05 (1993); *Elgin Board of Education School District U-46 v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 943, 949 (2011). An occupational activity need not be the sole or principal causative factor, as long as it was *a* causative factor in the resulting condition of ill-being. *Sisbro, Inc.*, 207 Ill. 2d at 205; *Freeman United Coal Mining Co. v. Industrial Comm'n*, 308 Ill. App. 3d 578, 586 (1999).

¶ 42 Whether a causal relationship exists between a claimant's employment and his or her condition of ill-being is a question of fact. *Certi-Serve, Inc. v. Industrial Comm'n*, 101 Ill. 2d 236, 244 (1984); *Bolingbrook Police Department v. Illinois Workers' Compensation Comm'n*, 2015 IL App (3d) 130869WC, ¶ 52. It is the function of the Commission to decide questions of fact, judge the credibility of witnesses, and resolve conflicts in the evidence. *Hosteny*, 397 Ill. App. 3d at 674. This is especially true with respect to medical issues, to which we owe the Commission heightened deference because of the expertise it possesses in the medical field. *Long v. Industrial Comm'n*,

76 Ill. 2d 561, 566 (1979). As a reviewing court, we cannot reject or disregard permissible inferences drawn by the Commission simply because different or conflicting inferences may also reasonably be drawn from the same facts, nor can we substitute our judgment for that of the Commission on such matters unless the Commission's findings are against the manifest weight of the evidence. *Zion-Benton Township High School District 126 v. Industrial Comm'n*, 242 Ill. App. 3d 109, 113 (1993). A decision is against the manifest weight of the evidence only if an opposite conclusion is clearly apparent. *Ravenswood Disposal Services v. Illinois Workers' Compensation Comm'n*, 2019 IL App (1st) 181449WC, ¶ 15.

¶ 43 Applying the foregoing standards, we find sufficient evidence to support the Commission's causation finding. It is undisputed that claimant suffered from preexisting cervical degenerative disc disease prior to the accident of June 15, 2016. Despite her preexisting condition, claimant was asymptomatic prior to the accident and able to work full duty as a bus driver. After the accident, however, claimant had ongoing problems with her cervical area. In this regard, claimant testified that she had stiffness and numbness in her neck. Although claimant denied any neck pain during her initial visit to Carle, Jacobs, the physician's assistant, noted that claimant's neck was tight. Moreover, on June 21, 2016, just days after her initial examination, claimant told Jacobs that she was experiencing a trapezius strain radiating towards the neck. Upon examination, the trapezius area on the left had increased hypertonicity (tightness) and was sore to the touch. Claimant's neck symptoms improved with injections, but the relief was temporary, and they persisted through the date of arbitration. Respondent suggests that the onset of claimant's symptoms was purely coincidental to the timing of the work accident. It is well-settled, however, that evidence showing a deterioration in the claimant's condition coincident with an accident is sufficient to support an inference of causation. See *Schroeder v. Illinois Workers' Compensation Comm'n*, 2017 IL App

(4th) 160192WC, ¶ 26 (noting that "if a claimant is in a certain condition, an accident occurs, and following the accident, the claimant's condition has deteriorated, it is plainly inferable that the intervening accident caused the deterioration"); *Gano Electric Contracting v. Industrial Comm'n*, 260 Ill. App. 3d 92, 96 (1994) (noting that a causation finding can be based upon direct or circumstantial evidence and the reasonable inferences which can be drawn from such evidence). Moreover, there was medical evidence linking the work accident to claimant's cervical condition. In his addendum report, Dr. Ross unequivocally opined that claimant's cervical condition was causally related to her work accident. In support of this conclusion, Dr. Ross observed that claimant denied any symptoms involving the cervical spine prior to the accident and he had not been presented with any medical records that called into question her veracity on this matter. Dr. Ross also cited the fact that claimant reported improvement following the C3-C4 injection administered by Dr. Ahmad. Although Dr. Singh disagreed with Dr. Ross's causation opinion, even he acknowledged at his deposition that the underlying disc degeneration of claimant's cervical spine "was aggravated" by claimant's fall. Thus, based on the record before us, there is clearly support for the Commission's finding that the work-related accident of June 15, 2016, aggravated claimant's preexisting condition. For this reason, we reject respondent's argument that the Commission's finding of a causal connection between claimant's current condition of cervical ill-being and her work accident was against the manifest weight of the evidence.

¶ 44 Respondent acknowledges that Dr. Ross proffered a causation opinion in support of a causal connection between claimant's work accident and the condition of her cervical spine, but argues that Dr. Ross was not a credible witness because he gave conflicting evidence regarding claimant's *lumbar* spine. Respondent also asserts that the Commission ignored claimant's inconsistent pain complaints and objective examinations. In this regard, respondent observes that

claimant denied neck symptoms to Jacobs at her initial visit to Carle on the day of the accident, Dr. Tipirneni opined that claimant magnified her neck symptoms, and Dr. Ahmed opined that claimant's pain symptoms were not emanating from the neck. Respondent's argument, however, is merely an invitation for this court to reweigh the evidence in the record, which is something we are not tasked to undertake. As noted earlier, it is the Commission's function to judge the credibility of the witnesses, determine the weight to be accorded to their testimony, and resolve conflicting medical evidence. *Hosteny*, 397 Ill. App. 3d at 674. And based upon the record before us, we cannot say that the Commission's resolution of those issues was against the manifest weight of the evidence.

¶ 45 Respondent also takes issue with the Commission's decision to accord more weight to the causation opinion of Dr. Ross over that of the conflicting causation opinion of Dr. Singh. An appellate court's review of the Commission's decision involves only the determination of whether there is proper medical evidence in the record sufficient to support the decision. *Crane Co. v. Industrial Comm'n,* 32 Ill. 2d 348, 352-53 (1965). It does not involve a determination of which medical expert is more worthy of belief. *Crane Co*, 32 Ill. 2d at 352-53. Indeed, as noted above, it is well settled that determinations regarding the credibility of witnesses and the resolution of the conflicting medical opinions are within the exclusive purview of the Commission. *Hosteny*, 397 Ill. App. 3d at 674; *Long*, 76 Ill. 2d at 566. Thus, the Commission was not required to adopt Dr. Singh's opinion. Indeed, we observe that there were inconsistencies in Dr. Singh's report and deposition testimony that the Commission could have found to impact his credibility. In his report, Dr. Singh wrote that he did not believe that claimant sustained an aggravation of her underlying degenerative condition as a result of her work accident. At his deposition, however, Dr. Singh testified that claimant's cervical degenerative disc disease was aggravated by the work accident of

June 15, 2016. Further, in his report, Dr. Singh stated that an injury at C3-C4 would result in trapezial pain, not in arm pain, but claimant never manifested trapezial discomfort. Yet, the record is replete with claimant's complaints of trapezial discomfort. And, at his deposition testimony, Dr. Singh acknowledged that claimant reported trapezial symptoms. Given this inconsistent evidence, the Commission could reasonably conclude that Dr. Ross's opinion was entitled to more weight than that of Dr. Singh.

¶ 46 In short, given the state of the record, we cannot say that a conclusion opposite that of the Commission on the issue of causation as it relates to claimant's cervical spine is clearly apparent or that, in turn, the Commission's decision was against the manifest weight of the evidence.

¶ 47 B. Remaining Issues

¶ 48 Respondent also challenges the Commission's findings that claimant was entitled to medical expenses, prospective medical care, and TTD benefits as they relate to claimant's cervical spine condition.[4] Respondent's arguments are based on the assertion that the condition of ill-being of claimant's cervical spine is not causally related to claimant's work accident of June 15, 2016. As discussed above, however, we have concluded that the Commission's finding of a causal connection between claimant's work accident and the condition of ill-being of her cervical spine was not against the manifest weight of the evidence. Accordingly, for the same reasons that we rejected respondent's arguments addressed to the causal connection finding, we conclude that the Commission did not err in finding that claimant was entitled to medical expenses, prospective medical care, and TTD benefits related to her cervical spine. See *Tower Automotive v. Illinois*

[4] Although respondent disputes on appeal claimant's entitlement to these benefits, it does not challenge the trial court's decision to increase the period of TTD awarded by the Commission.

Workers' Compensation Comm'n, 407 Ill. App. 3d 427, 436 (2011) (holding that arguments based upon the rejected premise that the Commission's causation finding is erroneous may be rejected without further analysis).

¶ 49 III. CONCLUSION

¶ 50 For the reasons set forth above, we affirm the judgment of the circuit court of Vermilion County, which confirmed in part and set aside in part the decision of the Commission. This matter is remanded to the Commission for further proceedings pursuant to *Thomas*, 78 Ill. App. 3d 327.

¶ 51 Affirmed and remanded.