2013 IL App (5th) 120182WC-U

NO. 5-12-0182WC

IN THE

APPELLATE COURT OF ILLINOIS

FIFTH DISTRICT

WORKERS' COMPENSATION COMMISSION DIVISION

KATARZYNA RADECKA, Appellant, v. THE ILLINOIS WORKERS' COMPENSATION COMMISSION *et al.* (Tara Therapy, L.L.C., Appellee).	)	Appeal from the Circuit Court of Madison County. No. 11-MR-198 Honorable Barbara L. Crowder, 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's condition of ill-being did not arise out of or in the course of her employment and was not causally related to a work accident was not against the manifest weight of the evidence where the claimant suffered from neck and back pain for years before the accident, she never mentioned to three treating physicians that her pain was work-related, and there was conflicting medical evidence.

¶ 2 The claimant, Katarzyna Radecka, filed an application for adjustment of claim against her employer, Tara Therapy, L.L.C., seeking workers' compensation benefits for cervical and lumbar injuries allegedly resulting from repetitive trauma and an accident she sustained on July 23, 2009, while assisting with a patient transfer. The claim proceeded to an expedited arbitration hearing under the Workers' Compensation Act (the Act) (820 ILCS 305/1 to 30 (West 2008)). The arbitrator found that the claimant did not sustain an accident that arose out of and in the course of her employment, that her condition of ill-being was not causally

related to a work accident, and that she did not give timely notice of her accident to the employer.

¶ 3 The claimant appealed to the Illinois Workers' Compensation Commission (Commission), which affirmed and adopted the decision of the arbitrator. She filed a timely petition for review in the circuit court of Madison County. The circuit court confirmed the Commission's decision, and the claimant appealed.

¶ 4 BACKGROUND

¶ 5 The claimant testified that she began working as a physical therapist in 1993. She stated that she first started working for the employer on March 1, 2006, as the director of rehabilitation. Her workload was split between delivering patient care and management duties. In January 2009, she stepped down to work as a full-time staff therapist. The claimant testified that as a staff physical therapist she worked with 10 to 15 patients per day and that 85% of her work day was spent on direct patient care. Her job entailed helping patients move from one surface to another, assisting them with physical therapy, and gait-belt walking or pushing patients in a wheelchair from the nursing facility to the therapy room. The claimant testified that she also performed home assessments of patients returning to their homes.

¶ 6 The claimant admitted that as far back as 2004 she was having some neck and lower back pain. She stated that in January 2009, she was not seeing any doctors for neck or low back complaints.

¶ 7 The claimant testified that in November 2008 she purchased a horse. In the spring of 2009 she began riding. She stated that she rode the horse a couple of times per week. Also in 2008, she started doing Pilates, an exercise program. She testified that she continued to do Pilates consistently from 2008 until the date of the arbitration hearing.

¶ 8 The claimant testified that in 2009, after she started working for the employer as a

full-time therapist, she noticed that her neck was sore to the point that she started to limit her range of motion and throughout the night her left arm would go completely numb. Prior to 2009, she stated that she would wake up with discomfort in her neck primarily on the left side and sometimes with lower back pain, but she attributed it to sleeping patterns. She claimed that prior to 2009 she did not have any radicular pain in her arms and she did not have pain in her neck or low back that prevented her from engaging in any sort of activity.

¶ 9 The claimant testified that the first doctor she went to see about her neck and low back complaints was Dr. Bijoy Hegde. In Dr. Hegde's patient notes dated July 7, 2009, he wrote that the claimant came to him complaining of severe neck pain that radiated to her upper extremity causing numbness and tingling, and low back pain that radiated to the right lower extremity. He advised her to have a magnetic resonance imaging (MRI) scan. There is nothing in Dr. Hegde's patient notes about a work accident or that the claimant's work activities had caused her pain.

¶ 10 The claimant testified that on July 23, 2009, while helping a certified nursing assistant (CNA) with a patient transfer, she felt her neck and low back pop. She continued working the rest of the day.

¶ 11 On July 24, 2009, the claimant had an MRI scan of her cervical spine. The claimant testified that the MRI scan was scheduled by Dr. Hegde prior to the July 23, 2009, accident. Dr. Albert Hammerman read the MRI scan and concluded that the claimant had a very small central posterior disc herniation at the C4-C5 level, a small to moderate sized broad-based left posterior disc herniation at the C5-C6 level which mildly impressed upon the adjacent cervical cord, and a small to moderate broad-based left posterolateral disc herniation at the C6-C7 level which resulted in moderate to marked narrowing of the left C6-C7 nerve root foramina. The claimant also had an MRI scan of the lumbar spine. Dr. Hammerman found that there was disc dessication and diffuse disc bulging at the L4-L5 level associated with

mild to moderate bilateral foraminal narrowing at that level.

¶ 12 Michael L. Mertens testified that he worked for the employer as the director of rehabilitation. He stated that when therapists were injured they were supposed to report the injury to him and he would compile a form to submit to the regional director. He stated that the claimant was familiar with the procedure for reporting an accident because she had worked as director herself. He testified that the claimant never reported a work accident of any kind to him. He did not learn of her accident until April 2010 when the claimant filed the application for adjustment of claim.

¶ 13 The claimant testified that on August 3, 2009, she telephoned Mr. Mertens, while on the way to the emergency room, to tell him she might not be able to return to work that day. Missouri Baptist Medical Center emergency room records show that the claimant came to the hospital complaining of headache, dizziness, some chest pain, shoulder pain to elbow, and stiff jaw. In the history of the present illness Dr. Timothy Kella, her treating doctor, wrote that the claimant told him that four days before she was lifting a heavy medical chart and felt a severe and sudden increase in neck pain associated with an unusual tingling-type diffuse headache as well as some transient dizziness. She stated she had suffered from similar headaches and dizziness intermittently since the initial episode. Dr. Kella diagnosed the claimant with acute cervical disk disease with a secondary diagnosis of headache and dizziness. The claimant was discharged to go home.

¶ 14 The claimant testified that she requested and received one week off work pursuant to the Family and Medical Leave Act. She stated that when she returned to work after the first week of absence she went to Mr. Mertens and expressed her concern about assisting residents with toilet transfers.

¶ 15 On August 11, 2009, the claimant went to Dr. Hegde for treatment for bulging discs at C4-C5 and C6-C7. He noted that she had been having physical therapy which had helped.

He advised her to continue with therapy.

¶ 16 The claimant testified that in August 2009 there was a change in her workload and she was required to spend 95% of her time performing direct patient care. She stated that throughout August her neck pain worsened and progressed to the point where she could no longer perform her work duties. She testified that on September 1, 2009, she went to Mr. Mertens and told him, "I just don't think I can do what I'm here for and I'd like to go back and see a doctor." She stated that was her last day of work.

¶ 17 On September 1, 2009, the claimant went to Dr. Hegde complaining of severe pain radiating to her shoulder and preventing her from working. He noted that he was unable to perform the exam because of the claimant's severe pain. He recommended the claimant see neurosurgeon Dr. Kennedy. Dr. Hegde advised the claimant not to work at that time.

¶ 18 On September 10, 2009, the claimant saw Dr. Kennedy. In his office notes he wrote that the claimant had been experiencing pain at the base of her cervical spine with radiating pain into the left arm and interscapular area. He diagnosed her with cervical radiculopathy and lumbar pain due to spondylosis. There was no mention of the claimant's work activities or of a work accident.

¶ 19 Dr. Hegde examined the claimant on September 15, 2009, for neck pain and headache. He wrote in his office notes that he recommended epidural injections, but she said "she [was] scared to have an injection." He advised her to continue therapy. He examined her for the final time on October 13, 2009.

¶ 20 On September 17, 2009, the claimant had a computed tomography (CT) cervical spine scan. Dr. Christine Osmon wrote that at C4-C5 there was a small central shallow disc protrusion, and at C5-C6 there was disc space narrowing, a central protusion, and end plate spurring. There was also bilateral uncovertebral degeneration, mild midline canal stenosis, and minor neuroforaminal narrowing bilaterally. At C6-C7 Dr. Osmon noted prominent

broad-based left disc and end plate spur complex also involving the left uncovertebral joints which were asymmetrically degenerated and hypertrophied. There was severe left neuroforaminal narrowing and mild to moderate canal stenosis.

¶ 21 Mr. Mertens testified that in the middle of September 2009, he received notice that the claimant had seen Dr. Hegde "about what could have been causing her neck and back pain including some hereditary issues that she mentioned, her mom had similar pain in the past and that that was probably what contributed most to this injury."

¶ 22 Dr. Elizabeth Carazo testified by evidence deposition. She stated that she specializes in internal medicine, but that she is not board certified. The claimant testified that Dr. Carazo was her primary care physician. She stated that she first met Dr. Carazo when they both worked for the employer. She stated that she became Dr. Carazo's patient when she left the nursing home to become a part of another medical practice.

¶ 23 Dr. Carazo testified that she first treated the claimant on October 13, 2009. The claimant complained of neck pain, left arm pain with numbness and weakness, and low back pain. She did not indicate that her problems were the result of any sort of trauma. Dr. Carazo ordered nerve conduction studies to rule out neuropathy. The studies were done on October 19, 2009, and showed no radiculopathy.

¶ 24 Dr. Carazo testified that she saw the claimant again on October 15, 2009. She prescribed pain medication, muscle relaxants, and physical therapy. Dr. Carazo recommended the claimant go to Dr. Feinberg for injections. She also ordered diagnostic testing of the claimant's left arm.

¶ 25 On referral from Dr. Carazo, the claimant had an electromyography on October 19, 2009. The electromyographer physician who wrote the report concluded that the study was within normal limits and did not provide electrodiagnostic abnormalities to support median/ulnar neuropathy or cervical radiculopathy.

¶ 26 Dr. Kennedy examined the claimant on October 21, 2009. He noted that the claimant continued to have considerable pain in the base of her cervical spine and left arm. He referred her to Dr. Heidi Prather, at her request, to pursue nonoperative pain management. He noted that he was not sure her problems would respond to conservative measures but felt it was worth trying due to her reluctance to proceed with operative intervention.

¶ 27 On November 18, 2009, the claimant was examined by Dr. Kennedy. He wrote in his patient notes that she had a considerable amount of pain at the base of her cervical spine and intermittently into the left arm. She also had pain in the lower lumbar area and tightness into the psoas muscle on the left side. He noted she was being treated by Dr. Feinberg. He opined that she might benefit from injections.

¶ 28 Dr. Rachel Feinberg gave the claimant injections on December 2, December 7, and December 16, 2009, and on January 16 and January 20, 2010.

¶ 29 Dr. Prather, an associate professor and chief of section of physical medicine and rehabilitation with Washington University Orthopedics, examined the claimant on December 10, 2009. On a form completed by the claimant she wrote that her neck and low back pain had been present for the "past few years." She also wrote "not sure" if "this problem start[ed] at work?" In her office notes Dr. Prather wrote that the claimant's chief complaint was neck pain with left-sided arm pain and numbness, and low back pain. She wrote that the claimant presented with a five-plus year history of neck pain with left-sided radiating symptoms as well as low back pain. She wrote that the patient's symptoms increased after she increased her activity as a physical therapist and had worsened since July 2009. Dr. Prather diagnosed the claimant with low back pain, intermittent, L4 versus L3 radicular pain, and neck pain, periscapular pain with known disc protrusion at C4-C5, C5-C6, and C6-C7.

¶ 30 Dr. Kennedy examined the claimant again on January 19 and March 2, 2010. Because her symptoms had not resolved despite her treatment with Dr. Feinberg, he set her up with

a lumbar myelogram to assess her condition further.

¶ 31 On March 5, 2010, the claimant had a computed radiography (CR) exam of the lumbar spine. It revealed mild degenerative changes involving the sacroiliac joints and the facets at L5-S1 and mild levoconvexed scoliosis. On the same day she had a lumbar myelography. It revealed mild levoconvexed scoliosis and no segmental instability or root sleeve filling abnormality. She also had a CT scan of the lumbar spine. It revealed mild levoconvexed scoliosis, mild degenerative changes involving facets in the lower lumbar spine, and a mild broad-based bulging disc lateralized somewhat to the left at L4-L5.

¶ 32 The claimant testified that she did not realize that her condition was work-related until March 2010. At that time she was talking to an attorney acquaintance about her condition and was advised she may have a workers' compensation claim.

¶ 33 Dr. Brett Taylor, a board-certified orthopedic surgeon, testified by evidence deposition. He stated that he deals exclusively with patients with spine issues. He testified that, at the request of the claimant's attorney, he performed an independent medical evaluation of the claimant on June 23, 2010. He testified that the claimant completed a questionnaire and wrote that her pain or problem had been present for several years. In his report he wrote that the claimant told him that on July 23, 2009, she was helping a CNA with a patient transfer and experienced a marked increase in her symptoms. The claimant tried to work through the pain, but it culminated in severe pain requiring an emergency room visit in August.

¶ 34 In his report Dr. Taylor opined that the claimant had signs and symptoms consistent with cervical disc herniation, cervical radiculopathy, and cervicogenic neck pain, and evidence of lumbar discogenic back pain with mild lumbar radiculopathy. Dr. Taylor testified that based on his examination of her he found that she possibly had neurologic dysfunction that would affect sensation from the nerves coming from the cervical spine at

the C6 nerve root and the C7 nerve root. He testified that he was concerned that the claimant had both cervical pathology in the C5-C6 and C6-C7 level in the form of disc herniations, as well as lumbar pathology, which was consistent with radicular symptoms, and he was concerned with both the L4-L5 and the L5-S1 level. He stated that there was no evidence of nonorganic displays of pain or symptoms.

¶ 35 Dr. Taylor testified that he told the claimant that in his practice a treatment protocol would include exhausting nonoperative treatments before considering surgery as an absolute last resort. He stated that if she went through a nonoperative course then she would be at maximum medical improvement from nonoperative treatment. He stated that she was potentially a candidate for surgery.

¶ 36 Dr. Taylor averred that, to a reasonable degree of medical certainty, the claimant's job activities could aggravate her condition and that it was possible that they could aggravate them to a point where she would be incapable of performing the usual and customary functions of her employment. In his report he wrote that the claimant was currently totally disabled from her usual employment and that her "work related exposure/event ha[d] aggravated her condition causing her to become symptomatic." He noted that this applied to both her cervical and lumbar spine.

¶ 37 Dr. Carazo testified that she examined the claimant on March 2, 2010, and felt that she could return to work with restrictions. She stated that the claimant would not be able to perform her usual and customary job duties as a physical therapist with these restrictions. Dr. Carazo testified that she treats the claimant about once per month to manage her pain medication.

¶ 38 Dr. Carazo testified that the claimant's job possibly caused or contributed to the degenerative disc disease in her cervical spine and could have aggravated any degenerative disc disease that existed in her cervical spine. She testified that to a reasonable degree of

medical certainty, the claimant's work activities as a physical therapist over the last five or more years could have caused or aggravated the degenerative disc disease and the herniated disc in her lumbar spine. She concluded that the stenosis and the multiple herniated discs were either caused or aggravated by the claimant's employment to the point that she required medical care. She stated that her work activities had caused the claimant to be temporarily totally disabled from the first time she examined the claimant in October 2009 to the present. Dr. Carazo testified that she could not state to a reasonable degree of medical certainty what caused the degenerative disc disease in the claimant's neck or low back or the spinal stenosis in her neck or low back.

¶ 39 Dr. Carazo testified that the claimant's patient records did not reflect that the claimant stated her work activities caused her neck or back pain. She stated that the claimant told her that the work activities aggravated her condition. Dr. Carazo stated that she was familiar with the claimant's job duties because she used to work for the employer and she witnessed the claimant performing her job.

¶ 40 On November 9, 2010, Dr. Robert Bernardi performed an independent medical evaluation of the claimant at the employer's request. In the patient history, Dr. Bernardi wrote that the claimant told him she injured her neck and low back while working as a staff physical therapist for the employer. She told him she had been off work since September 2009 and had not done any other work since then. She reported to Dr. Bernardi that in the spring of 2009, she was not sleeping well, had problems with nocturnal left arm numbness, and suffered from low back and neck pain. She then began to notice that when she walked patients with a gait belt and wheelchair her left arm would go numb. She told Dr. Bernardi that she walked patients through a heavy therapy door 20 to 30 times per day and pushing the door and holding it to let patients through caused shoulder discomfort. She told Dr. Bernardi that she reported this to her supervisor. The claimant described an incident on July

23, 2009, where she helped a CNA transfer a patient and experienced an immediate onset of severe left-sided neck pain. The next day she had an MRI scan which had already been scheduled. It showed three herniated disks. She saw her physiatrist who prescribed physical therapy. The claimant told Dr. Bernardi that on July 30, 2009, she had a flare-up of symptoms after picking up a heavy chart at work. She had neck pain and dizziness. She stated that on August 3, 2009, she went to the emergency room after waking up and being unable to open her jaw, involuntarily biting her tongue, and experiencing dizziness and diffuse tingling.

¶ 41 The claimant complained of low back and neck pain. Dr. Bernardi reviewed the claimant's medical records.

¶ 42 Dr. Bernardi diagnosed the claimant with C5-C6 and C6-C7 degenerative disc disease, degenerative left C7 foraminal stenosis, neck pain and nonradicular left arm pain of uncertain etiology, L4-L5 degenerative disc disease, and low back pain of uncertain etiology. He noted that she did not have cervical radiculopathy and that the foraminal stenosis seen at C6-C7 on her MRI scan and CT scan were not symptomatic. He felt that the degenerative disc disease in her neck did not contribute to her symptoms. He opined that her symptoms were most consistent with myofascial pain involving her rhomboid and trapezius muscles. He averred that there is no modern medical literature to support the notion that occupational/recreational activities, whether repetitive or not, significantly contributed to the development of degenerative disc disease. He stated that the progression of spondylosis appears to be primarily determined by genetic factors.

¶ 43 Dr. Bernardi opined that the claimant's medical records did not support a causal relationship between her neck/low back complaints and her employment. He went on to state, "Were it not for the independent medical evaluation of Dr. Taylor's on 6/23/10, nearly a year after the alleged event, it is difficult for me to believe that a reasonable person could

review this record and conclude that [the claimant's] neck and/or low back symptoms were in anyway related to her work activities." He stated that the job history the claimant provided him with was not sufficient to establish a causal relationship between her lower back complaints and her work activities. She informed him that between January 2009 and July 2009, she started noticing back pain when she squatted down in front of patients' wheelchairs. He stated that he found it difficult to conclude that this caused her pain "in light of the fact that the medical records suggests she participates in Pilates on a regular basis and rides horses. These activities unquestionably place more stress and strain on the low back than squatting in front of a wheelchair." He went on to state that if the claimant's soft-tissue pain was the result of repetitive work activities, she should have recovered because soft-tissue injuries heal within four to six weeks and she had not worked in more than a year.

¶ 44 Dr. Bernardi stated that the accident on July 23, 2009, is consistent with the type of event that could produce a cervical sprain/strain or even a cervical disk herniation. He stated that he could not conclude that her current symptoms were causally related to that event because she had neck symptoms prior to that accident and may have been having neck pain and left arm numbness for some years. He noted that her MRI and CT scans showed degenerative changes, not a disc herniation or other findings that could legitimately be considered posttraumatic. He found that her symptoms were not consistent with cervical radiculopathy. Finally he opined that if the July accident had produced a cervical sprain/strain, it would have recovered by that point. He concluded that the claimant's neck symptoms were not causally related to the July 23, 2009, accident she described to him.

¶ 45 Dr. Bernardi noted that the claimant's neck and low back pain had not responded to time, activity modifications, medications, physical therapy, or multiple injections. He opined that she did not have an abnormality in either her cervical or lumbar spine that would be amenable to surgical intervention. He further averred that she did not need any additional

treatment to either her neck or low back. He stated that he believed she was at maximum medical improvement. He stated that he could not fully explain all of the claimant's complaints. He did not believe she was consciously magnifying her symptoms or malingering. He felt she did not fully understand the relatively benign nature of her condition. He stated that he felt a degree of anxiety was contributing to her ongoing complaints. Dr. Bernardi concluded that ongoing medical/surgical intervention for the claimant's neck and low back symptoms would be counterproductive and would perpetuate her sense of illness and disability.

¶ 46 The claimant testified that since she stopped working for the employer, she made 47 contacts looking for a job as a personal assistant, babysitter, or in retail. At the time of the arbitration hearing she had recently found a marketing job at Insite Architect Consulting.

¶ 47 The arbitrator found that the claimant failed to prove that she sustained an accident that arose out of and in the course of her employment and failed to prove that her condition of ill-being was causally related to her work activities. He found that her testimony was inconsistent with the medical records and that the medical opinion of Dr. Bernardi was more persuasive than those of Dr. Taylor and Dr. Carazo. He further found that she did not give timely notice of an accident to the employer. He found that she testified she knew her work was causing her condition of ill-being in 2009, she had significant training in physical therapy, and yet she did not report any work injury to the employer until she filed her application for adjustment of claim on April 12, 2010.

¶ 48 The claimant sought review of the arbitrator's decision. The Commission affirmed and adopted the arbitrator's decision. The claimant appealed the Commission's decision to the circuit court. The circuit court confirmed the Commission. The claimant filed a timely notice of appeal.

¶ 49 ANALYSIS

¶ 50 The claimant argues that the Commission's determination that her condition of ill-being did not arise out of and in the course of her employment and was not causally related to a work accident is against the manifest weight of the evidence.

¶ 51 To obtain compensation under the Act, a claimant must show by a preponderance of the evidence that she has suffered a disabling injury arising out of and in the course of her employment. *Land & Lakes Company v. Industrial Comm'n*, 359 Ill. App. 3d 582, 591, 834 N.E.2d 583, 591-92 (2005). "The 'arising out of' component addresses the causal connection between a work-related injury and the claimant's condition of ill-being." *Id.* at 592, 834 N.E.2d at 592. To establish causation under the Act, a claimant must prove that some act or phase of her employment was a causative factor in her ensuing injury. *Id*.

¶ 52 Whether a causal connection exists between a claimant's condition of ill-being and her employment is an issue of fact to be decided by the Commission, and the Commission's resolution of the issue will not be disturbed on review unless it is against the manifest weight of the evidence. *Tower Automotive v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 427, 434, 943 N.E.2d 153, 160 (2011). "A reviewing court will not reweigh the evidence, or reject reasonable inferences drawn from it by the Commission, simply because other reasonable inferences could have been drawn." *Durand v. Industrial Comm'n*, 224 Ill. 2d 53, 64, 862 N.E.2d 918, 924 (2006). The Commission's decision is not against the manifest weight of the evidence when there is sufficient evidence in the record to support the Commission's determination. *R&D Thiel v. Illinois Workers' Compensation Comm'n*, 398 Ill. App. 3d 858, 866, 923 N.E.2d 870, 877 (2010).

¶ 53 "In resolving questions of fact, it is within the province of the Commission to assess the credibility of witnesses, resolve conflicts in evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." *Hosteny v. Illinois Workers'*

Compensation Comm'n, 397 Ill. App. 3d 665, 674, 928 N.E.2d 474, 482 (2009). It is the Commission's function to resolve conflicting evidence, including medical evidence. *Edward Hines Precision Components v. Industrial Comm'n*, 356 Ill. App. 3d 186, 196, 825 N.E.2d 773, 782 (2005). "Interpretation of medical testimony is particularly within the province of the Commission." *Freeman United Coal Mining Co. v. Illinois Workers' Compensation Comm'n*, 386 Ill. App. 3d 779, 783, 901 N.E.2d 906, 910 (2008).

¶ 54 Reviewing the record under these standards, we cannot conclude that the Commission's finding with respect to causation is against the manifest weight of the evidence.

¶ 55 On her application for adjustment of claim the claimant alleged that she suffered a work accident on July 23, 2009, and also alleged that she suffered from a repetitive trauma injury. The claimant testified that on July 23, 2009, she was helping a CNA with a patient transfer and felt her neck and low back pop. She did not report this to Mr. Mertens in accordance with the employer's accident procedures. Mr. Mertens testified that the claimant was familiar with the procedure because dealing with accident reports was part of the job of the director of rehabilitation and the claimant had performed that job.

¶ 56 The claimant had an MRI on July 24, 2009. However, that was scheduled on July 7, 2009, prior to the July 23, 2009, accident, when the claimant went to see Dr. Hegde complaining of neck and low back pain. When the claimant went to the emergency room on August 3, 2009, she did not report the July 23, 2009, incident to the treating physician, but instead told him she hurt herself lifting a heavy medical chart. There is no mention of a July 23, 2009, accident in the patient notes of any of the claimant's treating physicians. The first time the July 23, 2009, accident appears in any medical records is in the independent medical evaluations performed by Dr. Taylor and Dr. Bernardi. Dr. Taylor examined the claimant 11 months after the July 23, 2009, accident, and Dr. Bernardi examined her more than one

year after the accident.

¶ 57 The Commission found that the claimant did not sustain an accident that arose out of and in the course of her employment. The claimant did not report the July 23, 2009, accident to her supervisor or any of her treating physicians. It was not until an attorney acquaintance suggested she may have a workers' compensation claim that she first reported the accident to Dr. Taylor, who was performing an independent medical evaluation at the request of her attorney. It was not against the manifest weight of the evidence for the Commission to conclude that the claimant did not sustain an accident that arose out of and in the course of her employment on July 23, 2009.

¶ 58 The claimant argues that she suffered a repetitive trauma injury. "An employee who alleges injury from repetitive trauma must still meet the same standard of proof as other claimants alleging accidental injury." *Edward Hines Precision Components*, 356 Ill. App. 3d at 194, 825 N.E.2d at 780. The employee must show that the injury is work-related and not the result of a normal degenerative aging process. *Id*.

¶ 59 In the instant case, the claimant testified that she experienced neck and back pain as far back as 2004. When the claimant first saw Dr. Prather she completed a patient questionnaire on December 10, 2009, and wrote that her neck and low back pain had been present for the "past few years" and that she was "not sure" if "this problem start[ed] at work." Dr. Prather wrote in her office notes that the claimant presented with a five-plus year history of neck pain with left-sided radiating symptoms as well as low back pain. Dr. Taylor testified that the claimant wrote on a patient questionnaire that her pain had been present for several years. There is sufficient evidence in the record to conclude that the claimant suffered from neck and back problems prior to working for the employer.

¶ 60 Dr. Carazo admitted that the claimant's patient records do not indicate that she stated her work activities were causing her neck or back pain or that she reported any trauma to

these areas. Dr. Carazo testified that while it was not in her records, the claimant told her that the work activities aggravated her condition. Dr. Carazo testified that the claimant's job may have caused or contributed to her degenerative disc disease in her cervical spine and could have aggravated any degenerative disc disease in her cervical spine. She further testified that the claimant's work activities as a physical therapist could have caused or aggravated the degenerative disc disease and herniated disc in her lumbar spine.

¶ 61 Dr. Taylor testified that, to a reasonable degree of medical certainty, the claimant's job activities could aggravate her condition and that her work-related exposure had aggravated her condition, causing her to become symptomatic.

¶ 62 Dr. Bernardi testified that the claimant's MRI and CT scans showed degenerative changes, not a disc herniation or other findings that could be considered posttraumatic. Dr. Bernardi diagnosed the claimant with degenerative disc disease. He went on to state that there is no modern medical literature to support the finding that activity, repetitive or not, significantly contributes to the development of degenerative disc disease. He stated that the progression of spondylosis is primarily determined by genetic factors. He opined that her medical records did not support a causal relationship between her neck and low back complaints and her employment. He noted that her Pilates and horseback riding place more stress and strain on her low back than the job-related activities that she told him caused her pain.

¶ 63 Mr. Mertens testified that the claimant told him in September 2009 that she had hereditary issues that could have been causing her neck and back pain and that her mother suffered from similar pain.

¶ 64 The Commission found that the claimant's testimony was inconsistent with her medical records. It further found that the medical testimony of Dr. Bernardi was more persuasive than that of Dr. Taylor and Dr. Carazo. As the trier of fact, the Commission

resolved the issues of whether a causal relationship existed between the claimant's condition of ill-being and her July 23, 2009, accident and whether her condition was the result of repetitive trauma against the claimant. There was evidence that the claimant suffered from neck and back pain for years before the July 23, 2009, accident. She never reported the July 23, 2009, accident to her treating physicians or Mr. Mertens. She saw Dr. Hegde on July 7, 2009, and scheduled an MRI scan prior to her July 23, 2009, accident. The claimant never mentioned to Dr. Hegde, Dr. Kennedy, or Dr. Feinberg that her condition was related to her work activities. Conflicting medical evidence was presented. Dr. Taylor and Dr. Carazo opined that her condition of ill-being was causally related to her employment, and Dr. Bernardi averred that it was not. The Commission assessed the credibility of the witnesses, resolved conflicts in the evidence, assigned weight to be accorded the evidence, drew reasonable inferences from the evidence, and found in favor of the employer. We cannot say based on the record before us that the Commission's decision is contrary to the manifest weight of the evidence. Because the Commission's decision was not against the manifest weight of the evidence, we do not need to address the claimant's arguments that she reported her injury in a timely fashion, that her injury prevented her from returning to work as a physical therapist, and that she proved she was entitled to a wage differential.

¶ 65 CONCLUSION

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

¶ 67 Affirmed.