Illinois Official Reports

Appellate Court

***Montgomery v. Illinois Workers' Compensation Comm'n*,**
2022 IL App (3d) 210604WC

Appellate Court Caption	KURT MONTGOMERY, Appellant, v. THE ILLINOIS WORKERS' COMPENSATION COMMISSION *et al.* (Caterpillar Logistics Services, Inc., Appellee).
District & No.	Third District, Workers' Compensation Commission Division No. 3-21-0604WC
Filed Rehearing denied	November 15, 2022 December 20, 2022
Decision Under Review	Appeal from the Circuit Court of Will County, Nos. 18-MR-1942, 21-MR-182; the Hon. John C. Anderson, Judge, presiding.
Judgment	Circuit court affirmed in part and reversed in part. Commission decision reversed in part; cause remanded with directions.
Counsel on Appeal	Michael D. Block and Kyler W. Juckins, of Block, Klukas, Manzella & Shell P.C., of Joliet, for appellant. Michelle L. LaFayette, of Ganan & Shapiro, P.C., of Chicago, for appellee.

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

OPINION

¶ 1 Pursuant to section 8(a) of the Workers' Compensation Act (Act) (820 ILCS 305/8(a) (West 2010)), petitioner, Kurt Montgomery, sought payment from respondent, Caterpillar Logistics Services, Inc., for past and future medical expenses to treat a workplace injury he sustained while employed by respondent. The Illinois Workers' Compensation Commission (Commission) issued two decisions on the section 8(a) petition. One decision was interlocutory, the other final. After the issuance of the final decision, petitioner appealed to the circuit court of Will County, which confirmed the two decisions by the Commission, finding neither decision to be against the manifest weight of the evidence. Petitioner now appeals from the circuit court's judgment.

¶ 2 For the reasons that follow, we affirm the circuit court's judgment in part and reverse it in part, affirm the Commission's decision in part and reverse it in part, and remand the matter to the Commission with directions.

¶ 3 I. BACKGROUND

¶ 4 A. Procedural History

¶ 5 On April 8, 1994, petitioner was driving a forklift for respondent when his forklift was bumped by another forklift. He had hold of the accelerator with his right hand and was thrown forward in the cab, resulting in a jarring or jamming of his right arm. The pain in his arm would not go away.

¶ 6 In May 1994, petitioner filed a workers' compensation claim relating to the injury. According to his application for adjustment of the claim, the parts of his body affected were his neck, shoulder, and arms. The "Nature of Injury" was described as "[right] arm in sling."

¶ 7 In December 1996, the parties entered into a workers' compensation lump-sum settlement agreement, which the Commission approved in January 1997. According to the agreement, the affected parts of petitioner's body were the "[n]eck, shoulder[,] and right arm." The nature of the injury was "[r]ight upper extremity sympathetic dystrophy" and "lower right extremity migration." While acknowledging that causation remained in dispute, the agreement obligated respondent to pay petitioner a lump sum of $86,000. In return, petitioner waived all rights under the Act except his right to future medical treatment under section 8(a).

¶ 8 In 2011, petitioner filed a section 8(a) petition against respondent, alleging wrongful denial of medical treatment. He afterward moved for penalties and attorney fees pursuant to sections 16 and 19(k) (*id.* §§ 16, 19(k)), accusing respondent of an unreasonable and vexatious refusal to pay medical expenses.

¶ 9 In June 2017, a hearing was held on the disputed section 8(a) petition. In the hearing, petitioner submitted invoices from 20 medical providers. The invoices were for the period of July 20, 2001, to May 18, 2017, and totaled over $50,000. Also, petitioner submitted bills and

receipts totaling $32, which, he claimed, represented expenses incidental to his medical treatment for the workplace injury. In testimony on June 14, 2017, respondent's adjuster, Diane L. Moncrief, admitted that respondent had failed to pay $1600 in travel expenses that respondent previously agreed to pay. She further admitted that respondent had received from petitioner's attorney a packet of medical bills and that respondent had not paid those bills, either.

¶ 10 In addition to the claims for incurred expenses, petitioner requested that the Commission authorize all future medical treatments (as to both modalities and frequency) listed in a life care plan prepared by Dr. Mila Carlson. Petitioner's attorney hired a registered nurse, Dr. Carlson, to draft a life care plan for petitioner. Dr. Carlson, who has a Ph.D. in health administration, was an expert in the preparation of life care plans.

¶ 11 The life care plan for petitioner went through a couple of revisions. In the version of November 21, 2016, Dr. Carlson described the workplace injury and the treatment that petitioner had received for the injury since 2013. Dr. Carlson listed the medications that petitioner has been prescribed in the preceding two years. Next, Dr. Carlson listed the diagnoses that, by her understanding, were related to the workplace injury: cervical pain disease, chronic pain disorder, CRPS, insomnia secondary to chronic pain, lumbar disc disease, muscle spasm, migraine headaches with vision changes, thoracic spondyloarthritis, esophagitis with gastrointestinal reflux, hematemesis, erosive gastritis, esophageal stricture requiring dilation, dysphagia, nausea and vomiting, abdominal pain, hiatal hernia, gastroesophageal reflux disease, and a left knee injury. Under the heading "Future Medical Treatment Projection," Dr. Carlson predicted the medical treatments that petitioner (age 49 at the time) would need for the rest of his life, the frequency of the treatments, and their cost. She set out this information in a table that continued for several pages. There were 36 medical treatments in the chart—which did not include medications; there was another chart for them. By Dr. Carlson's calculations, the total cost of medical treatment and pharmaceuticals for petitioner over the remaining 32 years of his life expectancy would be $15,232,552 without acupuncture and $17,823,599 with acupuncture. (Medical experts disagreed on the efficacy of acupuncture in the treatment of chronic regional pain syndrome (CRPS).) Respondent disputed the reasonableness and necessity of these medical and incidental expenses.

¶ 12 In May 2018, before Commissioner DeVriendt and Panel B of the Commission, oral arguments were made on the section 8(a) petition.

¶ 13 On June 26, 2018, the Commission issued a "Decision and Order on § 8(a) Petition." In its decision, the Commission identified "[t]he primary issue in this case" as "the appropriate treatment course based on Petitioner's complicated diagnosis and progression" of his CRPS. (CRPS is the current term for what formerly was called reflex sympathetic dystrophy (RSD).)

¶ 14 First, the Commission directed that the "care and treatment" of petitioner's CRPS "shall be managed by one central treating physician to oversee the care plan and direct all tangential modalities of treatment and medications." The central treating physician was to make bi-annual reports of petitioner's medical progress. "[T]his treater," the Commission emphasized, "must oversee ALL treatment and attendant care related to the April 8, 1994, injury." The Commission explained that, in imposing this requirement of having a central treating physician, the Commission was following the recommendation of an independent medical examiner, Dr. Michael Stanton-Hicks of Cleveland Clinic, an expert on CRPS. In the report of his independent medical examination, Dr. Stanton-Hicks had criticized " 'the discontinuous

efforts that ha[d] been made by numerous facilities' " and the lack of " 'a continuum of CRPS pain management,' " resulting in repeated returns to " 'square one' " in the treatment of petitioner (to quote the Commission quoting Dr. Stanton-Hicks).

¶ 15 Second, the Commission "[found] this [central] treater [could not] be the Petitioner's current physician, Dr. Wayne Kelly." The Commission gave the following reasons for this finding:

> "Dr. Kelly has previously discontinued treatment including sympathetic block, psychological counseling, physical therapy, and stopping writing prescriptions or monitoring acupuncture, physical therapy or biofeedback. Dr. Kelly has additionally increased the amount of opioids prescribed, rather than taper down these medications. The Commission finds that Petitioner's treatment will be better served by a central treatment physician to oversee all modalities of treatment and taper down opioid medications."

Dr. Stanton-Hicks had "[r]ecommend[ed] opioid and benzodiazepine taper as these medications have poor evidence in the treatment of CRPS and when combined, they facilitate tolerance and opioid hyperalgesia" (to quote from his report). Dr. Richard Rotnicki, who was board-certified in gastroenterology and internal medicine, opined that petitioner's chronic gastroesophageal reflux disease, nausea, vomiting, and constipation were owing to "[n]arcotic bowel syndrome." The record contains recommendations by other physicians that petitioner undergo detoxification from opioids and that benzodiazepine not be prescribed with opioids—a reputedly dangerous combination of drugs.

¶ 16 Third, the Commission ordered that the central treating physician—besides being a physician other than Dr. Kelly—had to be affiliated with a major medical institution. Specifically, the central treating physician had to "be either from the Cleveland Clinic; or from an accredited, university-based center in the Chicago[ ] area such as Northwestern Memorial Hospital, Rush [University], University of Chicago, or Loyola [University]; or from an accredited and university-based center in Arizona where Petitioner currently resides." This requirement likewise was pursuant to recommendations by Dr. Stanton-Hicks and other physicians.

¶ 17 The Commission determined that the proposed life care plan was "premature and should not be considered until a medical care plan," administered by a central treating physician, was "implemented pursuant to [its] order."

¶ 18 Next, the Commission found that petitioner "ha[d] failed to prove that his radiculopathy [was] causally related to the April 8, 1994, accident." Therefore, "treatment and attendant care for the radiculopathy [was] denied."

¶ 19 The Commission found that "Petitioner's gastrointestinal issues [were] causally related to the April 8, 1994, accident." Therefore, the Commission ordered that respondent was "liable for reasonable and necessary medical treatment associated with Petitioner's gastrointestinal issues to be managed at the direction of the central treater."

¶ 20 The Commission also ordered the payment of broadly described medical expenses and found that petitioner "did not treat outside the chain of physicians."

¶ 21 Finally, the Commission denied petitioner's request for penalties and attorney fees.

¶ 22 Both parties sought judicial review of the Commission's decision in the circuit court of Will County, which, in 2019, confirmed the Commission's decision of June 26, 2018, finding it was not against the manifest weight of the evidence. Both parties then appealed.

¶ 23 In 2020, this court found that the Commission's decision of June 26, 2018, was interlocutory and that the circuit court lacked jurisdiction to review it. Specifically, we held that the Commission's June 26, 2018, "Decision and Order on § 8(a) Petition" merely "recit[ed] respondent's statutory duty to pay reasonable and necessary medical and incidental expenses, without specifying which of petitioner's claimed expenses that respondent had to pay pursuant to that statutory duty." *Montgomery v. Illinois Workers' Compensation Comm'n*, 2020 IL App (3d) 190351WC-U, ¶ 11. Consequently, we vacated the circuit court's judgment and remanded the case to the Commission for further proceedings. *Id.* ¶ 14.

¶ 24 On December 23, 2020, the Commission issued its final decision, which was titled "Decision and Order on 8(a) Petition on Remand." In that decision, the Commission announced that the parties had reached a settlement under which respondent's payment to petitioner of $44,000 would be "the full extent of [r]espondent's liability for the unpaid balances and other expenses claimed by [p]etitioner." "Much of [p]etitioner's treatment," the Commission noted, "was paid for by either Medicare or Medicaid." In addition to paying petitioner the $44,0000, respondent was to "hold [him] harmless and pay the Medicare or Medicaid lien if asserted." The Commission adopted and incorporated into its final decision "all other facts findings and conclusions in the Order & Decision on 8(a) Petition of June 26, 2018."

¶ 25 After the Commission's decision on remand, petitioner again sought review in the circuit court. On December 7, 2021, the circuit court confirmed the Commission's decisions of June 26, 2018, and December 23, 2020, finding neither decision to be against the manifest weight of the evidence. The present appeal by petitioner is from the circuit court's judgment of December 7, 2021.

¶ 26 II. ANALYSIS

¶ 27 A. Life Care Plan

¶ 28 Petitioner contends that, by rejecting the life care plan without support from utilization review, the Commission violated section 8.7(i)(3) of the Act (820 ILCS 305/8.7(i)(3) (West 2010)). The petitioner also maintains that the Commission's rejection of the life care plan lacked any evidentiary basis, considering that several physicians, including Dr. Kelly and Dr. Stanton-Hicks, had generally approved of the life care plan. According to petitioner, then, the life care plan "should be implemented by this Court by its order immediately."

¶ 29 Petitioner also challenges, as statutorily unauthorized, the Commission's command that his future medical care be managed by a central treating physician, other than Dr. Kelly, who is affiliated with Cleveland Clinic or with an accredited, university-based medical center. According to petitioner, the Act "only contemplates that an employer will have to pay for treatment that is reasonable and necessary, not that [the employer] or the Commission can select the doctors or the classes of doctors to treat."

¶ 30 Respondent argues that, under section 8.7 of the Act, utilization review is not binding on the Commission. As respondent correctly argues, utilization review is not conclusive on that question. Rather, under section 8.7(i), "[a]n admissible utilization review shall be considered by the Commission, along with all other evidence and in the same manner as all other evidence,

and must be addressed along with all other evidence in the determination of the reasonableness and necessity of the medical bills or treatment."

¶ 31 Respondent also contends that, under section 8(a) of the Act, the Commission has authority to determine the necessity and reasonableness of future medical treatment; therefore, the Commission has authority to determine that future medical treatment is necessary and reasonable only on the condition that the future medical treatment is approved and managed by a central treating physician of a certain description, who must make bi-annual reports. We disagree.

¶ 32 The Commission has only the powers bestowed by the Act (see *Daniels v. Industrial Comm'n*, 201 Ill. 2d 160, 165 (2002)). In our *de novo* interpretation of the Act (see *Hamilton v. Industrial Comm'n*, 203 Ill. 2d 250, 254-55 (2003)), we find no provision empowering the Commission to attach conditions to its finding of whether future medical care is necessary and reasonable. If the respondent were correct, the Commission would have the powers to choose among physicians and to regulate the manner in which medical treatment is carried out. Section 8(a) cannot be plausibly interpreted as giving the Commission such powers. We agree with petitioner that the Act "contemplates decisions [by the Commission] based on treatment provided or to be provided, not on who provides it." The Commission lacked statutory authority to order the designation of a central treating physician or to disqualify Dr. Kelly from that role in favor of another physician. By commanding the designation of a central treating physician, other than Dr. Kelly, who is affiliated with Cleveland Clinic or with an accredited, university-based medical center, the Commission exceeded its statutory authority.

¶ 33 For these reasons, we reverse both (1) that portion of the Commission's decision directing that the petitioner's future care and treatment be managed by a central treating physician, other than Dr. Kelly, who is affiliated with a major medical institution and (2) that portion of the circuit court's judgment that confirmed the Commission's decision in that regard.

¶ 34 "Whether a medical expense is either reasonable or necessary is a question of fact to be resolved by the Commission ***." *Absolute Cleaning/SVMBL v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 463, 470 (2011). It was the Commission's function in this case to determine which, if any, of the future medical treatments and pharmaceuticals recommended in the life care plan were necessary and reasonable. On remand, we direct the Commission to decide whether the future medical services and pharmaceuticals itemized in the life care plan were proven to be necessary and whether the expected cost of each necessary item was proven to be reasonable. See *City of Chicago v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 258, 267 (2011).

¶ 35 B. Whether Radiculopathy Is Causally Related to the Forklift Accident

¶ 36 The petitioner argues that the Commission's finding of no causal connection between his radiculopathy and the workplace accident is against the manifest weight of the evidence. According to petitioner, the settlement contract of December 1996 indicated that the accident had caused the radiculopathy. He claims that in 1997 an osteopathic physician, Dr. Richard A. Feely, "found deficits in the cervical, thoracic[,] and lumbar spine." According to the petitioner, "Dr. Stanton-Hicks stated clearly in his report that he found there to be a causal relationship between [petitioner's] spinal condition and the CRPS."

¶ 37 The respondent asserts that the petitioner "provided no medical opinion establishing a causal relationship between his radiculopathy and his work-related accident or the condition of CRPS." Respondent disputes that Dr. Stanton-Hicks drew a causal connection between radiculopathy and the workplace accident. On this issue, we agree with the respondent.

¶ 38 Petitioner has radiculopathy in his neck and back. In a note dated September 20, 2007, Dr Kelly opined that, "The persistence of [the petitioner's] RSD in the long run is likely related to his multiple cervical, thoracic and lumbosacral polyradiculopathies. These polyradiculopathies are also related to his original injury with the forklift." However, Dr. Stanton-Hicks was more ambivalent on the question of a causal relationship between the radiculopathy and the workplace injury. He wrote in his report:

> "[T]he C5-C6 radiculopathy *** may have a relationship to the patient's right upper extremity and chronic course of CRPS. The chronicity of the upper extremity CRPS may well influence the musculoskeletal stability of the cervical spine that was described by [Dr. Kelly]. *** However the chronic C5-C6 radiculopathy is diagnosed by the EMG report, 07/12/2007, the causation of which at this juncture is difficult to assign.
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> ***
>
> I do not believe that the L5-S1 radiculopathy has anything to do with the patient's CRPS but again may have resulted from the patient's general deconditioning."

¶ 39 Whether a causal relationship exists between a petitioner's employment and his work-related injury is a question of fact to be resolved by the Commission. The Commission's resolution of the issue will not be disturbed on review unless it is against the manifest weight of the evidence. *Certi-Serve, Inc. v. Industrial Comm'n*, 101 Ill. 2d 236, 244 (1984). For the Commission's resolution of a fact question to be contrary to the manifest weight of the evidence, an opposite conclusion must be clearly apparent. *Tolbert v. Illinois Workers' Compensation Comm'n*, 2014 IL App (4th) 130523WC, ¶ 39. Whether a reviewing court might reach the same conclusion is not the test of whether the Commission's determination of a question of fact is supported by the manifest weight of the evidence. Rather, the appropriate test is whether there is sufficient evidence in the record to support the Commission's determination. *Benson v. Industrial Comm'n*, 91 Ill. 2d 445, 450 (1982). For the Commission's resolution of a fact question to be contrary to the manifest weight of the evidence, an opposite conclusion must be clearly apparent. *Tolbert*, 2014 IL App (4th) 130523WC, ¶ 39.

¶ 40 It was the function of the Commission to resolve conflicts in the evidence, including medical testimony; assess the credibility of the witnesses; assign weight to the evidence; and draw reasonable inferences from the evidence. *ABF Freight System v. Illinois Workers' Compensation Comm'n*, 2015 IL App (1st) 141306WC, ¶ 19. In this case, according to Dr. Stanton-Hicks, the petitioner's L5-S1radiculopathy has nothing to do with his CRPS, and the causation of his C5-C6 radiculopathy is difficult to assign. If believed by the Commission, as it evidently was, that opinion is sufficient to support the Commission's finding that the petitioner failed to prove a causal connection between his radiculopathy and his work-related accident and to support its denial of an award of expenses associated with that condition.

¶ 41 C. The Denial of Penalties and Attorney Fees

¶ 42 Petitioner contends that respondent willfully and vexatiously failed to pay medical bills and that the Commission, therefore, should have awarded penalties and attorney fees pursuant to sections 16 and 19(k) of the Act. Petitioner complains that respondent "reviewed all bills going back over [10] years to claim an overpayment based on a Medicare[-]based system not specifically authorized by [s]ection 8 of the Act." He quotes admissions by Moncrief that respondent had failed to pay certain expenses.

¶ 43 Respondent disagrees that its refusals to pay were in bad faith. Petitioner had been undergoing medical treatment for decades at respondent's expense, "jumping from provider to provider," as respondent puts it. With each change of physician, "treatment returned to square one." Several physicians had criticized the opioid prescriptions. Respondent also notes that the petitioner agreed to accept $44,000 in settlement of the controversy over past medical expenses, leaving only future medical expenses in dispute. This settlement, respondent argues, rendered moot the petition for penalties and attorney fees.

¶ 44 We agree that, in their second settlement agreement, the parties resolved their dispute over past medical expenses and all forms of liability therefor. In its decision on remand, the Commission announced that, in return for respondent's payment of $44,000 to petitioner and his attorney, the parties had "resolve[d] all issues and disputes as to the unpaid balance and other expenses [p]etitioner claimed." The Commission continued, "The agreement reached between the parties is the full extent of [r]espondent's liability for the unpaid balances and other expenses claimed by [p]etitioner. Petitioner, in turn, waives any and all claims for outstanding medical expenses and other expenses incurred by [p]etitioner through June 14, 2017."

¶ 45 The Commission could have reasonably concluded that (1) penalties and attorney fees pursuant to sections 16 and 19(k) would have been forms of "liability for the unpaid balances and other expenses claimed by [p]etitioner" and (2) by the settlement terms the Commission recited in its final decision, $44,000 was "the full extent of" such "liability." It would not have been arbitrary or unreasonable of the Commission to regard claims for penalties and attorney fees as waived by the parties' second settlement agreement. See *Material v. Illinois Workers' Compensation Comm'n*, 2021 IL App (2d) 200413WC-U, ¶ 67 (explaining that "[a]n abuse of discretion occurs when the Commission's ruling is arbitrary, fanciful, unreasonable, or where no reasonable person would take the view adopted by the Commission"). Therefore, the Commission did not abuse its discretion by denying petitioner's motion for penalties and attorney fees under sections 16 and 19(k). See *McMahan v. Industrial Comm'n*, 183 Ill. 2d 499, 516 (1988); *Prairie Material*, 2021 IL App (2d) 200413WC-U, ¶ 67.

¶ 46 III. CONCLUSION

¶ 47 For the foregoing reasons, we reverse those portions of the circuit court's judgment that confirmed the Commission's refusal to consider the life care plan as premature and the Commission's direction that the future care and treatment of the petitioner shall be managed by a central treating physician, other than Dr. Kelly, who is affiliated with a major medical institution. We further (1) affirm the circuit court in all other respects, (2) reverse those portions of the Commission's decision refusing to consider the life care plan as premature and its direction that the future care and treatment of the petitioner shall be managed by a central treating physician, other than Dr. Kelly, who is affiliated with a major medical institution, and

(3) remand this cause to the Commission with directions to determine whether the proposed prospective medical services and pharmaceuticals itemized in the life care plan are necessary and whether their projected costs are reasonable and to enter an order for prospective medical care and/or pharmaceuticals, if any, in accordance with those findings.

¶ 48 Circuit court judgment affirmed in part and reversed in part.

¶ 49 Commission decision reversed in part; cause remanded with directions.