2017 IL App (2d) 170115WC-U
No. 2-17-0115WC
Order filed December 19, 2017

IN THE

APPELLATE COURT OF ILLINOIS

SECOND DISTRICT

WORKERS' COMPENSATION COMMISSION DIVISION

PRISCILLA KELLY,	)	Appeal from the Circuit Court
	)	of Kane County.
Appellant,	)	
	)	
v.	)	No. 16-MR-230
	)	
THE ILLINOIS WORKERS'	)	
COMPENSATION COMMISSION, et al.,	)	Honorable
	)	David Akemann,
(Jewel Food Stores, Appellee).	)	Judge, Presiding.

JUSTICE HUDSON delivered the judgment of the court.

Presiding Justice Holdridge and Justices Hoffman, Harris, and Overstreet concurred in the judgment.

ORDER

¶ 1 *Held*: (1) Neither the law-of-the-case doctrine nor collateral estoppel apply to preclude respondent from challenging medical treatment claimant received subsequent to the initial arbitration hearing; (2) the Commission's finding that claimant exceeded the permissible choice of physicians was not against the manifest weight of the evidence; (3) claimant forfeited argument that Commission's award of medical expenses was erroneous; and (4) the Commission's denial of attorney fees and penalties was neither against the manifest weight of the evidence nor an abuse of discretion.

¶ 2 Claimant, Priscilla Kelly, appeals from an order of the circuit court of Kane County which confirmed a decision of the Illinois Workers' Compensation Commission (Commission) denying her petition for additional benefits pursuant to section 19(h) of the Workers' Compensation Act (Act) (820 ILCS 305/19(h) (West 2008)), granting in part and denying in part her petition for medical treatment pursuant to section 8(a) of the Act (820 ILCS 305/8(a) (West 2008)), and denying her petition for attorney fees pursuant to section 16 of the Act (820 ILCS 305/16 (West 2008) and penalties pursuant to sections 19(k) and 19(l) of the Act (820 ILCS 305/19(k), (l) (West 2008)). On appeal, claimant challenges the Commission's findings related to her petition for medical treatment under section 8(a) of the Act and her petition for attorney fees and penalties under sections 16, 19(k), and 19(l) of the Act. For the reasons that follow, we affirm the judgment of the circuit court.

¶ 3 I. BACKGROUND

¶ 4 The following factual recitation is taken from the testimony presented and evidence admitted at the September 26, 2014, hearing on claimant's petitions. Claimant worked for respondent, Jewel Food Stores, as a deli clerk and management trainee. On September 29, 1997, while placing a ham into a cooler, claimant felt an electrical-like shock in her left hand and up her arm. Claimant initially sought treatment for her injury at Mercy Center, where she complained of pain to the left scapula and shoulder. The following day, claimant reported that the left shoulder pain extended into her neck. Claimant then had a conversation with her store manager, who told her to see Dr. Mark Lewis. Claimant treated with Dr. Lewis, undergoing physical therapy and trigger-point injections. Dr. Lewis referred claimant to other medical professionals, including a chiropractor (Mark Glesener) and a Dr. Mazur.

¶ 5 Claimant eventually underwent two surgeries on her neck, one in May 1998 by Dr. Mazur and the other in October 1998 by Dr. Andrew Chenelle. Following the surgeries, claimant was treated for myofascial pain syndrome and prescribed various medications, including Lidoderm and Duragesic patches, Neurontin, and Oxycontin. She also presented to Delnor Community Hospital (Delnor) for acute flare ups of pain and underwent pain management treatment with Dr. Maridas Chinthagada at Loyola University Medical Center (Loyola).[1] During claimant's treatment, several medical providers voiced concern over her reliance on prescription pain relievers.

¶ 6 Claimant sought benefits for her injury under the Act. The matter proceeded to a hearing before an arbitrator on May 18, 2005.[2] In a decision dated June 9, 2005, the arbitrator determined that claimant sustained a compensable injury to her neck and left shoulder and that her condition of ill-being was causally related to her work accident. The arbitrator awarded claimant 92-1/7 weeks of temporary total disability (TTD) benefits (820 ILCS 305/8(b) (West 1996)), 225 weeks of permanent partial disability (PPD) benefits pursuant to section 8(d)2 of the Act (820 ILCS 305/8(d)2 (West 1996)) (representing 45% loss of use of the person as a whole), and $16,929.27 for necessary medical services (820 ILCS 305/8(a) (West 1996)). In addition, the arbitrator, noting that there was "no objection that [claimant] exceeded the statutory chain of referrals," found respondent "liable for [claimant's] continued treatment with Dr. Chinthagada." The arbitrator explained:

[1] Dr. Chinthagada is also referred to in the record as "Dr. Das."

[2] Neither the transcript of the May 2005 arbitration hearing nor the exhibits, if any, admitted at that hearing have been included in the record of this appeal.

> "[Claimant's] continued reliance on the pain medication prescribed by Dr. Chinthagada is causally connected to her injury as the medical records show. * * * [Claimant] has chosen to follow the recommendations of Dr. Chinthagada, who was within Respondent's chain of referrals. Dr. Chinthagada has attempted to reduce [claimant's] reliance on narcotics with some limited success. Certainly there is no evidence he has acted indiscriminately or outside the range of accepted medical practice. [Claimant] is entitled to continue this treatment and Respondent is liable for the reasonable and necessary costs."

¶ 7 Respondent sought review of the arbitrator's decision before the Commission, and the matter was docketed as case 07 IWCC 1154. On August 31, 2007, the Commission issued its decision. The Commission modified the decision of the arbitrator regarding PPD, concluding that claimant was entitled to an award only to the extent of 37.5% loss of use of the person as a whole, but otherwise affirmed and adopted the decision of the arbitrator. No further review of the matter was taken.

¶ 8 On or about December 8, 2009, claimant filed a petition pursuant to section 19(h) of the Act (820 ILCS 305/19(h) (West 2008)) for additional TTD benefits and a petition for medical treatment pursuant to section 8(a) of the Act (820 ILCS 305/8(a) (West 2008)). In her section 8(a) petition, claimant alleged that she required further medical treatment, which respondent has refused to authorize. She also alleged that respondent has refused to cover treatment she received at Loyola, Marianjoy Medical Group (Marianjoy), or Delnor, as well as prescriptions related to that treatment. In addition, claimant filed a petition for attorney fees pursuant to section 16 of the Act (820 ILCS 305/16 (West 2008)) and penalties pursuant to sections 19(k) and 19(l) of the Act (820 ILCS 305/19(k), 19(l) (West 2008)) based on respondent's alleged

failure to authorize future medical treatment. Claimant filed identical petitions on January 7, 2011. Thereafter, respondent filed a response to claimant's petition for medical treatment and her petition for attorney fees and penalties. Respondent also filed a motion to dismiss claimant's section 19(h) petition as untimely. Following numerous continuances, the matter proceeded to a hearing before Commissioner Thomas Tyrell beginning on September 26, 2014, and concluding on January 30, 2015.

¶ 9 At the hearing, claimant testified regarding her history of medical providers. She related that following her injury, she visited the emergency room. Her manager then referred her to Dr. Lewis. Dr. Lewis then referred her to various medical providers, including chiropractor Glesener, Dr. Richard Krieger of Marianjoy, and Dr. Mazur.[3] Dr. Mazur referred claimant to a Dr. Witt. Claimant testified that she saw a Dr. Schiffman on her own. Dr. Schiffman referred her to a Dr. Kazan. Claimant also underwent independent medical examinations with a Dr. Shea, Dr. Chenelle, Dr. Howard Konowitz, and Dr. Kenneth Candido. Claimant testified that Dr. Chenelle performed her second neck surgery "per [her] request." Following the second operation, Dr. Chenelle referred claimant to Dr. Chinthagada.

¶ 10 Claimant continued to treat with Dr. Chinthagada following the first arbitration hearing. Claimant testified, however, that she had "an issue" with Dr. Chinthagada regarding her prescription medication. According to claimant, she repeatedly told Dr. Chinthagada that her pain was not under control and requested new medication, but he refused to prescribe anything. In the summer of 2005, claimant was also treating with and receiving narcotics from Dr. Philip Branshaw, her primary-care physician. On July 28, 2005, Dr. Chinthagada contacted Dr.

[3] Marianjoy is also referred to in the record as Rehabilitation Medicine Clinic.

Branshaw after learning that claimant had been receiving narcotics from both physicians. Dr. Chinthagada informed Dr. Branshaw that because claimant had violated the "contract" between her and Loyola regarding opioid use, he would no longer treat claimant. Dr. Branshaw discussed the situation with claimant and referred her to Dr. Jeffrey Oken of Marianjoy for pain control. In a letter dated August 16, 2005, Dr. Chinthagada informed claimant of his decision to withdraw from further treatment. Claimant began seeing Dr. Oken in September 2005. Subsequently, Dr. Oken referred claimant to Dr. Christopher Mocek in Arkansas, where clamant was considering relocating.

¶ 11 Claimant denied any subsequent accidents or injuries involving her neck or left shoulder since the initial arbitration hearing. However, claimant acknowledged an injury to her low back in October 2009, following a fall at a casino. Claimant treated with Dr. Chenelle for the back injury and underwent a two-level lumbar fusion. Claimant continued to treat with Dr. Chenelle for her back through July 15, 2013. Claimant filed a lawsuit against the casino and was awarded $300,000. According to claimant, however, she received only $100,000 of the award due to medical liens.

¶ 12 Claimant offered into evidence a group exhibit of medical bills totaling $320,684.58, divided as follows: (1) $2,894 for treatment from Dr. Branshaw between June 9, 2005, and November 13, 2009; (2) $36,294 for treatment at Marianjoy between September 20, 2005, and January 2, 2014; (3) $58,630.23 for treatment at Delnor between May 16, 2005, and August 28, 2008; (4) $36,741.42 for prescriptions from IWP Pharmacy between November 13, 2013, and September 11, 2014; (5) $37,805.43 for a lien from her husband's group insurance for the period between September 20, 2005, and June 16, 2006; and (6) $148,319.50 for assorted pharmacy

bills incurred between May 31, 2005, and September 29, 2012. Respondent objected to the admission of the group exhibit.

¶ 13 Dr. Oken testified in his February 2014 deposition that he first began treating claimant on September 20, 2005, for chronic neck pain, upon the referral of Dr. Branshaw. At the time, claimant was taking various medications, including Oxycontin, Vicodin, and Flexeril. Dr. Oken's diagnoses included failed neck syndrome and chronic myofascial pain. His treatment regimen included trigger-point injections to the neck. Dr. Oken stated the need for the trigger-point injections was the surgery related to claimant's neck injury. He explained that because of the surgery, claimant's neck muscles tightened up. Dr. Oken further stated that the treatment claimant received for her neck had been reasonable and was necessary as a result of the September 1997 work injury. He explained that the work injury ultimately led to her surgery, which caused the myofascial pain which led to chronic pain syndrome. Dr. Oken admitted claimant's medication usage increased following the 2009 fall at the casino. Dr. Oken attributed the increase to back problems or to tolerance for opiate usage. He continued to treat claimant until January 2014, and noted that his later treatment notes reflected medical care for both claimant's low back as well as her neck.

¶ 14 On cross-examination, Dr. Oken testified that Dr. Krieger is a partner at Marianjoy. Dr. Oken stated that he never consulted with Dr. Krieger with regard to claimant and he never examined Dr. Krieger's records pertaining to claimant. Dr. Oken added that he and Dr. Krieger do not work in the same office or building. Dr. Oken testified that although claimant requested a reduction in her medication during her initial visit, the narcotics she received were steadily increased. Dr. Oken agreed that while it would be a good idea to wean claimant off narcotics,

she has intractable pain and needs the medication to function. Dr. Oken also agreed that if a patient was asking for medication from several different providers, it could indicate an addiction.

¶ 15 On May 27, 2010, at respondent's request, Dr. Konowitz performed an examination pursuant to section 12 of the Act (820 ILCS 305/12 (West 2008)). The report of Dr. Konowitz's evaluation was admitted into evidence. Dr. Konowitz noted waxing and waning symptoms which had periodically been treated with trigger-point injections. At the time he saw her, claimant was recovering from an October 2009 fall which resulted in a fractured tailbone. Claimant was contemplating future lumbar surgery to address the symptoms of the fall. Dr. Konowitz diagnosed myofascial pain and recommended weaning claimant off narcotics. He concluded she could continue to work in a light-duty capacity. In a supplemental report, he noted there had been no change in claimant's neck and scapular conditions between December 2003 (when he previously evaluated her) and the May 2010 examination.

¶ 16 On October 18, 2011, Dr. Candido examined claimant pursuant to section 12 of the Act at respondent's request. Dr. Candido generated a report of his findings and testified by evidence deposition. Dr. Candido's diagnoses included opioid dependence, polysubstance dependence, degenerative disc disease of the cervical spine, degenerative disc disease of the lumbar spine, and myofascial pain of the cervical spine. He opined that claimant's primary complaints were related to myofascial pain, not the original accident. He noted no findings of cervical radiculopathy, which would be needed to make a finding of causal connection. Dr. Candido further opined that the treatment provided by Dr. Branshaw and Dr. Oken was not related to cervical stenosis or cervical nerve-root compression or irritation, and as such was not related to the workplace accident. Dr. Candido opined that claimant had resolved the primary problem which brought her to the attention of the neurological surgeon initially, that being cervical radiculopathy. He felt

that she would have reached maximum medical improvement sometime between 1999 and 2003. Dr. Candido recommended that claimant be weaned off opiates and advised that cessation of smoking would also assist in the resolution of the myofascial muscular pain. He further opined that a pain pump would not be indicated for a diagnosis of myofascial pain given current medical literature. Dr. Candido believed claimant could work light duty as outlined by Dr. Konowitz and in earlier treatment records.

¶ 17 Initially, the Commission denied claimant's petition for additional benefits pursuant to section 19(h) of the Act. In this regard, the Commission agreed with the opinions of Dr. Konowitz and Dr. Candido and determined that claimant had not sustained a material change in her physical condition relative to the original injury which would require amendment to the PPD assessment earlier rendered in the case. The Commission noted that claimant had ongoing health concerns, including significant lumbar surgeries, which were related to an independent intervening accident and not to the injury in the case at bar.

¶ 18 Regarding claimant's petition for additional medical pursuant to section 8(a) of the Act, the Commission granted the request in part. In this regard, the Commission addressed the chain of physician referrals. The Commission found that Dr. Lewis was referred to claimant by respondent and that Dr. Schiffman was her first choice of provider. The Commission found that Dr. Kazan was also within the first chain of referrals as he was referred to claimant by Dr. Schiffman. The Commission further found that although claimant was sent to Dr. Chenelle by respondent, the referral was for a section 12 examination, not for treatment. It was only at claimant's own request that Dr. Chenelle became a treating physician. As a result, the Commission concluded that Dr. Chenelle was claimant's second choice of provider. Further, Dr. Chinthagada was referred to claimant by Dr. Chenelle. Thus, Dr. Chinthagada was within the

second chain of referrals. The Commission observed, however, that Dr. Chinthagada discharged claimant for violating her opioid contract with his office. The Commission concluded that claimant's actions ended the referral chain and "suggest[ed] that the treatment the claimant was interested in pursuing[] was not medically supported." As a result, the Commission concluded that Dr. Branshaw, Dr. Oken, and Dr. Mocek were outside the permissible chain of referrals. In addition, the Commission rejected claimant's argument that Dr. Oken and Dr. Krieger constituted a singular provider based on their affiliations with Marianjoy. In this regard, the Commission, citing the testimony of Dr. Oken, determined that Dr. Krieger and Dr. Oken work in separate offices and do not share records or patients. Moreover, the Commission found that Dr. Krieger did not refer claimant to Dr. Oken.

¶ 19 The Commission ordered respondent to pay "[a]ny costs borne by the group carrier which apply against Dr. Lewis or his referral chain." However, the Commission denied reimbursement for those medical expenses charged by Dr. Branshaw, Dr. Oken, and Delnor, and any prescriptions issued by them. The Commission explained:

> "Medical records and claimed expenses following the unrelated 2009 fall in the casino demonstrate ongoing and increasing use of pain medication following that time, and the Commission notes that such would be unrelated to the original injury, despite the claimant's dubious denials of increased symptoms to that anatomy. The records reflect extensive treatment for her low back with Drs. Branshaw, Chenelle, and Oken; the claimant admitted that she settled her [personal injury] case against the casino for $300,000, although she testified she only cleared $100,000 after the medical liens and attorneys' fees. Dr. Oken's records in January 2014 clearly note ongoing complaints in the lower back and thighs; her allegations that her ongoing disability related exclusively

> to the 1997 accident defy credulity. Moreover, the claimant has persisted in her attempts to secure ever-increasing narcotic medication despite the persuasive recommendations of Drs. Chinthagada, Konowitz, and Candido."

The Commission also noted that while the bills related to Dr. Branshaw and Marianjoy were contained in the subpoenaed exhibits containing the medical records of those providers, the remaining bills were neither certified nor produced subject to a subpoena. Moreover, although claimant testified that she provided respondent's billing information to her medical providers, respondent denied receiving the bills prior to the hearing, either directly from the providers or from claimant's attorney.

¶ 20 Finally, the Commission denied claimant's requests for attorney fees pursuant to section 16 of the Act and penalties pursuant to sections 19(k) and 19(l) of the Act for respondent's failure to pay medical bills following the Commission's initial decision. The Commission rejected claimant's allegation that respondent's conduct was vexatious or unreasonable. The Commission explained as follows:

> "[W]hile [the arbitrator] found, and the Commission confirmed, that Dr. Chinthagada's pain management treatment was reasonable and necessary and causally related to [claimant's] work injury, Dr. Chinthagada thereafter discharged the claimant from treatment for noncompliance, having violated the narcotics control protocol. Dr. Oken did not review Dr. Chinthagada's treatment records and began an independent program, for which the Respondent was not liable. The medical bills were not provided to the Respondent, despite repeated requests, until the date of the hearing. The Respondent further correctly noted a significant intervening incident and secured Section

12 examinations of the claimant contravening her medical care, and properly objected to perceived violations of Section 8(a) referral requirements."

¶ 21 On judicial review, the circuit court of Kane County confirmed the decision of the Commission. This appeal followed.

¶ 22 II. ANALYSIS

¶ 23 On appeal, claimant raises four issues. First, she argues that either the law-of-the-case doctrine or collateral estoppel apply to preclude respondent from challenging her ongoing medical care. Second, she asserts that the Commission erred in finding that she exceeded the permissible choice of physician referrals. Third, claimant contends that the Commission erred in failing to award her medical bills in the amount of $320,684.58. Finally, she maintains that the Commission erred in failing to assess attorney fees pursuant to section 16 of the Act (820 ILCS 305/16 (West 2008)) and penalties pursuant to sections 19(k) and 19(l) of the Act (820 ILCS 305/19(k), (l) (West 2008)). We address each contention in turn.

¶ 24 A. Law of the Case/Collateral Estoppel

¶ 25 Claimant first argues that respondent is bound by the law of the case as it was established in the underlying decision of the Commission. According to claimant, the Commission's decision in case No. 07 IWCC 1154 established respondent's liability for ongoing medical care related to her neck and left shoulder. Respondent does not dispute that it is obligated to comply with the Commission's decision in case No. 07 IWCC 1154. Respondent asserts, however, that the Commission's initial decision is not binding with respect to the medical care at issue because it was administered following the initial arbitration hearing and therefore involves "different benefits in subsequent proceedings."

¶ 26 " 'Under the law-of-the-case doctrine, a court's unreversed decision on an issue that has been litigated and decided settles the question for all subsequent stages of the action.' " *Help at Home v. Illinois Workers' Compensation Comm'n*, 405 Ill. App. 3d 1150, 1151 (2010) (quoting *Ming Auto Body/Ming of Decatur v. Industrial Comm'n*, 387 Ill. App. 3d 244, 252 (2008)). This court has held that principles underlying the law-of-the-case doctrine should be applied to matters involving proceedings before the Commission. *Irizarry v. Industrial Comm'n*, 337 Ill. App. 3d 598, 606 (2003). Thus, our initial task is to determine the scope of medical care awarded by the Commission in case No. 07 IWCC 1154.

¶ 27 Following the hearing in May 2005, the arbitrator determined that claimant sustained a compensable injury to her neck and left shoulder and that her condition of ill-being was causally related to her work accident. At that time, the arbitrator ordered respondent to pay $16,929.27 for necessary medical services. The arbitrator also found that Dr. Chinthagada was "within Respondent's chain of referrals" and that respondent was "liable for [claimant's] continued treatment with Dr. Chinthagada." The Commission affirmed and adopted these findings, and neither party took any further appeal. Thus, case No. 07 IWCC 1154 involved medical treatment through the date of the arbitration hearing plus continued treatment with *Dr. Chinthagada*. This award of medical benefits became the law of the case.

¶ 28 Subsequent to the May 2005 arbitration hearing, Dr. Chinthagada withdrew from further treatment of claimant because she violated his treatment protocol by obtaining prescription narcotics through another physician. After Dr. Chinthagada's withdrawal, claimant treated with other medical providers. She then filed the petitions at issue after respondent refused to pay for the treatment administered by these additional medical providers. Respondent contested its liability for this treatment on various grounds, including that it was outside the permissible chain

of referrals. Given the limited scope of the care authorized by the Commission in case No. 07 IWCC 1154, we conclude that the law-of-the-case doctrine did not bar respondent from challenging the propriety of the medical expenses at issue. Quite simply, the medical care in dispute occurred after the initial arbitration hearing and was administered by medical providers other than Dr. Chinthagada. As a result, contrary to claimant's argument, the propriety of this care was not and could not have been litigated and decided at the initial arbitration hearing. See *Weyer v. Illinois Workers' Compensation Comm'n*, 387 Ill. App. 3d 297, 306-08 (2008) (holding that where first and second section 19(b) hearings involved different factual and legal issues, the law-of-the-case doctrine did not prohibit the litigation of any new issues). In so finding, we note that even if, as claimant represents, she was awarded "open medical," this does not mean that respondent is liable for any and all future treatment she may receive. Indeed, claimant does not cite any authority for this proposition. Moreover, respondent raises a legitimate question as to whether, in light of Dr. Chinthagada's withdrawal from claimant's care, the treatment provided by the subsequent medical providers fell within the permissible chain of referrals. For these reasons, we reject claimant's argument that the law-of-the-case doctrine applies to preclude respondent from challenging her ongoing medical treatment.

¶ 29 Alternatively, claimant argues that respondent is collaterally estopped from relitigating its liability for her ongoing medical care. Initially, we find claimant has forfeited this argument. Although claimant sets forth the elements of collateral estoppel in her brief, other than a statement that "[i]t is clear that all of the essential elements for collateral estoppel *** have been established," she fails to set forth how each element has been satisfied. See Ill. S. Ct. R. 341(h)(7) (eff. Jan. 1, 2016) (requiring appellant's brief to contain "the contentions of the appellant and the reasons therefor" and further providing that "[p]oints not argued are waived

and shall not be raised in the reply brief, in oral argument, or on petition for rehearing"); *Guarantee Trust Life Insurance Co. v. Platinum Supplemental Insurance, Inc.*, 2016 IL App (1st) 161612, ¶ 41.

¶ 30 Even absent forfeiture, however, claimant's argument fails on the merits. " 'Collateral estoppel prohibits the relitigation of an issue essential to and actually decided in an earlier proceeding by the same parties or their privies.' " *City of Chicago v. Illinois Workers' Compensation Comm'n*, 2014 IL App (1st) 121507WC, ¶ 51 (quoting *McCulla v. Industrial Comm'n*, 232 Ill. App. 3d 517, 520 (1992)). Collateral estoppel may be asserted when: (1) the issue decided in the prior adjudication is identical to the issue in the current action; (2) the issue was "necessarily determined" in the prior adjudication; (3) the party against whom estoppel is asserted was a party or in privity with a party in the prior action; (4) the party had a full and fair opportunity to contest the issue in the prior adjudication; and (5) the prior adjudication resulted in a final judgment on the merits. *Mabie v. Village of Schaumburg*, 364 Ill. App. 3d 756, 758 (2006). In this case, claimant clearly fails to establish the first element of collateral estoppel. As noted above, case No. 07 IWCC 1154 involved medical treatment through the date of the arbitration hearing plus continued treatment with Dr. Chinthagada. The issue presented to the Commission here involved claimant's treatment after the initial arbitration hearing in May 2005 and treatment from medical professionals other than Dr. Chinthagada. Thus, the issue decided in the underlying litigation is not identical to the issue in the current action. As such, we also reject claimant's collateral estoppel argument.

¶ 31 B. Chain of Physician Referral

¶ 32 Claimant next argues that the Commission erred in finding that she exceeded her choice of physicians. Section 8(a) of the Act (820 ILCS 305/8(a) (West 2008)) sets forth the so-called

"two-physician rule." *Absolute Cleaning/SVMBL v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 463, 468 (2011). Pursuant to that provision, an employer's liability to pay for medical services is limited to (1) first aid and emergency treatment plus (2) two additional doctors chosen by the employee and (3) any additional providers and services recommended by the two physicians selected by the employee. 820 ILCS 305/8(a) (West 2008); *Bob Red Remodeling, Inc. v. Illinois Workers' Compensation Comm'n*, 2014 IL App (1st) 130974WC, ¶ 47. Questions regarding the permissible chain of referrals are questions of fact for the Commission. *Absolute Cleaning/SVMBL*, 409 Ill. App. 3d at 468. We will reverse the Commission's factual findings only if they are against the manifest weight of the evidence. *Bassgar, Inc. v. Illinois Workers' Compensation Comm'n*, 394 Ill. App. 3d 1079, 1085 (2009). A decision is against the manifest weight of the evidence only if an opposite conclusion is clearly apparent. *Will County Forest Preserve District v. Illinois Workers' Compensation Comm'n*, 2012 IL App (3d) 110077WC, ¶ 15.

¶ 33 Regarding the chains of referral, the Commission concluded that Dr. Lewis was referred to claimant by respondent, thereby making Dr. Schiffman claimant's first choice of provider. The Commission further concluded that although claimant was sent to Dr. Chenelle by respondent, the referral was for a section 12 examination, not for treatment. It was only at claimant's own request that Dr. Chenelle became a treating physician. As a result, the Commission concluded that Dr. Chenelle was claimant's second choice of provider. The Commission found that Dr. Chinthagada was within the second chain of referrals because he was referred to claimant by Dr. Chenelle. The Commission observed, however, that Dr. Chinthagada discharged claimant for violating her opioid contract with his office. The Commission concluded that claimant's actions ended the referral chain and "suggest[ed] that the treatment the

claimant was interested in pursuing[] was not medically supported." As a result, the Commission concluded that the subsequent treatment by Dr. Branshaw, Dr. Oken, and Dr. Mocek were outside the permissible chain of referrals.

¶ 34 Claimant first argues that the Commission erred "when it determined Dr. Chenelle was a treating physician." According to claimant, the Commission determined in case No. 07 IWCC 1154 that Dr. Chinthagada was "within the *Respondent's* chain of referral." (Emphasis added.) Because this determination was never appealed and because Dr. Chenelle referred claimant to Dr. Chinthagada, claimant posits that Dr. Chenelle must also fall within "respondent's chain of referral." Thus, she reasons, the Commission's conclusion that Dr. Chenelle constituted *her* choice of physician is contrary to the law of the case. We disagree. As noted above, for the law-of-the-case doctrine to apply, an issue must have been " 'litigated and decided.' " *Help at Home*, 405 Ill. App. 3d at 1151 (quoting *Ming Auto Body/Ming of Decatur*, 387 Ill. App. 3d at 252). The issue of the chain of referrals was not before the arbitrator or the Commission in case No. 07 IWCC 1154. Indeed, as the arbitrator stated in her decision, "[t]here is no objection that [claimant] exceeded the statutory chain of referrals." Thus, any issue regarding the permissible chain-of-referrals could not have been litigated and decided at the earlier hearing. We also observe that in this case, respondent is raising the chain-of-referral issue with regard to treatment that occurred *after* the May 2005 arbitration hearing. While respondent is bound by any medical award arising from the Commission's decision in case No. 07 IWCC 1154, respondent could not have forfeited the application of the two-physician rule as it relates to treatment administered by additional medical providers after the initial arbitration hearing. Indeed, claimant cites no authority that a party is precluded from challenging the propriety of medical treatment occurring after the initial arbitration hearing.

¶ 35 Alternatively, claimant argues that Dr. Branshaw was her second choice of provider, so any treatment rendered by him or any of the medical providers he referred are within the permissible chain of referrals.[4] As noted above, however, the Commission determined that Dr, Schiffman was claimant's first choice of provider and Dr. Chenelle was claimant's second choice of provider. The Commission conceded that claimant was initially sent to Dr. Chenelle by respondent. However, it reasoned that respondent's referral was for a section 12 examination, not for treatment, and claimant thereafter chose on her own to treat with Dr. Chenelle. Claimant does not address the Commission's reasoning, and we find the Commission's finding a reasonable conclusion from the evidence presented. Accordingly, we cannot say that the Commission's findings that Dr. Chenelle constituted claimant's second choice of physician and that Dr. Branshaw fell outside the permissible chain of physicians were against the manifest weight of the evidence.

¶ 36 Claimant also suggests that the treatment from Dr. Oken is an extension of treatment from Dr. Krieger since both of those physicians practice with Marianjoy. Claimant testified that Dr. Lewis referred her to various medical providers, including Dr. Krieger, who is associated

[4] During oral arguments, claimant's attorney asserted that Dr. Branshaw was actually claimant's *first* choice of provider. Aside from the fact that this claim contradicts the position claimant takes in her brief, it finds no support in the record. Neither the arbitrator nor the Commission references any treatment by Dr. Branshaw in their decisions in the underlying claim. More significant, according to the "transaction history report" provided by claimant in the record, she did not begin seeing Dr. Branshaw until October 1999, one year *after* Dr. Chenelle performed surgery at claimant's "request" in October 1998.

with Marianjoy. The Commission found that Dr. Lewis (and the medical providers referred by him) fell within the permissible chain of referrals because claimant was referred to him by respondent. However, the Commission rejected claimant's argument that Dr. Oken (who is also associated with Marianjoy) and Dr. Krieger constituted a singular provider based on their affiliations with Marianjoy. In this regard, the Commission, citing Dr. Oken's testimony, found that Dr. Oken and Dr. Krieger work in separate offices and they do not share either records or patients. The Commission also observed that Dr. Krieger did not refer claimant to Dr. Oken. In light of Dr. Oken's testimony, the Commission's finding that Dr. Oken and Dr. Krieger did not constitute a singular provider was reasonable. As such, based on the record before us, we cannot say that a conclusion opposite that of the Commission is clearly apparent. Hence, the Commission's finding in this regard is not against the manifest weight of the evidence.

¶ 37 Finally, claimant suggests that she was forced to seek care from another physician because Dr. Chinthagada refused to treat her. Thus, she argues the two-physician limitation should not apply to treatment rendered by Dr. Branshaw and the medical providers referred by him. In support of this claim, claimant directs us to *Lanter Courier v. Industrial Comm'n*, 282 Ill. App. 3d 1 (1996).

¶ 38 In *Lanter Courier*, the claimant's second-choice of physician advised her on the second visit that he would not treat her unless she lost a substantial amount of weight. *Lanter Courier*, 282 Ill. App. 3d at 7. We held, under the limited factual scenario in that case, that the physician's refusal to treat the claimant compelled her to seek treatment from another physician, and therefore the refusing physician did not constitute a "choice" under section 8(a) of the Act. *Lanter Courier*, 282 Ill. App. 3d at 8. *Lanter Courier* does not apply to the facts of this case. In *Lanter Courier*, the physician's refusal to treat was not the result of the claimant's violation of

the physician's established treatment protocol. Here, in contrast, Dr. Chinthagada's refusal to provide ongoing treatment stemmed from claimant's decision to obtain prescription narcotics through another physician while she was treating with Dr. Chinthagada. This was in violation of the treatment protocol between claimant and Dr. Chinthagada. For these reasons, we reject claimant's reliance on *Lanter Courier* and affirm the Commission's findings regarding the two-physician limitation.

¶ 39 C. Medical Expenses

¶ 40 Next, claimant challenges the Commission's finding relative to the payment of additional medical expenses. According to claimant, she is entitled to an award in the amount of $320,684.58 for "medical bills not paid by respondent pursuant to section 8(a) of the Act and the law of the case from 07 IWCC 1154." At the outset, we observe that the Commission denied these bills, in part, on the basis that respondent denied receiving them. Claimant insists that she sent the bills to respondent by email at the time her section 8(a) petition was filed. However, the pages of the record claimant cites in support of her position are merely the petition itself and bills from Dr. Oken's treatment at Marianjoy. As noted, Dr. Oken's treatment falls outside the permissible chain of referrals and, therefore, was properly denied.

¶ 41 The remainder of claimant's "argument" consists of one short paragraph in which she notes that the group of medical bills she tendered consists of expenses incurred between May 16, 2005, and September 26, 2014. Claimant then states that the decision of the Commission in case No. 07 IWCC 1154 "provided for open medical and pain management that she was then receiving from Dr. Chinthagada in the form of pain medication, injections, and analgesics" and that "[r]espondent did not pay for any pain management treatment following the 5/18/05 hearing." Claimant concludes that "[n]o legal basis exists for respondent's refusal to pay for the

bills submitted." Claimant, however, fails to direct us to any bill from Dr. Chinthagada or any other medical professional within the permissible chain of referrals that has not been paid. Although she does refer us to a group exhibit containing medical bills that reportedly remain unpaid, this exhibit consists of more than 100 pages from several medical providers (Dr. Branshaw, Marianjoy, Delnor, IWP, her husband's group insurance carrier, and various pharmacies) with thousands of line items. The Commission denied these expenses and claimant does not address the Commission's rationale for doing so, other than her brief claim that she emailed the bills to respondent. It has often been stated that a court of review "is not a repository into which an appellant may foist the burden of argument and research." *Ramos v. Kewanee Hospital*, 2013 IL App (3d) 120001, ¶ 37 (citing *Velocity Investments, LLC v. Alston*, 397 Ill. App. 3d 296, 297 (2010)). Illinois Supreme Court Rule 341(h)(7) (eff. Jan. 1, 2016) requires the appellant's brief to contain "the contentions of the appellant and the reasons therefor, with citation of the authorities *** relied on." Under this rule, points not argued are forfeited. *Compass Group v. Illinois Workers' Compensation Comm'n*, 2014 IL App (2d) 121283WC, ¶ 33; see also *Ramos*, 2013 IL App (3d) 120001, ¶ 37 (providing that the failure to properly develop an argument and support it with citation to relevant authority results in forfeiture of that argument). In light of claimant's failure to develop this argument, direct us to the bills from the permissible chain of referrals that have not been paid, clearly address the reasons cited by the Commission for rejecting her claim for these medical expenses, or cite any authority in support of her position, we deem this argument forfeited. Even had claimant not forfeited this issue, we observe that the bills in claimant's group exhibit primarily pertain to treatment outside the permissible chain of referrals. As such, they would have been properly denied.

¶ 42 D. Penalties and Attorney Fees

¶ 43 Finally, claimant challenges the Commission's denial of attorney fees under section 16 of the Act (820 ILCS 305/16 (West 2008)) and penalties under sections 19(k) and 19(l) of the Act (820 ILCS 305/19(k), (l) (West 2008)). According to claimant, she is entitled to attorney fees and penalties due to claimant's "vexatious refusal to authorize and pay medical expenses related to the treatment of [her] work injury despite the fact that she had open medical benefits pursuant to section 8(a) of the Act, and *** pain treatment was specifically awarded by the Commission in [case No.] 07 IWCC 1154."

¶ 44 The intent of sections 16, 19(k), and 19(l) is to implement the Act's purpose to expedite the compensation of industrial workers and to penalize employers who unreasonably, or in bad faith, delay or withhold compensation due an employee. *Avon Products, Inc. v. Industrial Comm'n*, 82 Ill. 2d 297, 301 (1980). However, the standard for granting penalties under section 19(l) differs from the standard for granting penalties under section 19(k) and attorney fees under section 16.

¶ 45 Penalties under section 19(l) are in the nature of a late fee. *McMahan v. Industrial Comm'n*, 183 Ill. 2d 499, 515 (1998). The assessment of a penalty under section 19(l) is mandatory if a payment is late and the employer or its insurer cannot show an adequate justification for the delay. *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 763 (2003). The standard for determining whether an employer has "good and just cause" for a delay in payment is defined in terms of reasonableness. *Mechanical Devices*, 344 Ill. App. 3d at 763 "The employer has the burden of justifying the delay, and the employer's justification for the delay is sufficient only if a reasonable person in the employer's position would have believed that the delay was justified." *Jacobo v. Illinois Workers' Compensation Comm'n*, 2011 IL App (3d) 100807WC, ¶ 20. Thus, where the employer relies upon "responsible medical opinion or

when there are conflicting medical opinions," penalties under section 19(l) are not ordinarily imposed. *Avon Products, Inc. v. Industrial Comm'n*, 82 Ill. 2d 297, 302 (1980); *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 763 (2003). The Commission's evaluation of the reasonableness of the employer's delay is a question of fact that will not be disturbed unless it is contrary to the manifest weight of the evidence. *Crockett v. Industrial Comm'n*, 218 Ill. App. 3d 116, 121-22 (1991).

¶ 46 In contrast to section 19(l) of the Act, section 19(k) allows penalties for "any unreasonable or vexatious delay of payment or intentional underpayment of compensation." 820 ILCS 305/19(k) (West 2008). Penalties under Section 19(k) are "intended to address situations where there is not only a delay, but the delay is deliberate or the result of bad faith or improper purpose." *McMahan*, 183 Ill. 2d at 515. Section 16 of the Act, in turn, provides for an award of attorney fees when an award of additional compensation under section 19(k) is appropriate. 820 ICLS 305/16 (West 2008). The imposition of attorney fees under section 16 of the Act and of penalties under section 19(k) of the Act is discretionary and will not be disturbed on appeal unless the trial court has abused that discretion. *McMahan*, 183 Ill. 2d at 515. In this case, we conclude that the Commission's denial of attorney fees and penalties is neither against the manifest weight of the evidence nor an abuse of discretion.

¶ 47 The claimant maintains that she is entitled to attorney fees and penalties because respondent vexatiously refused to authorize and pay medical expenses related to the treatment of her work injury despite the fact that she had open medical benefits pursuant to section 8(a) of the Act. As noted above, the Commission in case No. 07 IWCC 1154 did award claimant medical through the May 18, 2005, arbitration hearing as well as continued treatment with Dr. Chinthagada. The record in this case, however, shows that Dr. Chinthagada withdrew from

further treatment of claimant because she violated his treatment protocol by obtaining prescription narcotics through another physician. Claimant now seeks reimbursement for treatment from medical providers other than Dr. Chinthagada. In addition, as the Commission observed, claimant sustained a significant intervening accident for which respondent secured section 12 opinions disputing claimant's position that her ongoing complaints are causally related to her September 1997 work accident. Under these circumstances, the Commission could reasonably conclude that respondent's conduct did not meet the standard for unreasonable delay under section 19(l), or the higher standard of bad faith for awarding attorney fees and penalties under sections 16 and 19(k), respectively. Accordingly, the Commission properly denied the claimant's petition for attorney fees and penalties.

¶ 48 III. CONCLUSION

¶ 49 For the reasons set forth above, we affirm the judgment of the circuit court of Kane County which confirmed the decision of the Commission granting in part and denying in part claimant's petition for additional medical under section 8(a) of the Act and denying her petition for attorney fees under section 16 of the Act and penalties under sections 19(k) and 19(l) of the Act.

¶ 50 Affirmed.