2014 IL App (3d) 130347WC-U
No. 3-13-0347WC
Order filed June 19, 2014

IN THE

APPELLATE COURT OF ILLINOIS

THIRD DISTRICT

WORKERS' COMPENSATION COMMISSION DIVISION

EMPRESS CASINO,	)	Appeal from the
	)	Circuit Court of
	)	Will County.
Appellant,	)	
	)	
v.	)	No. 12-MR-892
	)	
ILLINOIS WORKERS' COMPENSATION COMMISSION, *et al.*,	)	
	)	Honorable
	)	Bobbi N. Petrungaro
(Renata Zettek, Appellee).	)	Judge, Presiding.

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

ORDER

¶ 1 *Held*: The Commission's determination that the claimant was permanently and totally disabled is not against the manifest weight of the evidence where there is medical evidence and testimony supporting the determination. Because the claimant's condition had not stabilized and she had not reached maximum medical improvement

until November 29, 2010, the Commission's determination to award temporary total disability until November 28, 2010, is not against the manifest weight of the evidence. Where there is evidence in the record that the medical treatments the claimant received provided relief from her work-related injury, the medical expenses the employer was ordered to pay were reasonable even though they did not cure her condition.

¶ 2 The claimant, Renata Zettek, filed an application for adjustment of claim against her employer, Empress Casino, seeking workers' compensation benefits for injuries she allegedly sustained to her back on December 23, 2003. The claim proceeded to an arbitration hearing under the Workers' Compensation Act (the Act) (820 ILCS 305/1 *et seq*. (West 2002)). The arbitrator found that the claimant did sustain an accident that arose out of and in the course of her employment. She was awarded temporary total disability (TTD) benefits of $194.52 per week for 330 1/7 weeks, reasonable and necessary medical expenses of $119,856.31, and permanent total disability (PTD) benefits of $379.51 per week for life because the injury sustained caused complete disability of the claimant rendering her totally and permanently disabled. The employer appealed to the Illinois Workers' Compensation Commission (Commission). The Commission affirmed and adopted the arbitrator's decision. The employer filed a timely petition for review in the circuit court of Will County which confirmed the Commission's decision. The employer appeals. We affirm.

¶ 3 BACKGROUND

¶ 4 The following factual recitation is taken from the evidence presented at the arbitration hearings conducted on July 16, 2009, and June 13, 2011.

¶ 5 The claimant testified that she started working for the employer on January 4, 1996, as a cocktail waitress. She worked from 11:00 p.m. until 6:00 a.m. Her job entailed providing drinks and other items to guests in the 50,000 square foot facility. Because of the numerous slot machines, she had to twist and turn to move around the floor. The claimant testified that she carried a tray with her left hand and she typically carried 10 to 15 drinks on the tray at a time. She was also responsible for replacing dirty ashtrays with clean ones. The claimant stated that her tray was always full and that a full tray weighed between 30 to 50 pounds. The claimant testified that there was a metal shelf about three inches wide next to the slot machines where she placed the guest's drink and ashtray. The shelf was approximately 24 inches from the ground. The claimant estimated that she had to bend over to put a drink on the tray or retrieve an empty glass or ashtray 1,000 times per shift.

¶ 6 The claimant testified that prior to her accident she was able to perform all of her duties as a cocktail waitress, other than a brief difficulty with her foot, and that she had never had problems with her low back. She stated that prior to December 2003, she had not received medical treatment for her low back.

¶ 7 The claimant testified that at around 3:00 a.m. on December 23, 2003, she was carrying a tray full of ashtrays weighing approximately 30 pounds. She bent down to pick up another ashtray when she felt a "very painful pop in [her] lower back." She testified that the pain was unbearable and that she had never experienced that type of pop or pain in her low back before.

¶ 8 The pain increased, and on December 25, 2003, the claimant went to the Morris Hospital emergency room by ambulance. The emergency room record shows that the claimant complained of pain to her lower right back for the past several days. She reported that she had no history of back pain. The claimant received a shot and was told to follow up with her physician.

¶ 9 On December 29, 2003, Dr. Astar Khan examined the claimant. In his patient notes he wrote that the claimant came to see him for severe lower back pain that started a week prior at work and that radiated into her leg. Dr. Khan treated her on a number of occasions and recommended she follow up with a neurologist.

¶ 10 On January 2, 2004, the claimant had a magnetic resonance imaging (MRI) scan of her lumbar spine. The scan revealed a large disc extrusion at L5-S1 on the right that compressed and displaced the right S1 nerve root and the thecal sac. It also showed a diffuse disc bulge at L4-L5.

¶ 11 Dr. Joseph Bylak examined the claimant on January 13, 2004. In his patient notes he wrote that she presented with complaints of significant pain in her lower back radiating down into her heel. She complained of numbness in the posterior heel of her right foot, and in the right medial posterior calf. He wrote that he reviewed MRI studies of the lumbar spine which revealed a herniated disc at the L5-S1 level. He diagnosed her with an acute herniated disc of L5-S1. He opined that she should see a spine surgeon for further care and referred her to neurosurgeon Dr. George DePhillips. He recommended that she remain off work.

¶ 12 Dr. DePhillips testified by evidence deposition. He stated that he first examined the claimant on January 22, 2004. He diagnosed the claimant with a large herniated disc with an extruded fragment at L5-S1 with radiculopathy, and discogenic low back pain due to the herniated disc as well as degenerative disc disease. He recommended that the claimant have surgery to her low back to decompress the disc fragment at L5-S1. He noted that due to the large size of the herniation and the degree of internal disc disruption, a decompression alone might not provide the relief required to have a reasonable degree of pain control so a fusion may be needed in the future.

¶ 13 At the request of the employer, the claimant had an independent medical evaluation by Dr. Alexander Ghanayem on January 28, 2004. After examining the claimant and reviewing the MRI scan, Dr. Ghanayem found that the claimant had a large L5-S1 disk herniation. He wrote in his report that a lumbar discectomy at L5-S1 was a reasonable course of medical action.

¶ 14 On January 30, 2004, Dr. DePhillips performed a lumbar microdiscectomy right side L5-S1, right side S1 foraminotomy, and excision of extruded disc fragment on the claimant.

¶ 15 Following the surgery the claimant had physical therapy at Morris Hospital. Dr. DePhillips testified that the initial physical therapy aggravated the claimant's back pain. The claimant testified that she did not experience any relief from the surgery. Dr. DePhillips examined the claimant on February 12, 2004, and March 11, 2004. On April 29, 2004, Dr. DePhillips ordered an MRI scan to make certain that the entire disc fragment had been removed and that there was no residual nerve root impingement. On

May 6, 2004, the claimant had an MRI scan. Dr. DePhillips testified that there was no evidence of residual disc herniation, no pressure on the S1 nerve root, and the scar tissue was not displacing the nerve root. On May 13, 2004, he treated the claimant and explained that her only surgical option was a fusion and he recommended conservative treatment to give her time to see whether her symptoms would improve with non-operative treatment. He referred her to a pain clinic.

¶ 16 On June 10, 2004, Dr. Ghanayem performed an independent medical evaluation of the claimant at the employer's request. He found that the claimant was having ongoing back pain after a large disc herniation. He recommended that she undergo an appropriate course of rehabilitation to see if she would improve. He noted that if she did not respond favorably, then a lumbar fusion may be necessary. He felt that given that she was not driving and was taking a number of medications, she should remain off work. He opined that he could not predict maximum medical improvement at that time.

¶ 17 On July 2, 2004, Dr. Gary Koehn, a pain management specialist, examined the claimant on referral from Dr. DePhillips. He noted in his patient history that the claimant had a work injury, failed conservative treatment, and underwent an L5-S1 discectomy/foraminotomies/laminectomy. He recommended transforaminal epidural steroid injections. On July 9, 2004, July 27, 2004, and August 31, 2004, Dr. Koehn gave the claimant transforaminal right L5-S1 epidural steroid injections.

¶ 18 The claimant continued her treatment with Dr. DePhillips. He noted that she experienced no relief from her epidural steroid injections. He testified that they did not help primarily because the steroid could not penetrate the scar tissue and could not reach

the disc or the nerve root in order to be effective. He opined that she would need a spinal fusion to relieve her pain. He ordered a discogram to assess the discs above the pathologic level because one of the concerns regarding a fusion is placing stress on adjacent levels.

¶ 19 On September 24, 2004, Dr. Koehn examined the claimant for a diagnostic provocation discography. The claimant underwent a computed tomography (CT) scan of the lumbar spine and a discography of the lumbar spine. Dr. DePhillips testified that the results of the discogram showed that at L5-S1 the injections reproduced her everyday pain, including low back and right leg pain. At L3-L4 and L4-L5 the post-discogram CT scan showed tears in the annulus. Although they did not provoke concordant pain, they were morphologically abnormal and showed signs of degeneration. Dr. DePhillips diagnosed the claimant with segmental instability L5-S1 with discogenic low back pain. He recommended that the claimant undergo a spinal fusion at the L5-S1 level.

¶ 20 On November 8, 2004, Dr. Fred Geisler examined the claimant. He diagnosed her with low-back discomfort with the main pain generator at L5-S1 as determined by both the MRI scan and discogram. He recommended a fusion at L5-S1. Dr. Geisler wrote in his report that he told the claimant that after the fusion she would need rehabilitation and her outcome would be determined not only by how well she did in rehabilitation but by the health of the L3-L4 and L4-L5 disc space.

¶ 21 On February 16, 2005, at the request of the employer, Dr. Andrew Zelby performed an independent medical evaluation of the claimant. He wrote in his report that the claimant had tremendous complaints of pain and did have an iatrogenic instability at

L5-S1 with an incompetent right L5-S1 facet. He opined that she needed a fusion at L5-S1. Dr. Zelby wrote that it was his opinion that the claimant's condition was not work-related. After surgery he stated that she should be able to return to work at the highest level of work allowed by a valid functional capacity evaluation (FCE).

¶ 22 The claimant continued treating with Dr. DePhillips. On March 24, 2005, Dr. DePhillips examined the claimant. He wrote in his patient notes that her March 9, 2005, MRI scan revealed disc space collapse and narrowing at the L5-S1 level. He wrote that he explained to the claimant that she had "post-laminectomy instability which [was] related to the discectomy. Since the discectomy was necessary because of the herniated disc, which was the result of her work related injury, it [was his] opinion that the need for the spinal fusion and the instability [was] causally related to the initial work related injury."

¶ 23 On April 15, 2005, Dr. DePhillips performed a spinal fusion at the L5-S1 level on the claimant. The claimant remained under the care of Dr. DePhillips after the spinal fusion and participated in a course of physical therapy. She also continued to see Dr. Koehn for pain management.

¶ 24 On April 20, 2006, Dr. Mark Nolden, an orthopedic surgeon, performed an independent medical evaluation of the claimant at the employer's request. He opined that the claimant had reached maximum medical improvement following her interbody and posterolateral arthrodesis at L5-S1. He wrote in his report that all the treatment that she had undergone was appropriate. He recommended an FCE. He felt that she was more than capable of performing light duty activities at that time. He averred that appropriate

restrictions would be limiting heavy lifting to less than 30 pounds on occasion throughout an eight-hour work shift.

¶ 25 On May 4, 2006, the claimant returned to Dr. DePhillips. He wrote in his patient notes that Dr. Nolden felt that the claimant had reached maximum medical improvement, but he felt that prior to making this determination she should be reevaluated by Dr. Koehn for pain management and to evaluate her current medication regime. On September 7, 2006, Dr. DePhillips examined the claimant. He recommended an FCE.

¶ 26 The claimant testified that on September 18, 2006, she returned to work for the employer for four hours per day doing data input in the marketing department. The claimant testified that the employer kept increasing her hours. She stated that her work station was on the second floor of the employer's facility. She parked in the employee lot and would have to cross a lot the size of a football field to get to the building. After a few weeks, she was provided with a handicap permit and was able to park closer to the entrance. Once inside the building, she went through a variety of doors, up two large flights of stairs to the very last office on the floor. She also performed work in the accounting department on the opposite side of the building. The cafeteria was located in the basement of the building. At times there was an elevator she could use, but it was also used by the catering and banquet staff and she had to stand and wait for long periods of time to use it.

¶ 27 The claimant testified that when she returned to work she began to experience pain in her lower back that radiated into her legs and hips. She developed numbness in the sides of her left leg and on the left side of her left foot. Her tolerance for sitting was 30 to

45 minutes. Walking would aggravate her symptoms immediately. The only way to alleviate the symptoms was to lie down for a period of time. She was told that if she was in significant pain she could lay on the carpeted floor of the back room where she worked. The claimant testified that she did not do so because she had to dress professionally for work and her attire made it impractical.

¶ 28 On September 28, 2006, the claimant had an FCE. The evaluator Jennifer Flage Hobson wrote in her report that based on the dynamic strength, position tolerance, and mobility sections of the evaluation, the claimant was capable of performing physical work at the sedentary level. Ms. Hobson noted modified lifting was required, that the claimant had functional instability caused by lower extremity and low back weakness, gait deviation, limited balance on uneven surfaces, and pain in the lower back. Ms. Hobson felt that the claimant was unable to return to her waitressing position, but that she could return to her position with the employer doing computer data entry for 4 hours per day increasing up to an 8 hour day as tolerated. Ms. Hobson found that the claimant had not reached rehabilitation maximum at that time. Ms. Hobson recommended physical therapy two to three times per week for four to six weeks.

¶ 29 On October 26, 2006, Dr. DePhillips reviewed the claimant's FCE. He felt that she had not reached maximum medical improvement. He released her to begin working at a sedentary level four hours per day with the restrictions set out in the FCE, increasing her hours as tolerated up to an eight hour day. He further recommended physical therapy two to three times per week for four to six weeks for lumbar stabilization.

¶ 30 On December 21, 2006, Dr. DePhillips examined the claimant. He wrote in his patient notes that the physical therapist recommended four to six weeks of additional therapy. She was to remain on the restrictions.

¶ 31 On March 16, 2007, Dr. DePhillips examined the claimant. He wrote in his patient notes that she had returned to light duty work with the employer, but that it involved climbing stairs and walking long distances. Her pain had worsened in her lower back and radiated to her lower extremities. He modified her restrictions and recommended an MRI scan of the lumbar spine. He testified that the claimant's worsening symptoms were caused by her work activities.

¶ 32 On March 26, 2007, the claimant had an MRI scan. Dr. DePhillips testified that he reviewed the scan with the claimant on April 27, 2007. He felt that there was pathology at the L4-L5 level where the disc was beginning to degenerate. There was facet arthropathy and he opined that returning to work was aggravating the level above the fusion, the adjacent level L4-L5, by placing stress on that disc. He recommended that she not return to work. He averred that he felt that she was unemployable by virtue of the nature of her fusion, the fact that her restrictions made her essentially unemployable, and the fact that the L4-L5 level was now a pain generator. The claimant stopped working.

¶ 33 On July 19, 2007, Dr. Nolden performed an independent medical evaluation on the claimant at the employer's request. He noted in his report that the claimant's chief complaint was low back pain with radiation into the left buttock and left posterior proximal thigh. Dr. Nolden opined that the claimant exhibited pain out of proportion to any stimuli during her examination and also exhibited exaggerated pain behavior during

the examination. Dr. Nolden wrote that the claimant's surgical outcome had been suboptimal. He noted that she had reached maximum medical improvement for her work-related injury post L5-S1 microdiscectomy and subsequent L5-S1 posterior spinal fusion and extensive postoperative rehabilitation. He opined that no further treatments should be pursued based on her poor response to her surgeries and multiple inorganic findings on evaluation including her tendency for symptom amplification. He wrote that based on his review of her FCE and his experience with this type of surgery in the working population, the claimant was capable of performing any sedentary/clerical job which did not involve repetitive lifting, bending, or twisting. He did not recommend the pursuit of chronic and permanent disability status. He recommended that all attempts should be made to wean her from narcotic medications. He restricted her to lifting 30 to 35 pounds on occasion, not repetitively, and not frequently during a single work shift.

¶ 34 Dr. DePhillips testified that he reviewed Dr. Nolden's independent medical evaluation and disagreed with his opinion that the claimant was able to return to work. He opined that the claimant was unemployable based on the restrictions, her failed attempt to return to work, and on the condition of her spine at the L4-5 level. He disagreed with Dr. Nolden that the claimant did not need further treatment. Dr. DePhillips felt that the claimant would need chronic pain management and might need surgery in the future. He also disagreed with Dr. Nolden's assessment that the claimant exhibited behavior of symptom magnification. He testified that over the years that he had been treating the claimant he had never been suspicious of malingering and there were never any signs of symptom magnification.

¶ 35 Dr. DePhillips examined the claimant on June 14, 2007, August 31, 2007, and November 28, 2007. On January 7, 2008, Dr. DePhillips examined the claimant and found that her symptoms had worsened. Her December 3, 2007, MRI scan showed disc protrusions at the L3-L4 and L4-L5 levels, and mild to moderate spinal stenosis. He told the claimant that the fusion created stress on the adjacent levels which were now becoming symptomatic. He recommended conservative treatment, but told her that she may ultimately need to undergo a discography with extension of the fusion. He felt that she remained permanently and totally disabled and was not capable of meaningful employment. He testified that he believed any further work activities would aggravate her condition not only at L5-S1, but more importantly at the levels above the fusion, L3-L4, and L4-L5. He opined that the claimant's condition of ill-being was causally related to her work injury on December 23, 2003. He further stated that it was his opinion, to a reasonable degree of neurosurgical certainty, that the claimant's condition of permanent and total disability was causally related to her December 23, 2003, work injury.

¶ 36 On September 19, 2008, Dr. DePhillips examined the claimant. He opined that she remained permanently and totally disabled. He recommended a lumbar discography at the L2-L3, L3-L4, and L4-L5 levels.

¶ 37 Dr. DePhillips testified that he referred the claimant to Dr. Udit Patel for pain management. The claimant began treatment for pain management with Dr. Patel on January 21, 2008. She saw him approximately monthly until the time of the arbitration hearing in June 2011. Dr. Patel administered various injections including sacroiliac joint injections, sacral median nerve block injections, and facet joint injections. He also

performed radiofrequency ablation of the sacroiliac joint strip lesion and medial branch nerves. All of these procedures resulted in temporary relief. Dr. Patel recommended a peripheral field nerve stimulator trial.

¶ 38 On November 13, 2008, Dr. Ghanayem performed another independent medical evaluation of the claimant. She complained of low back pain and leg pain. In his report, he wrote that he reviewed the claimant's March 2007 and December 2007 MRI scans and noted no neurocompressive lesions. He opined that it was unlikely that extending her fusion would give her relief from her symptoms which had been present for a long time. He wrote that "a longer fusion in the context of no neurocompressive lesions with multilevel degenerative changes does not stand a reasonable chance of making her any better considering her lack of success with two much smaller procedures." He felt that continuing with pain management in order to maximize her function and minimize her use of medications would be appropriate. He averred that the claimant could return to some level of occupational activity in a restricted capacity. He wrote that she should obtain an FCE and return to work at the level defined by the FCE. He opined that she was at maximum medical improvement.

¶ 39 Dr. DePhillips testified that he disagreed with Dr. Ghanayem's finding that there were no neurocompressive lesions. He felt that the December 3, 2007, MRI scan showed a mild spinal stenosis which could be considered neurocompressive. Dr. DePhillips testified that he disagreed with Dr. Ghanayem's opinion that extending the fusion would be unlikely to give the claimant relief. He testified that he had performed three level fusions for a number of years and while the success rate is not as high as with one or two

level fusions, in his practice at least 50% of the patients will significantly improve in terms of functional outcome or pain relief. Dr. DePhillips testified that he agreed with Dr. Ghanayem's opinion that the claimant should continue with pain management and that attempts should be made to wean her off medications. He did not agree that she could return to work. Dr. Ghanayem opined that the claimant would need restrictions to return to work. Dr. DePhillips testified that he felt that she would need restrictions and that the restrictions would make her unemployable and, therefore, totally disabled.

¶ 40 On November 29, 2010, Dr. Patel wrote a letter addressing the employer's questions. He wrote that the claimant had reached a point of maximum improvement in terms of her low back injury. He noted that he did not feel that further surgery was indicated; however, he deferred to a spine surgeon to make that determination. He wrote that aside from a spinal cord stimulator or a peripheral nerve stimulator, there were no further treatments that would likely improve the claimant's overall condition. The claimant needed further medication therapy for her pain. He noted that she has chronic pain as a diagnosis along with postlaminectomy failed back syndrome and would require medication for the rest of her life to help control the pain. He felt she might need injections periodically to help with acute and chronic flare-ups of lower back pain. He opined that the claimant is disabled from all types of work because pain limits her activity and any increase would further increase her pain and require further medication therapy. He averred that the claimant's chronic pain and back pain was a result of her work accident on December 23, 2003.

¶ 41 On December 1, 2010, Dr. DePhillips examined the claimant. In his patient notes he wrote that she complained of lower back pain with pain radiating into the left buttock and posterior thigh and calf to the ankle with numbness in her left foot, and bilateral hip pain. He diagnosed her with adjacent segment disease and discogenic pain at the L3-L4 and L4-L5 levels. He wrote that, in his opinion, the discs will continue to degenerate and her discogenic pain will more likely than not worsen. If that occurred he recommended considering extension of the fusion or dynamic stabilization adjacent to the fusion. He opined that from a neurosurgical standpoint she had reached maximum medical improvement. He noted that Dr. Patel would continue to manage her pain. He opined that her symptoms were chronic and permanent, and she remained unemployable and totally disabled.

¶ 42 Dr. DePhillips testified that, to a reasonable degree of medical certainty, the claimant's initial disk herniation at L5-S1 was causally related to her work activities on December 23, 2003. He further opined that, to a reasonable degree of medical certainty, the claimant's condition of instability in her lumbar spine, specifically at L5-S1 requiring the need for a spinal fusion, was causally related to her work activities on December 23, 2003, because the instability was caused by the large herniated disc at L5-S1 which was the result of the work related injury. Dr. DePhillips testified that the series of MRI scans performed following the fusion revealed progression of spondylitic changes at the L4-L5 level in terms of disc bulging, disc degeneration, and facet arthropathy. He stated that the most recent MRI scan showed evidence of foraminal stenosis at the L4-L5 level. He attributed those changes to adjacent or level failure in terms of the stress of the fusion on

the L4-L5 levels. Additionally, he noted that the disc at the L4-L5 level was not normal even before the fusion as the discogram performed prior to the surgery revealed tears in the annulus at the L4-L5 and the L3-L4 levels. He stated that the claimant's work activities including prolonged sitting, prolonged standing, repetitive bending and twisting, and repetitive climbing aggravated her condition.

¶ 43 Dr. DePhillips testified that, to a reasonable degree of medical certainty, the lumbar discogram and recommendations for further treatment based on the results were reasonable and necessary to provide relief to the claimant for her December 23, 2003, work accident. He stated that it is very common for patients who have had lumbar fusions and suffer residual back pain to be unable to tolerate even sedentary levels of work because of the requirement of prolonged sitting. He testified that the claimant's inability to work and her disability were causally related to her work accident on December 23, 2003. He stated it was his opinion, to a reasonable degree of neurological certainty, that the claimant should continue pain management with Dr. Patel. He felt she may require additional surgical treatment including extension of her fusion as well as a spinal cord stimulator placement. He opined that if she did not receive surgery or other treatment modalities, she is unemployable and totally disabled.

¶ 44 On March 9, 2011, Dr. Ghanayem performed an independent medical evaluation of the claimant at the employer's request. He opined that the claimant has remained stable since he last evaluated her in November 2008. He averred that Dr. DePhillips' opinion that the claimant was unemployable was incorrect. He wrote in his report that she was articulate, able to read and write, and had normal function of her upper

extremities. He felt that she could at least function at the light demand level in an ergonomically correct and proper work environment. He averred that from a pain management standpoint, someone needed to manage her medications. He felt that additional intervention such as an implantable pain stimulator or additional injections would not be fruitful.

¶ 45 The claimant testified that her health was deteriorating and that her back and leg pain was worse. She stated that her back pain was so severe that it was "almost a nightmare to live through this every day." She stated she felt constant pain in her lower back and legs, terrible pain in her left leg that goes into the bone, pain in both hips, and constant numbness in her left foot. She stated that the numbness has caused her to have weakness when walking. She stated that she can stand for about 30 minutes without complete pain. She can walk for 15 to 30 minutes and sit for 45 minutes. She cannot perform bending or twisting motions. The claimant testified that to relieve the pain she has to put ice on her back and lay down with her feet elevated. She stated that she has to lay down 50 to 60 percent of the day. She stated that she started receiving social security disability in December 2010. She has not suffered an injury to her back since December 23, 2003.

¶ 46 The arbitrator found that the claimant sustained an accident that arose out of and in the course of her employment with the employer and that her condition of ill-being was causally related to her accident. The arbitrator ordered the employer to pay the claimant TTD benefits of $194.52 per week for 330 1/7 weeks commencing December 24, 2003, through September 17, 2006, and again April 27, 2007, through November 28, 2010. The

employer was given a credit of $44,091.20 for TTD benefits that it had already paid. The arbitrator found that the medical treatment that the claimant received was causally related to her work accident she sustained on December 23, 2003, and that the medical bills she submitted were reasonable and necessary medical treatment. The employer was ordered to pay $119,856.31 in reasonable and necessary medical services. The employer was further ordered to pay the claimant $379.51 per week for life commencing November 29, 2010, for permanent and total disability benefits because the injury she sustained caused her complete disability rendering her totally and permanently disabled. The arbitrator noted that his finding was based upon the testimony of the claimant which he found to be credible. He noted that Dr. DePhillips, Dr. Patel, and Dr. Ghanayem opined that the claimant's condition of ill-being was causally related to her December 23, 2003, work accident. The arbitrator found that the opinion of Dr. Zelby was less credible than the opinions offered by Dr. DePhillips, Dr. Patel, and Dr. Ghanayem.

¶ 47 The employer sought review of this decision before the Commission. The Commission affirmed and adopted the arbitrator's decision. The employer sought judicial review of the Commission's decision in the circuit court of Will County. The circuit court confirmed the Commission's decision. The employer now appeals.

¶ 48 **ANALYSIS**

¶ 49 The employer argues that the Commission's finding regarding the nature and extent of the claimant's condition is against the manifest weight of the evidence because there is insufficient evidence that she was permanently and totally disabled.

¶ 50 "The extent and permanency of claimant's medical disability is a question of fact for the Commission and we will not disturb that decision unless it is against the manifest weight of the evidence." *Alexander v. Industrial Comm'n*, 314 Ill. App. 3d 909, 914-15, 732 N.E.2d 1166, 1170 (2000). A factual finding is against the manifest weight of the evidence only when the opposite conclusion is clearly apparent. *Shafer v. Illinois Workers' Compensation Comm'n*, 2011 IL App (4th) 100505WC, ¶ 38, 976 N.E.2d 1, 12. A reviewing court should not overturn the Commission's findings simply because a different inference could have been drawn, nor should it substitute its judgment for that of the Commission. *Old Ben Coal Co. v. Industrial Comm'n*, 217 Ill. App. 3d 70, 84, 576 N.E.2d 890, 899 (1991).

¶ 51 An injured employee can establish her entitlement to permanent total disability benefits by a preponderance of the medical evidence, by showing a diligent but unsuccessful job search, or by demonstrating that because of age, training, education, experience, and condition there are no available jobs for a person in her circumstance. *Professional Transportation, Inc. v. Illinois Workers' Compensation Comm'n*, 2012 IL App (3d) 100783WC, ¶ 34, 966 N.E.2d 40. An employee is totally and permanently disabled when she is unable to make some contribution to the work force sufficient to justify the payment of wages or when she cannot perform any service except those that are so limited in quantity, dependability or quality that there is no reasonably stable market for them. *Alexander*, 314 Ill. App. 3d at 915, 732 N.E.2d at 1170. An employee is not totally and permanently disabled if she is qualified and capable of obtaining gainful employment without seriously endangering her health or life. *Id*.

¶ 52 In the instant case, the claimant returned to light duty work on September 18, 2006. Her work duties involved sitting, climbing stairs, and walking long distances. These activities aggravated her condition causing her pain to increase. At the arbitration hearing the claimant testified that she was in constant pain and that her ability to sit, stand, and walk were limited. She testified that the only way to relieve her pain was to lie down and apply ice to her back. She estimated that she spent 50 to 60 percent of each day lying down. The Commission found the claimant's testimony credible.

¶ 53 Medical evidence was presented that the claimant was permanently and totally disabled. Dr. DePhillips began treating the claimant on January 22, 2004. His treatment included performing the claimant's lumbar microdiscectomy and her spinal fusion. After the claimant returned to light duty work and her symptoms worsened, Dr. DePhillips examined her on April 27, 2007, and reviewed the claimant's March 26, 2007, MRI scan with her. He stated that the MRI scan revealed pathology at the L4-L5 level where the disc was beginning to degenerate. He opined that returning to work aggravated the level above the claimant's fusion by placing stress on that disc. He advised the claimant not to return to work. Dr. DePhillips concluded that the claimant was totally and permanently disabled by virtue of the nature of her fusion, the fact that her restrictions made her essentially unemployable, and the condition of her spine at the L4-L5 level.

¶ 54 On January 7, 2008, Dr. DePhillips examined the claimant. He reviewed an MRI scan from December 3, 2007, and noted that it showed protrusions at the L3-L4 and L4-L5 levels, and mild to moderate spinal stenosis. He averred that the fusion had created

stress on the adjacent levels of the spine which were now symptomatic. He felt that the claimant remained permanently and totally disabled and that she was not capable of meaningful employment. He testified that work activities would aggravate her condition. Dr. DePhillips examined the claimant again on December 1, 2010. He diagnosed her with adjacent segment disease and discogenic pain at the L3-L4 and L4-L5 levels. He opined that her symptoms were chronic and permanent, and that she remained unemployable and totally disabled.

¶ 55 Dr. Patel commenced treating the claimant on January 21, 2008, and treated her approximately monthly until the arbitration hearing in June 2011. On November 29, 2010, Dr. Patel wrote a letter in which he stated that the claimant was disabled from all types of work because pain limited her activities and any increase would further increase her pain requiring additional medication therapy.

¶ 56 The employer argues that the Commission failed to consider the opinions of Dr. Ghanayem, Ms. Hobson, and Dr. Nolden. Ms. Hobson performed the FCE of the claimant and found that the claimant could perform light duty work. At the time of the FCE, Dr. DePhillips agreed that the claimant could return to light duty work. It was not until after she returned to work and her condition was aggravated by her work activities that Dr. DePhillips found that the claimant was permanently and totally disabled.

¶ 57 Both Dr. Ghanayem and Dr. Nolden performed independent medical examinations of the claimant and found that she was capable of some type of work with restrictions. Dr. DePhillips testified that he disagreed with Dr. Nolden's assessment. It is the province of the Commission to determine the credibility of the witnesses, to weigh the testimony,

and to determine the weight to be given to the evidence. *Illinois Mutual Insurance Co. v. Industrial Comm'n,* 201 Ill. App. 3d 1018, 1038, 559 N.E.2d 1019, 1033 (1990). "In the presence of conflicting medical opinion, the Commission's determination is given substantial deference and will be upheld unless it is contrary to the manifest weight of the evidence." *Old Ben Coal Co,* 217 Ill. App. 3d at 83-84, 576 N.E.2d at 899. The Commission examined the conflicting medical evidence and gave more weight to the claimant's treating physicians, Dr. DePhillips and Dr. Patel, than to Dr. Ghanayem and Dr. Nolden who had been hired by the employer to perform independent medical evaluations.

¶ 58 The claimant testified that she must lie down at least half of each day in order to relieve her pain from her work-related injury. She stated that her ability to sit, stand, and walk were limited. Based on her physical limitations the Commission could conclude that the claimant cannot perform any services except those that are so limited in quantity, dependability, or quality that there is no reasonably stable market for them. Additionally, the medical evidence presented from Dr. DePhillips and Dr. Patel established that the claimant was permanently and totally disabled. The Commission's determination that the claimant is permanently and totally disabled is supported by the claimant's testimony and the opinions of Dr. DePhillips and Dr. Patel.

¶ 59 The employer argues that the Commission's decision to award the claimant TTD benefits from April 27, 2007, through November 28, 2010, was against the manifest weight of the evidence. It argues that Dr. Nolden and Dr. Ghanayem maintained the claimant had reached maximum medical improvement and was capable of performing

light duty work. The employer argues that the claimant's condition had stabilized and she was no longer entitled to TTD benefits after she returned to work on September 18, 2006.

¶ 60 The period during which a claimant is temporarily totally disabled is a question of fact to be resolved by the Commission. *Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Comm'n*, 236 Ill. 2d 132, 142, 923 N.E.2d 266, 272 (2010). The Commission's determination will not be disturbed unless it is against the manifest weight of the evidence. *Id.* When reviewing the Commission's decision, the test is whether there is sufficient evidence in the record to support it. *Id.*

¶ 61 The dispositive question in awarding TTD benefits is whether the claimant's condition has stabilized and she has reached maximum medical improvement. *Id.*, 923 N.E.2d at 271. On April 20, 2006, and July 19, 2007, Dr. Nolden determined that the claimant had reached maximum medical improvement. Dr. Ghanayem found that she had reached maximum medical improvement as of November 13, 2008. However, neither Dr. DePhillips nor Dr. Patel made such a finding until much later.

¶ 62 Dr. DePhillips examined the claimant on May 4, 2006, and wrote in his notes that he disagreed with Dr. Nolden and felt he could not declare the claimant had reached maximum medical improvement until she had been evaluated by Dr. Koehn. On September 7, 2006, he examined the claimant again and recommended an FCE. The claimant started light duty work for the employer on September 18, 2006. On September 28, 2006, she had an FCE. Ms. Hobson wrote in the FCE report that the claimant could work for the employer doing computer data entry for 4 hours per day. She recommended that the claimant have physical therapy two to three times per week for four to six weeks.

On October 26, 2006, Dr. DePhillips reviewed the FCE and wrote that he felt that the claimant had not yet reached maximum medical improvement. On December 21, 2006, Dr. DePhillips examined the claimant and noted that the physical therapist recommended four to six weeks additional therapy. On March 16, 2007, Dr. DePhillips examined the claimant and noted that her condition had worsened. On April 27, 2007, Dr. DePhillips reviewed the March 26, 2007, MRI scan with the claimant, opined that her return to work aggravated the level above the claimant's fusion, and recommended that she not return to work. He averred that she was unemployable. On January 7, 2008, Dr. DePhillips examined the claimant and found that the fusion created stress on adjacent levels. He informed the claimant that she may need an extension of the fusion. It was not until December 1, 2010, that Dr. DePhillips examined the claimant and wrote in his patient notes that she had reached maximum medical improvement from a neurosurgical standpoint. Even then he felt that the claimant needed to continue pain management with Dr. Patel and that she may require additional surgical treatment including an extension of her fusion as well as a spinal cord stimulator placement.

¶ 63 Dr. Patel started treating the claimant for pain management on January 21, 2008. He saw the claimant almost monthly, and it was not until November 29, 2010, that Dr. Patel wrote a letter in which he stated that the claimant had reached a point of maximum medical improvement. He continued to treat the claimant.

¶ 64 The Commission found that the testimony of the claimant relating to the increase in her low back symptoms after she returned to work for the employer which was documented in the medical records from Dr. DePhillips and Dr. Patel, showed that the

claimant's condition of ill-being had not stabilized or reached maximum medical improvement prior to November 28, 2010. During this time Dr. DePhillips and Dr. Patel employed various treatment modalities and recommended the possible implantation of a spinal cord stimulator or an extension of the lumbar fusion. At no time from April 27, 2007, until December 1, 2010, did Dr. DePhillips or Dr. Patel release the claimant to return to work in any capacity or declare that her condition had stabilized and she had reached maximum medical improvement. The Commission's finding that the claimant was entitled to TTD benefits from April 27, 2007, until November 28, 2010, is supported by the record.

¶ 65 The employer argues that the Commission's finding that the employer was liable for reasonable and necessary medical treatment was against the manifest weight of the evidence. It asserts that the Commission erred in finding that it was liable for medical treatment after September 2006 because several physicians opined that no additional treatment other than non-narcotic medication was necessary. The employer argues that Dr. Nolden and Dr. Ghanayem re-evaluated the claimant after she returned to light duty work in September 2006, and averred that no further invasive treatment should be pursued and recommended long term non-narcotic medications for pain management. The employer asserts that because the treatment the claimant received after September 2006, resulted in only temporary relief, it was not reasonable and necessary.

¶ 66 Under section 8(a) of the Act, an employer is required to pay for all the necessary medical, surgical, and hospital services that are reasonably required to cure or relieve the effects of an accidental injury sustained by an employee. 820 ILCS 305/8(a) (West

2002). "An employer's liability under this section of the Act is continuous so long as the medical services are required to relieve the injured employee from the effects of the injury." *Elmhurst Memorial Hospital v. Industrial Comm'n*, 323 Ill. App. 3d 758, 764, 753 N.E.2d 1132, 1137-38 (2001). Whether a medical expense is reasonable or necessary is a question of fact to be resolved by the Commission, and its determination will not be reversed on review unless it is contrary to the manifest weight of the evidence. *Absolute Cleaning/SVMBL v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 463, 470, 949 N.E.2d 1158, 1165 (2011). A Commission's finding of fact is against the manifest weight of the evidence only when the opposite conclusion is clearly apparent. *Elmhurst Memorial Hospital*, 323 Ill. App. 3d at 765, 753 N.E.2d at 1138.

¶ 67 The employer argues that because the medical treatment the claimant received after September 2006, provided only temporary relief, it was not reasonable or necessary. This argument is misplaced. In *Elmhurst Memorial Hospital* the claimant injured her right hand and arm while working as a nurse for the employer. *Elmhurst Memorial Hospital*, 323 Ill. App. 3d at 759, 753 N.E.2d at 1133. In a deposition on April 21, 1995, her treating physician stated that the claimant had reached maximum medical improvement, but had not been discharged from care because she had a chronic medical condition that would require periodic surveillance and follow up. *Id*. at 762, 753 N.E.2d at 1136. The claimant continued treatment with her physician and received 27 axillary local anesthetic nerve blocks each of which gave her approximately three weeks relief from her pain. *Id*. at 763, 753 N.E.2d at 1137. The arbitrator denied medical expenses for care after April 21, 1995. *Id*. at 764, 753 N.E.2d at 1137. The Commission ordered

the employer to pay medical expenses for services rendered after April 21, 1995, finding that the services were reasonable and necessary to provide relief for an ongoing condition. *Id*. The circuit court confirmed the Commission's decision. *Id*. The appellate court found that while the injection therapy the claimant received did nothing to cure her condition, it helped relieve the effects of her injury, namely her chronic pain. *Id*. at 765, 753 N.E.2d at 1138. It affirmed the circuit court's order confirming the Commission's decision. *Id*.

¶ 68 The instant case is similar to *Elmhurst*. While the treatments the claimant received after September 2006, did nothing to cure her condition, they did help relieve her symptoms. Because the treatments the claimant received after September 2006, helped relieve the symptoms she suffered as a result of her work-related injury, they were not unreasonable or unnecessary.

¶ 69 The employer argues that the Commission did not properly consider the opinions of Dr. Nolden, Dr. Zelby, and Dr. Ghanayem. The employer argues that Dr. Zelby performed an independent medical evaluation of the claimant and found that she needed "no additional treatment based partially on her malingering of symptoms." Dr. Zelby performed the evaluation on February 16, 2005, more than one year prior to the date on which services are being contested. He did not state that she needed no additional treatment. In fact, he opined that the claimant needed a fusion at L5-S1.

¶ 70 On July 19, 2007, Dr. Nolden performed an independent medical evaluation of the claimant and wrote in his report that the claimant had reached maximum medical improvement and that no further treatments should be pursued. Dr. DePhillips testified

that he disagreed with Dr. Nolden's assessment that the claimant had reached maximum medical improvement. He also disagreed that she did not need further treatment. He opined that she needed chronic pain management and that she may need surgery in the future. On December 1, 2010, Dr. DePhillips recommended that the claimant have an extension of her fusion or dynamic stabilization adjacent to the fusion.

¶ 71 On November 13, 2008, Dr. Ghanayem performed an independent medical evaluation of the claimant. He wrote in his report that it was unlikely that extending the claimant's fusion would give her relief. He also wrote that he felt continuing with pain management in order to maximize her function and minimize her use of medication would be appropriate. Dr. DePhillips testified that he disagreed with Dr. Ghanayem's opinion about the fusion. He stated that at least 50% of his patients who had a three level fusion significantly improved in terms of functional outcome or pain relief. He agreed with Dr. Ghanayem that the claimant should continue with pain management and attempts should be made to wean her off medications. On March 9, 2011, Dr. Ghanayem performed another independent medical evaluation of the claimant. He averred that from a pain management standpoint, the claimant needed physician supervision to manage her medications.

¶ 72 On November 29, 2010, Dr. Patel wrote a letter stating that the claimant had chronic pain with postlaminectomy failed back syndrome and would need pain medication for the rest of her life and might need injections to help with periodic flare-ups. Additionally, he felt that she might need a spinal cord stimulator or a peripheral nerve stimulator.

¶ 73 There is no evidence that the Commission failed to properly consider the opinions of Dr. Nolden, Dr. Zelby, and Dr. Ghanayem. In its decision awarding reasonable and necessary medical expenses, the Commission specifically refers to the opinions of Dr. Ghanayem, Dr. Nolden, and Dr. Zelby. The Commission stated that its finding was based on the opinion offered by the claimant's treating physician, Dr. DePhillips. The Commission weighed the conflicting medical evidence and gave more weight to the evidence presented by Dr. DePhillips and Dr. Patel. There is sufficient evidence in the record to support the Commission's decision that the claimant was entitled to expenses for reasonable and necessary medical services rendered after September 2006.

¶ 74 Based on the medical evidence presented by Dr. DePhillips and Dr. Patel, and the testimony of the claimant that her ability to sit, stand, and walk are severely limited due to her work-related injury, the Commission's decision that the claimant was permanently and totally disabled is not against the manifest weight of the evidence. The claimant's treating physicians Dr. DePhillips and Dr. Patel did not declare that the claimant had reached maximum medical improvement until December 1, 2010, and November 29, 2010, respectively. Because the claimant's condition had not stabilized and she had not reached maximum medical improvement until November 29, 2010, the Commission's determination to award TTD from April 27, 2007, until November 28, 2010, is not against the manifest weight of the evidence. While the treatments the claimant received after September 2006, did not cure her condition, they did provide relief from her work-related injury. Dr. DePhillips and Dr. Ghanayem both averred that the claimant needed to treat with a physician for pain management. Dr. DePhillips felt that the claimant

needed either an extension of her fusion or dynamic stabilization adjacent to the fusion. Dr. Patel opined that the claimant had chronic pain associated with failed back syndrome and would need medication for the rest of her life to help control the pain. He felt that she might also need a spinal cord stimulator, a peripheral nerve stimulator, or injections. There was sufficient evidence in the record to support a finding that the medical expenses the employer was ordered to pay after September 2006, were reasonably required to relieve the effects of the accidental work-related injury the claimant sustained.

¶ 75 **CONCLUSION**

¶ 76 For the foregoing reasons, we affirm the judgment of the circuit court of Will County confirming the decision of the Commission.

¶ 77 Affirmed.