2011 IL App (4th) 100986WC-U
No. 4-10-0986WC
Order filed October 3, 2011

IN THE

APPELLATE COURT OF ILLINOIS

FOURTH DISTRICT

WORKERS' COMPENSATION COMMISSION DIVISION

BRETT KOHL,	)	Appeal from the Circuit Court
	)	of Sangamon County.
Appellant,	)	
	)	
v.	)	No. 10-MR-220
	)	
ILLINOIS WORKERS' COMPENSATION	)	
COMMISSION, *et al*.,	)	Honorable
	)	John W. Belz,
(Harold O'Shea Builders, Appellee).	)	Judge, Presiding

JUSTICE HUDSON delivered the judgment of the court.

Presiding Justice McCullough and Justices Hoffman, Holdridge, and Stewart concurred in the judgment.

ORDER

Held: (1) Commission's finding that claimant's back condition was not causally related to his accident at work is not against the manifest weight of the evidence where medical evidence was conflicting and there was evidence presented at the arbitration hearing supporting the Commission's factual findings; and (2) given Commission's finding that claimant's back condition was not related to the accident at work, its finding that that claimant's need for back surgery was not causally related to his industrial accident is also not against the manifest weight of the evidence.

¶ 1 Claimant, Brett Kohl, filed an application for adjustment of claim pursuant to the Workers'

Compensation Act (Act) (820 ILCS 305/1 *et seq*. (West 2006)) seeking benefits from respondent, Harold O'Shea Builders, following an accident at work on July 13, 2007. Following a hearing held pursuant to section 19(b) of the Act (820 ILCS 305/19(b) (West 2006)), the arbitrator found that the accident of July 13, 2007, aggravated claimant's preexisting lumbar degenerative disc disease and a preexisting L5-S1 disc herniation and contributed to his need for prospective back surgery. However, the Illinois Workers' Compensation Commission (Commission) concluded that claimant's lower back problems were unrelated to the accident he sustained on July 13, 2007, and therefore denied prospective treatment. The circuit court of Sangamon County confirmed the decision of the Commission. On appeal, claimant challenges the Commission's findings that his lower back problems and his need for back surgery are not connected to his industrial accident. We affirm.

¶ 2 I. BACKGROUND

¶ 3 Claimant, a journeyman carpenter, began working a construction job for respondent on or about June 12, 2007. Claimant testified that prior to working for respondent, he had his left hip replaced in 2001. Subsequent to hip-replacement surgery, and prior to the accident at issue, claimant experienced problems with his lower back and left hip. In this regard, claimant was seen by Dr. Leo Ludwig on December 11, 2006, with complaints of severe pain in his left hip radiating down his leg after performing heavy lifting at work. Upon examination, Dr. Ludwig noted that claimant was tender in the buttocks, with straight-leg raising and tension signs "markedly positive." Although an X ray of the left hip was negative, an X ray of the lumbar spine showed "significant" spondylosis and "fairly significant" encroachment of the neural foramen at L5-S1 and L4-L5. Dr. Ludwig diagnosed left hip pain and lumbar spondylosis with spondyloradiculopathy. He opined that "the

problem is in [claimant's] back," and he recommended an MRI of the lumbar spine. Dr. Ludwig stated that he would consider either an epidural steroid injection or a spine consultation depending on the results of the MRI.

¶ 4 The MRI was taken on December 28, 2006, and revealed degenerative disc disease at L2-L3, L3-L4, and L4-L5, as well as a broad-based disc bulge with a small focal herniation in the left paracentral region and moderate foraminal compromise at L5-S1. On January 11, 2007, claimant saw his primary-care physician, Dr. Wayne Manson, for a cortisone shot. At the time of the injection, Dr. Manson believed that claimant's problem was "sciatica" and he noted that Dr. Ludwig was in agreement. Dr. Manson's follow-up note, dated January 24, 2007, indicates that claimant "still has a lot [*sic*] of radicular pain, paresthesia and anestheisa going down the left leg." Dr. Manson recommended an epidural and an appointment to see "either Russell or Pineda." The epidural steroid injection relieved the pain in claimant's left leg, and he did not seek additional treatment for his lower back or left leg.

¶ 5 Claimant testified that on July 13, 2007, he was at work when he fell onto a concrete surface from a four-foot step ladder. Claimant stated that he landed on his left side and struck his head. Claimant related that when he fell, he hurt "everywhere," including his head and his back. However, as it was close to quitting time, he continued to work.

¶ 6 The following day, a Saturday, claimant was unable to get out of bed because of pain in his lower back, down his side, and into his hip and buttocks. As a result, he went to see Dr. Manson. Dr. Manson's office note records a history of "pain off and on for the past six months." Claimant told Dr. Manson that he "wants something done about his lumbar disc." Claimant also told Dr.

Manson that he "fell off a ladder yesterday and he is in a lot of pain from that." Dr. Manson described the pain as a "radicular pain down to the level of [claimant's] hip." A physical examination revealed positive straight-leg raising, and Dr. Manson was unable to find any Achilles tendon reflexes on either side. Dr. Manson administered a shot of Depo-Medrol, scheduled an MRI of claimant's lumbar spine, prescribed Darvocet, and referred claimant to Dr. Stephen Pineda. The MRI revealed (1) multi-level Schmorl's nodes; (2) L2-L3, L4-L5, and L5-S1 disc desiccation; (3) left paracentral L5-S1 disc protrusion; (4) multi-level mild central canal stenosis; and (5) bilateral neural foraminal narrowing, most marked on the right.

¶ 7 Meanwhile, on July 16, 2007, claimant was seen at Midwest Occupational Health Associates (MOHA) by advanced practice nurse Sandra Elliott. Claimant referred to MOHA as the "company doctors." Claimant told Elliott that on July 13, 2007, he fell four feet from a step ladder while at work, landing on his left side and striking his buttock and the left side of his head. Elliott noted that claimant walked with a left-sided limp and had significantly decreased forward flexion at the waist. Elliott diagnosed a left hip contusion and a head contusion. Claimant was released to regular duty since he was working with door hardware, a position that was "pretty easy."

¶ 8 Claimant returned to MOHA on July 20, 2007. At that time, claimant reported that his head was fine but that his left hip continued to bother him. Claimant stated that the hip is very stiff and painful in the morning, but improves as the day progresses, and that he is able to work his regular job without difficulty. Claimant was continued on regular work duty and instructed to follow up in a week. At the follow-up appointment, Elliott's diagnosis remained unchanged and she instructed claimant to return in one week.

¶ 9 Claimant continued to treat at MOHA, where, on August 1, 2007, he was evaluated by Dr. Gregory Clem. Dr. Clem's examination revealed normal external and internal hip rotation, but positive straight-leg raising in the seated position. In addition, Dr. Clem noted that flexion and extension of the lumbar spine "bother" claimant. Dr. Clem diagnosed "[l]eft buttock pain, rule out sciatica." Dr. Clem opined that claimant's symptoms were "neurological in nature in terms of his symptoms at this time," and he prescribed prednisone. On August 6, 2007, claimant saw Dr. Jeff Brower at MOHA. Dr. Brower noted moderate tenderness along the left upper buttock and positive straight-leg raising on the left. Dr. Brower diagnosed a left hip contusion. He allowed claimant to continue working, and, noting no benefit from the prednisone, prescribed Flexeril.

¶ 10 Claimant saw Dr. Pineda on August 13, 2007, complaining of pain in the left buttock. Claimant told Dr. Pineda that the pain had been present for six months, but was much worse after he fell off a ladder in June. Dr. Pineda described claimant's pain as "focal in that it is tender to touch just behind the greater trochanteric area." Dr. Pineda noted, however, that claimant's back was "completely non-tender, no spasms identified of his back." Dr. Pineda also noted that an MRI showed degenerative changes most notably at L5-S1 with bulging at L4-L5 and a "relatively small" disc herniation at L5-S1. The source of claimant's pain was "unclear" to Dr. Pineda "because it does not appear to be from his spine in that it appears to be focal." Dr. Pineda recommended pain management with an injection. He reiterated, however, that he did not believe that "the small herniation *** is the source of [claimant's] pain, especially given that the pain is focal and palpable." Because claimant's pain complaints did not correlate with the MRI results, Dr. Pineda also ordered a bone scan. The bone scan revealed no evidence of fracture or loosening of the left

hip prosthesis. On August 14, 2007, claimant followed up with Dr. Pineda. At that time, claimant continued to complain of pain in the buttock area. Dr. Pineda noted that claimant's bone scan was normal. Claimant was instructed to return on an as-needed basis and referred to Dr. Koteswara Narla for pain management.

¶ 11 On August 16, 2007, claimant saw advanced practice nurse Jennifer Frank at MOHA. Claimant indicated that he was not doing any better. He described discomfort over the left hip area, but denied any back pain or problems. Examination revealed an antalgic gait. However, claimant would not allow Frank to perform a straight-leg raise on the left side in a sitting position. Claimant was continued on regular duty and instructed to return after his appointment with Dr. Narla.

¶ 12 On August 21, 2007, claimant followed up with Dr. Manson. At that time, claimant reported that he was still having a lot of pain in his left hip area. Dr. Manson suspected that when claimant fell off the ladder "he fell directly on the sciatic nerve" and the doctor noted that the sciatic nerve is where claimant is having the problem. Dr. Manson noted that claimant "has no back pain at all even though he has an MRI showing a herniated disc." Dr. Manson continued claimant on light-duty work pending his appointment with Dr. Narla and he prescribed Vicodin.

¶ 13 Claimant saw Dr. Narla on August 28, 2007. Dr. Narla recorded a history of pain in the posterolateral aspect of the gluteal area just posterior and superior to the greater trochanter following a fall from a ladder onto claimant's buttocks on July 13, 2007. Claimant denied any back pain at the time of his visit with Dr. Narla. Physical examination revealed some tenderness locally and "very limited" straight-leg raising, but there was no tenderness over the posterior superior iliac spine suggestive of any sacroiliac joint dysfunction, no tenderness in the spinal area, and no paraspinal

muscle spasm. Dr. Narla's impression was pain in the left gluteal area and lateral aspect of the thigh following a fall. Dr. Narla recommended an EMG/NCV study to determine whether there is any neurophysiological evidence of radiculopathy even though claimant denied any back pain. In addition, Dr. Narla wanted to compare claimant's MRI scans and stated that he would consider local steroid injections and physical therapy if the comparison "is very similar to what it was before." The EMG/NCV study did not reveal any abnormality, and Dr. Narla recommended a trigger point injection and physical therapy.

¶ 14 On September 14, 2007, claimant returned to Dr. Narla's office with both sets of MRI films. Dr. Narla examined the films, noting that the more recent one "shows a significant L5-S1 left-sided disk protrusion." Dr. Narla stated that this condition "might be fractionally worse than before," but that he was "not certain given that the quality of the films is different." Dr. Narla noted that a local steroid injection in the posterior aspect of the gluteal area did not provide much benefit. Examination showed straight-leg raising was significantly limited on the left side, but claimant stated that he had no back pain. Dr. Narla noted that the pain seemed to be very localized in the posterior aspect of the thigh. Dr. Narla indicated that claimant could be suffering an S1 irritation from the L5-S1 disc protrusion, but he was not certain. Dr. Narla recommended a therapeutic steroid injection at the L5-S1 level on the left side with fluoroscopy. Dr. Narla stated that if this treatment was not effective, there would be little else he could do for claimant. Dr. Narla administered the injection on October 4, 2007.

¶ 15 On December 26, 2007, claimant returned to Dr. Narla. At that time, Dr. Narla noted that the steroid injection administered after claimant's last visit did not prove beneficial. Dr. Narla again

emphasized that claimant "has hardly any back pain or pain radiating down away from the site. It seems to be a very localized trigger point." Physical examination showed limited straight-leg raising with tenderness present in the posterolateral aspect of the gluteal area behind the greater trochanter, but no tenderness in the low back. Dr. Narla concluded that the origin of the pain "is most likely secondary to the hip joint pathology rather than any lumbar pathology," and he suggested claimant see an orthopaedic doctor.

¶ 16 On December 28, 2007, claimant returned to Dr. Manson to discuss his hip. Dr. Manson noted that Dr. Narla was unable to find anything "wrong" with claimant, and Dr. Manson stated that he has "no idea what is wrong with him either." Dr. Manson concluded that if there is nothing wrong with claimant's back, there must be something wrong with his hip. Dr. Manson referred claimant to Dr. Jeffrey Schopp.

¶ 17 Claimant saw Dr. Schopp on February 4, 2008. Prior to seeing Dr. Schopp, claimant filled out a patient history form with a drawing indicating that his pain was localized to his left hip. Dr. Schopp noted that claimant complained of symptoms which radiate from his left hip down to both feet since a fall at work. Upon examination, Dr. Schopp noted "diffuse tenderness over the entire hip radiating into the back and down to the knee." Dr. Schopp reviewed X rays which showed no evidence of fracture or that the hip prosthesis had loosened. Dr. Schopp made no diagnosis, referring claimant back to Dr. Pineda.

¶ 18 Claimant saw Dr. Manson on February 27, 2008. At that time, Dr. Manson told claimant he was taking too much Vicodin. Claimant responded that "he has to have somebody do something to get him out of pain." Dr. Manson noted that claimant was examined by several specialists, but no

one found anything to relieve his pain. Dr. Manson noted that Dr. Schopp referred claimant back to Dr. Pineda, but that claimant did not want to return to Dr. Pineda because Dr. Pineda "did not seem interested in doing anything." Dr. Manson further noted that Dr. Schopp's nurse scheduled claimant for an appointment to see Dr. William Payne.

¶ 19 Claimant saw Dr. Payne on March 20, 2008, complaining of pain in the left buttocks that worsens with forward flexion or internal rotation of the hip. Dr. Payne noted that an EMG/NCV was negative for signs of radiculopathy and that MRIs of the lumbar spine from 2006 and 2007 show a "very small" left-sided paracentral disc herniation. Physical examination revealed pain with straight-leg raising on the left side. Dr. Payne's assessment was hip-joint pain. Based on the negative EMG/NCV and the very small disc herniation shown on the MRIs, Dr. Payne did not recommend surgical intervention of the lumbar spine. Dr. Payne told claimant that he was "not sure what is causing his pain," but he did not think it was coming from the lumbar spine and that he did not have any diagnosis or treatment to offer him. Claimant informed Dr. Manson that Dr. Payne was unable to help him, and he requested a referral to someone else. Dr. Manson's office scheduled an appointment with Dr. Brian Russell.

¶ 20 Claimant saw Dr. Russell, a board-certified neurosurgeon, on June 24, 2008. Claimant told Dr. Russell that he fell off a step ladder at work in July 2007 and has since had left hip pain and occasional low back pain. Claimant also reported occasional numbness and tingling in the left leg. Dr. Russell noted that neither epidural injections nor Vicodin provided much benefit. Upon examination, Dr. Russell documented an antalgic gait, positive straight-leg raising with elevation of the left leg, and a diminished left ankle jerk. Dr. Russell also noted that forward flexion and

extension seem to exacerbate some back pain and that claimant's MRI suggested a small herniated disc at L5-S1 compressing the left S1 nerve root. Dr. Russell diagnosed a herniated lumbar disc. Dr. Russell recommended physical therapy and stated that if claimant's symptoms persist, he would recommend a lumbar microdiscectomy.

¶ 21 Claimant attended the initial physical therapy evaluation on August 19, 2008. At that time, claimant denied ever having back pain, but he told the therapist that Dr. Russell determined he had a ruptured disc at L5. The therapist developed a plan to see claimant once or twice a week. However, therapy records indicate that claimant was discharged after one session, after he told the therapist that he was going to have surgery.

¶ 22 Claimant saw Dr. Russell again on August 26, 2008. Claimant reported that the physical therapy did not provide much benefit and that he still experiences posterolateral leg pain. Dr. Russell reiterated his opinion that claimant's condition was secondary to his disc disease and that it was therefore "reasonable" to pursue a lumbar microdiscectomy.

¶ 23 Dr. Russell was deposed on January 23, 2009. After reviewing his office notes, Dr. Russell testified that he diagnosed claimant with S1 root symptoms attributable to his disc disease as evidenced on the July 24, 2007, MRI. Given the failure of conservative treatment and physical therapy, Dr. Russell recommended a discectomy.

¶ 24 Dr. Russell testified that at the time he examined claimant, he was not aware that claimant had previously treated with Dr. Pineda and Dr. Payne. Dr. Russell also testified that while he knew that claimant had undergone hip replacement surgery prior to July 13, 2007, he was not aware that claimant had been treated for back pain in December 2006 and January 2007 or that he had been

diagnosed with a left-sided disc protrusion at L5-S1 before the accident at work. He further testified that other than an intake form from Dr. Manson's office, he did not review any other physician's records. Dr. Russell was asked whether his surgery recommendation would differ knowing that neither Dr. Pineda, who saw claimant in the fall of 2007, nor Dr. Payne, who saw claimant in March of 2008, recommended surgery. Dr. Russell responded that their opinions were "reasonable" as their evaluations occurred early on in claimant's treatment.

¶ 25 Dr. Russell was asked to assume that claimant had an MRI which showed a small L5-S1 disc herniation, that he had an injection which improved the pain, and that after the fall at work the pain returned, but was not relieved by injections. He was asked to further assume that Dr. Narla compared MRI films from before and after the fall and he noted a change, with the more recent film showing a "somewhat larger" herniation. Based on this hypothetical, Dr. Russell was of the opinion, to a reasonable degree of neurosurgical certainty, that the fall off the ladder could have aggravated claimant's preexisting condition and caused it to become symptomatic to the point where injections would not have provided relief. Dr. Russell also felt that claimant's preexisting condition might also have contributed to his current condition and his need for surgery.

¶ 26 On cross-examination, Dr. Russell testified that claimant never specifically related that he had back pain prior to the July 13, 2007, accident and that he was not aware that claimant treated for back pain in December 2006 and January 2007. Dr. Russell further stated that if claimant had been experiencing leg pain prior to the July 13, 2007, accident, it could suggest that another incident could have initiated his leg pain. As such, Dr. Russell opined, given that claimant was diagnosed with degenerative disc disease as early as December 2006, it is possible that claimant would need

the surgery he recommended even without the aggravating incident of July 13, 2007. Dr. Russell stated that he was unaware how long claimant attended physical therapy. However, he would not consider attending two sessions sufficient to judge its benefit.

¶ 27 On redirect examination, Dr. Russell stated that the first time that any of claimant's physicians noted claimant to have an absent Achilles reflex was after July 13, 2007. He indicated that if, in fact, this was a new finding, it suggests more inflammation around the nerve and would be consistent with an aggravation of an underlying condition caused by the July 13, 2007, accident. Dr. Russell opined that falling and the natural degenerative process that accompanies aging are contributing factors to claimant's complaints of pain.

¶ 28 At the arbitration hearing, claimant testified that he continues to experience lower back pain radiating down his left leg. He treats the pain with various medications, including Vicodin, Darvocet, and Ibuprofen. Claimant testified that he still wants to proceed with the operation recommended by Dr. Russell.

¶ 29 The arbitrator adopted the opinions of Dr. Russell and found that claimant's accident of July 13, 2007, aggravated his preexisting lumbar degenerative disc disease and his preexisting L5-S1 disc herniation, causing it to become symptomatic. The arbitrator ordered respondent to pay any unpaid medical bills, finding that the medical expenses incurred by claimant were reasonable and necessary. In addition, the arbitrator ordered respondent to authorize and pay for the microdiscectomy surgery recommended by Dr. Russell.

¶ 30 The Commission concluded that while the medical records support a finding that claimant suffered an injury to his hip as a result of the accident on July 13, 2007, neither claimant's testimony

nor the medical records supported a finding that claimant's lower back problems were related to the accident. In so concluding, the Commission found that claimant's testimony "lacked credibility" when it came to describing his symptoms. The Commission noted that the medical evidence did not support claimant's testimony that he suffered low back pain since the accident. The Commission found that claimant's complaints following the accident mostly related to his hip and that claimant repeatedly told medical personnel that he did not have any back pain or problems. The Commission also pointed out that many of the treating physicians were aware of claimant's preexisting disc herniation, but excluded that condition as the source of his pain. In addition, when Dr. Russell referred claimant for physical therapy, claimant told the therapist that he never had any back pain. In support of its conclusion, the Commission adopted the findings of Dr. Pineda, Dr. Manson, and Dr. Payne. In light of its finding that claimant's back condition was not related to the accident at work, the Commission also denied claimant's request for the prospective medical care pertaining to his back. However, the Commission remanded the case to the arbitrator fur further proceedings pursuant to *Thomas v. Industrial Comm'n*, 78 Ill. 2d 327 (1980). The circuit court of Sangamon County confirmed the decision of the Commission. This appeal ensued.

¶ 31 II. ANALYSIS

¶ 32 On appeal, claimant argues that the Commission's finding that he did not carry his burden of proving that his lower back condition is causally related to his accident at work on July 13, 2007, is against the manifest weight of the evidence.

¶ 33 In cases involving a preexisting condition, recovery depends on the employee's ability to establish that a work-related accidental injury aggravated or accelerated the preexisting condition

such that the employee's current condition of ill-being can be said to be causally connected to the work-related injury and not simply the result of a normal degenerative process. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 204-05 (2003). The accidental injury need neither be the sole causative factor nor the primary causative factor as long as it was *a* causative factor. *Elgin Board of Education School District U-46 v. Workers' Compensation Comm'n*, 409 Ill. App. 3d 943, 949 (2011). Whether a claimant's preexisting condition was aggravated or accelerated by a work accident is a factual question for the Commission to resolve. *Sisbro, Inc.*, 207 Ill. 2d at 205. As with all factual inquiries, in making this determination, it is within the province of the Commission to judge the credibility of witnesses, assign weight thereto, and resolve conflicting medical evidence. *R&D Thiel v. Workers' Compensation Comm'n*, 398 Ill. App. 3d 858, 868 (2010); *Price v. Industrial Comm'n*, 278 Ill. App. 3d 848, 852 (1996). Accordingly, we must not disregard or reject permissible inferences drawn by the Commission merely because other inferences might be drawn. *Sisbro, Inc.*, 207 Ill. 2d at 206. Moreover, we must not substitute our judgment for that of the Commission unless the Commission's findings are against the manifest weight of the evidence. *Sisbro, Inc.*, 207 Ill. 2d at 206. A decision is against the manifest weight of the evidence only when the opposite conclusion is clearly apparent. *R&D Thiel*, 398 Ill. App. 3d at 868; *Circuit City Stores, Inc. v. Workers' Compensation Comm'n* 391 Ill. App. 3d 913, 990 (2009).

¶ 34 As noted above, claimant insists that the Commission's finding that his lower back problems are unrelated to the accident of July 13, 2007, is against the manifest weight of the evidence. In support of his position, claimant advances two principal arguments. First, claimant contends that in not finding him credible, the Commission misinterpreted his testimony at the arbitration hearing.

Second, claimant argues that the Commission erred in adopting the findings of Dr. Pineda, Dr. Manson, and Dr. Payne over the opinion of Dr. Russell. We address each contention in turn.

¶ 35 The Commission found that claimant's testimony "lacked credibility" when it came to describing his symptoms since the accident. The Commission noted that at the arbitration hearing, claimant testified that he has had low back pain since the accident. The Commission determined that claimant's testimony was contradicted by many of the medical records, which indicated that claimant reported no back pain or problems. Claimant acknowledges that he generically testified at the arbitration hearing that he was in constant pain since the accident. However, he claims that the Commission incorrectly inferred from this testimony that he was referring to *back* pain.

¶ 36 In support of his contention, claimant directs us to the following exchange at the arbitration hearing between him and his attorney:

> "Q . What are your symptoms now?
>
> A. Lower back pain, pain goes all the way down my leg.
>
> Q. Which leg is that?
>
> A. My left one and it never stops. It's a constant pain.
>
> Q. Has that been since the accident?
>
> A. Since the accident."

According to claimant, this testimony does not support an inference that he had constant back pain since the accident. Rather, claimant contends, when asked about his symptoms, he described back *and* leg pain. He was then asked which leg was in pain. He responded by identifying the leg and added, without further questioning, that the pain is "constant." Claimant insists that the only

reasonable interpretation of this testimony is that he has been suffering constant *left leg* pain since the accident. We disagree.

¶ 37 As noted earlier, it is within the province of the Commission to judge the credibility of witnesses, assign weight thereto, and resolve conflicting medical evidence. *R&D Thiel*, 398 Ill. App. 3d at 868; *Price*, 278 Ill. App. 3d at 852; see also *Chicago Messenger Service, Inc. v. Industrial Comm'n*, 356 Ill. App. 3d 843, 849 (2005). Based on our review of the testimony set forth above, we find it conceivable that claimant was in fact stating that he suffered from constant back pain since the accident. While claimant insists that it was his testimony that he was suffering from leg *and* back pain since the accident, a reasonable interpretation of the testimony is that claimant was suffering back pain which radiated down his left leg and that this pain as a whole has existed since the accident. Moreover, as the Commission points out, claimant's testimony that he suffered from constant back pain is contradicted by many of the medical records. For instance, when claimant saw Dr. Pineda on August 13, 2007, just one month after the accident, Dr. Pineda noted that claimant's back was "completely non-tender, no spasms identified of his back." Similarly, three days later, claimant denied any back pain or problems when he was seen at MOHA. Claimant also had no back pain when he treated with Dr. Manson on August 21, 2007, and when he treated with Dr. Narla one week later. In fact, the record shows that other than Dr. Manson's reference on July 14, 2007, that claimant wanted something done for his lumbar disc, claimant did not expressly complain of any back problems until he saw Dr. Russell on June 24, 2008, almost one year after the accident. Yet, *after* claimant saw Dr. Russell, he denied ever having back pain when he attended physical therapy. Moreover, even if, as claimant now insists, back pain has never been his primary complaint, the

Commission was still entitled to find that claimant was not credible given that there is ample support for the Commission's finding of inconsistencies between claimant's arbitration testimony about his back pain and the medical records. Accordingly, we cannot say that the Commission's finding that claimant was not a credible witness is against the manifest weight of the evidence.

¶ 38 Claimant next complains that the Commission's finding that he failed to prove a causal relationship between his current condition of ill-being and the accident is against the manifest weight of the evidence. Claimant insists there is a causal connection based on Dr. Russell's testimony that his fall off the ladder could have aggravated his preexisting back condition and caused it to become symptomatic. Claimant acknowledges that the Commission is entitled to weigh conflicting medical evidence and draw its own conclusion. He claims, however, that there is no *conflicting* medical evidence. He argues that the records of Dr. Pineda, Dr. Manson, and Dr. Payne do not include any facts or opinions which might "remotely suggest" that claimant's work accident was not a cause of his current condition of ill-being. Again, we disagree.

¶ 39 Claimant first treated with Dr. Pineda on August 13, 2007, complaining of pain in the left buttocks. Dr. Pineda's examination revealed that claimant's back was "completely non-tender, no spasms identified of his back." Dr. Pineda acknowledged that an MRI showed a small disc herniation at L5-S1. However, he did not believe that the herniation was the source of the pain because claimant's complaints were focal in nature. Similarly, Dr. Manson, noted that claimant had no back pain even though the MRI showed a herniated disc. He suggested that if there is nothing wrong with claimant's back, claimant's symptoms must be attributable to his hip. In March 2008, Dr. Payne diagnosed claimant with hip-joint pain. Although Dr. Payne was not entirely sure what

was causing claimant's pain, he did not believe that it was coming from the lumbar spine given the small disc herniation and the negative EMG/NCV study. This evidence clearly suggests that these three physicians did not believe that claimant's current condition of ill-being was related to any lumbar pathology. Thus, contrary to claimant's argument, there was conflicting medical evidence.

¶ 40 Moreover, we cannot say that the Commission erred in favoring the opinions of Dr. Pineda, Dr. Manson, and Dr. Payne over that of Dr. Russell. Dr. Russell testified that other than an intake form from Dr. Manson's office, he did not review any other physician's records. Further, Dr. Russell testified that although he knew that claimant had undergone hip-replacement surgery prior to July 13, 2007, he was not aware that claimant had been diagnosed with a left-sided disc protrusion at L5-S1 prior to the injury at work on July 13, 2007. Thus, the Commission could have concluded that Dr. Russell did not have the benefit of a complete and accurate medical history and therefore his opinion was entitled to less weight.

¶ 41 We also do not find persuasive claimant's reliance on the testimony of Dr. Narla. Claimant asserts that Dr. Narla's findings support the notion that the fall at work on July 13, 2007, aggravated or accelerated his preexisting back problem. Claimant notes that Dr. Narla compared the MRI taken after the fall with one taken about six months prior to the fall. Claimant further notes that Dr. Narla stated that claimant's herniated disc "might be fractionally worse than before." However, claimant ignores the rest of Dr. Narla's finding. Dr. Narla qualified this finding, stating that he was "not certain given that the quality of the films is different." Moreover, when claimant saw Dr. Narla in December 2007, he opined that the origin of claimant's pain "is most likely secondary to the hip

joint pathology rather than any lumbar pathology." Given this opinion and Dr. Narla's qualification of the statement cited by claimant, we decline to overrule the Commission's finding on this basis.

¶ 42 Claimant also suggests that *Price*, 278 Ill. App. 3d 848, is illustrative of why the Commission's causation finding is against the manifest weight of the evidence. Claimant's reliance on *Price* is misplaced. In contrast to this case, in *Price*, the Commission found that the claimant's work accident aggravated a preexisting condition. We affirmed the Commission's decision, finding that it was not against the manifest weight of the evidence. *Price*, 278 Ill. App. 3d at 855. Claimant insists that this case shares many factual similarities to *Price* and urges that just as the claimant in *Price* was not denied recovery based on a preexisting condition, there is no reason his medical treatment in January 2007, should preclude causation in the present case. In this case, however, it is clear that the Commission did not deny claimant benefits based on the fact that claimant had back problems prior to his accident at work. Rather, the Commission found that claimant failed to establish that his back pain was connected to the work injury. We also point out that our decision here is consistent with *Price*. In both cases, we affirmed the Commission's decision, in light of the substantial deference we owe the Commission under the manifest-weight standard of review.

¶ 43 In sum, we find that the Commission was presented with conflicting medical evidence regarding whether claimant's current back problems are related to his work accident. After considering this conflicting evidence, the Commission found that the claimant's current condition of ill-being was not related to his work accident. Based on the record before us, we cannot say that an opposite conclusion is clearly apparent.

¶ 44 Finally, claimant argues that the Commission erred in denying prospective medical benefits,

in particular the microdiscectomy prescribed by Dr. Russell. Claimant argues that even if this court affirms the Commission's finding that there is no causal connection between his back condition and the industrial accident, the surgery is still needed to relieve his leg pain. In support of this argument, claimant relies on the failure of conservative treatment and Dr. Russell's recommendation. However, claimant's argument fails to acknowledge that Dr. Russell's surgery recommendation was based on his diagnosis of a herniated lumbar disc at L5-S1, and the Commission rejected Dr. Russell's opinion that this condition was related to his work accident. Moreover, while some of the other physicians who examined claimant documented leg pain, aside from Dr. Russell, no one recommended surgical intervention. Accordingly, we conclude that the Commission's denial of prospective back surgery is not against the manifest weight of the evidence. See *Homebrite Ace Hardware v. Industrial Comm'n*, 351 Ill. App. 3d 333, 341-42 (2004) (applying manifest-weight standard to review of prospective medical benefits).

¶ 45 III. CONCLUSION

¶ 46 For the reasons set forth above, we affirm the judgment of the circuit court of Sangamon County, which confirmed the decision of the Commission. This cause is remanded pursuant to *Thomas*, 78 Ill. 2d 327.

¶ 47 Affirmed; cause remanded.