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IN THE  
APPELLATE COURT OF ILLINOIS  
FIFTH DISTRICT  
WORKERS' COMPENSATION COMMISSION DIVISION

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METROPLEX,	)	Appeal from the Circuit Court
	)	of Madison County.
Appellant,	)	
	)	
v.	)	No. 10-MR-204
	)	
ILLINOIS WORKERS' COMPENSATION	)	
COMMISSION <i>et al.</i>	)	Honorable
	)	Clarence W. Harrison II,
(Terry Sumner, Appellee).	)	Judge, Presiding.

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JUSTICE HUDSON delivered the judgment of the court.  
Presiding Justice McCullough and Justices Hoffman, Holdridge, and Stewart concurred in the judgment.

**ORDER**

¶ 1 *Held:* (1) Commission could have reasonably concluded that income claimant received from home-repair business was occasional and not regular and continuous; thus, its award of TTD benefits was not against the manifest weight of the evidence; (2) the failure of claimant's physician to comply with procedure for billing employer for treatment did not render Commission's award of medical expenses improper; (3) Commission's award of \$7,011.46 in medical expenses and its order that respondent authorize and pay for prospective medical treatment was not against the manifest weight of the evidence; (4) Commission's award of additional compensation pursuant

to section 19(l) of the Act would be reversed where employer had a good-faith dispute as to its liability for TTD benefits during period of time claimant worked for and received income from home-improvement business; and (5) Commission's awards of penalties pursuant to section 19(k) of the Act and attorney fees pursuant to section 16 of the Act were against the manifest weight of the evidence.

¶ 2 Claimant, Terry Sumner, filed an application for adjustment of claim pursuant to the Workers' Compensation Act (Act) (820 ILCS 305/1 *et seq.* (West 2006)) alleging that he sustained various injuries to his person on July 5, 2007, while employed by respondent, Metroplex. On July 24, 2008, a hearing was held pursuant to section 19(b) of the Act (820 ILCS 305/19(b) (West 2006)). The arbitrator determined that claimant sustained a work-related accident and awarded claimant 54 weeks of temporary total disability (TTD) benefits (see 820 ILCS 305/8(b) (West 2006)) and \$4,161.15 for medical expenses (see 820 ILCS 305/8(a) (West 2006)). In addition, the arbitrator ordered respondent to authorize and pay for prospective diagnostic testing and treatment. The Illinois Workers' Compensation Commission (Commission) reduced the period of TTD to 11-1/7 weeks, but otherwise affirmed and adopted the decision of the arbitrator. The Commission remanded the matter to the arbitrator for further proceedings pursuant to *Thomas v. Industrial Comm'n*, 78 Ill. 2d 327 (1980). Neither party sought review of the Commission's decision.

¶ 3 Upon remand, a second hearing pursuant to section 19(b) was held on November 19, 2009. Following that hearing, the arbitrator concluded that claimant's condition of ill-being remained related to the work injury of July 5, 2007. The arbitrator awarded claimant an additional 69 weeks of TTD benefits (see 820 ILCS 305/8(b) (West 2006)) and an additional \$7,011.46 in medical expenses (see 820 ILCS 305/8(a) (West 2006)) and ordered respondent to authorize prospective medical care. In addition, the arbitrator assessed penalties against respondent pursuant to section

19(k) of the Act (820 ILCS 305/19(k) (West 2006)), additional compensation pursuant to section 19(l) of the Act (820 ILCS 305/19(l) (West 2006)), and attorney fees pursuant to section 16 of the Act (820 ILCS 305/16 (West 2006)). The Commission affirmed and adopted the decision of the arbitrator in its entirety and again remanded the matter pursuant to *Thomas*. On judicial review, the circuit court of Madison County confirmed. Respondent now challenges the Commission's award of TTD benefits, medical expenses, penalties, and attorney fees. We affirm in part, vacate in part, and remand.

¶ 4

#### I. BACKGROUND

¶ 5 In November 2007, claimant filed an application for adjustment of claim alleging that on July 5, 2007, he sustained various injuries to his person while in respondent's employ. The matter proceeded to arbitration on July 24, 2008, pursuant to section 19(b) of the Act (820 ILCS 305/19(b) (West 2006)). A complete copy of the transcript of the July 24, 2008, hearing has not been included in the record on appeal. Accordingly, in setting forth the events testified to at that hearing, we rely principally on the statement of facts authored by the arbitrator.

¶ 6 Respondent operates two apartment buildings with approximately 104 units. Claimant learned of a job as respondent's maintenance supervisor when he was contacted by respondent's property manager in response to an advertisement claimant had placed. Claimant was eventually offered the position, and he accepted. On July 5, 2007, claimant was injured at work while attempting to move a 60-inch mower deck. Claimant testified that when he informed respondent of the injury, he was discharged.

¶ 7 Claimant presented to the emergency room at Memorial Hospital in Belleville on July 12,

2007. At that time, claimant complained of pain from the shoulders to the hands, in the chest wall, and in the right lower abdomen. Claimant indicated that the pain began a week earlier, after he attempted to install a 60-inch mower deck on a tractor. Claimant was diagnosed with musculoskeletal upper extremity and chest wall pain secondary to strain and a right inguinal hernia. On July 18, 2007, claimant followed up at Belleville Family Medical Associates (Belleville Medical) and was diagnosed with a shoulder/neck strain and an inguinal hernia. The physician referred claimant to a surgeon for hernia repair. However, claimant testified that he lacked health insurance and could not afford to see a surgeon. Claimant further testified that he asked respondent to authorize benefits through its workers' compensation carrier, but respondent refused.

¶ 8 Claimant was examined by Dr. Jacques Van Ryn on May 7, 2008, upon referral from his attorney. The history of injury provided to Dr. Van Ryn was consistent with the history provided to previous treaters. Dr. Van Ryn diagnosed possible herniated discs in the neck, radial tunnel syndrome, cubital tunnel syndrome with possible ulnar tunnel syndrome, a possible superior labral tear of the shoulder, possible lumbar herniated disc, and a right inguinal hernia. Dr. Van Ryn opined that each of these diagnoses were "a direct result" of the July 5, 2007, incident. Dr. Van Ryn recommended (1) MRIs of the neck, the thoracic spine, and the lumbar spine; (2) an MRI of the right shoulder with a gadolinium arthrogram; and (3) an EMG/nerve conduction velocity study of the right upper extremity. Dr. Van Ryn concluded that claimant was unable to do "useful work" because of his condition. However, at his deposition, Dr. Van Ryn acknowledged that claimant was not totally disabled and that he could perform sedentary work.

¶ 9 Claimant denied ever having a herniated disc in his cervical spine or a torn labrum in his

shoulder prior to the July 5, 2007, incident. Claimant did acknowledge that he was seen at Belleville Medical in 2001 for an injury to his neck. According to claimant, however, he had no ongoing problems after being treated for that injury and he was able to work full duty leading up to the event of July 5, 2007. Claimant also acknowledged that he was diagnosed with a hernia in 2001. He recounted that this was an incidental finding during a physical examination and that he had not seen the doctor specifically for problems in that area. Claimant stated that he had no pain in the area until after the episode in 2007 and that the bulge increased dramatically after the incident.

¶ 10 Claimant testified that he has not returned to work since the July 5, 2007, accident. He did admit to restarting a home-repair business he had owned and operated prior to going to work for respondent. However, he testified that all of the physical labor is done by family members and he only assists with the bids. Claimant testified that he continued to experience pain at the hernia site, especially when he tries to lift any weight. In addition, claimant reported ongoing problems with his neck, shoulders, upper extremities, and low back. Claimant testified that there remained outstanding medical bills totaling \$4,161.15.

¶ 11 Based on the foregoing evidence, the arbitrator concluded that claimant sustained a work-related accident on July 5, 2007, causing injuries to his back, upper extremity, and abdomen. The arbitrator also noted that Dr. Van Ryn causally related possible neck herniations, a torn labrum, and a hernia to the work injury. The arbitrator awarded claimant TTD benefits from July 12, 2007, through July 24, 2008, a period of 54 weeks. See 820 ILCS 305/8(b) (West 2006). In addition, the arbitrator awarded \$4,161.15 in medical expenses and ordered respondent to “authorize and pay for the recommended diagnostic testing and surgeries, specifically the hernia repair surgery, and others

if applicable.” The arbitrator denied claimant’s request for penalties and attorney fees.

¶ 12 In a decision filed on July 17, 2009, the Commission found that it was not until claimant saw Dr. Van Ryn on May 7, 2008, that he was authorized off work. As such, the Commission determined that claimant was entitled to TTD benefits only from May 7, 2008, through July 24, 2008, a period of 11-1/7 weeks. The Commission otherwise affirmed and adopted the decision of the arbitrator and remanded the matter for further proceedings pursuant to *Thomas*. Neither party sought further review of the Commission’s decision.

¶ 13 Upon remand, a second arbitration hearing was held on November 19, 2009, also pursuant to section 19(b) of the Act (820 ILCS 305/19(b) (West 2006)). At the remand hearing, claimant testified that during the pendency of the appeal of the arbitrator’s decision, he continued to treat with Dr. Van Ryn, who prescribed medication and authorized him to remain off work. Claimant further testified that following affirmance by the Commission of the arbitrator’s decision, respondent refused to authorize and pay for the diagnostic testing and treatment recommended by Dr. Van Ryn. Nevertheless, claimant did undergo an EMG/NCV study (which confirmed cubital tunnel syndrome) and MRIs of his neck, thoracic spine, and lumbar spine.

¶ 14 Dr. Van Ryn testified by evidence deposition taken on October 9, 2009, that he continued to see claimant after his initial examination. Dr. Van Ryn interpreted the MRI of the thoracic spine as showing some mild spondylosis. The MRI of the cervical spine (neck) showed decreased signal at all levels, indicating degenerative disc disease, and a small central disc protrusion at C3-4. The MRI of the lumbar spine showed loss of signal at the L4-5 disc and a bulging disc with some central spinal stenosis mildly at L3-4 and L5-S1. Dr. Van Ryn testified that claimant paid for the MRIs at

his own expense. Dr. Van Ryn's diagnoses remained essentially unchanged, and he continued to relate claimant's conditions to the event of July 5, 2007. Dr. Van Ryn recommended physical therapy and strength training for claimant's shoulder, a hernia-repair evaluation, an arthrogram for the shoulder, and an evaluation for radiculopathy of the neck and back. Dr. Van Ryn stated that since the treatment he had previously recommended had not been authorized, he instructed claimant on home exercise and prescribed medication and steroid injections. Dr. Van Ryn also continued to authorize claimant off work until completion of the recommended treatment.

¶ 15 Claimant testified that after the Commission affirmed the arbitrator's award, respondent referred him to Dr. R. Peter Mirkin for an independent medical examination. According to claimant, Dr. Mirkin only spent 10 minutes with him. Dr. Mirkin examined claimant on September 9, 2009, prepared a report of his findings, and testified by evidence deposition regarding the same. Dr. Mirkin did not know how long his visit with claimant lasted, although he stated that he typically allots 45 minutes for these types of examinations. Claimant provided a history to Dr. Mirkin of an injury occurring on July 5, 2007, while employed by respondent as a maintenance worker. Claimant explained that he was manipulating a 60-inch lawnmower deck onto a tractor when he experienced pain in his neck, low back, and both legs plus numbness in his right hand. Claimant also reported developing a hernia in the right inguinal area. Claimant denied any prior problems with his neck, back, or abdomen. Dr. Mirkin testified that when he showed claimant medical records to the contrary, claimant asserted that the authors of those records were untruthful. Claimant later acknowledged that he had a history of neck problems, but stated that he was unaware that he had a hernia before. Dr. Mirkin performed a physical examination and reviewed various medical records

and the MRI reports. Dr. Mirkin opined that claimant's symptoms were "out of proportion to what [he] saw on examination." He felt that claimant was "unreliable in his history" in that claimant had a preexisting hernia that was documented in the medical records and preexisting degenerative spine disease as documented in the medical records and confirmed by the MRI scans. Dr. Mirkin's diagnosis was a resolved cervical strain as a result of the work accident and severe symptom magnification behavior. Dr. Mirkin concluded that claimant was not in need of any additional medical care or surgery related to the incident at work, that claimant was at maximum medical improvement (MMI), and that claimant could return to work without restrictions.

¶ 16 Claimant testified that his symptoms have not improved since the first hearing. He continues to have pain at the site of the hernia as well as the sensation that the hernia wants to bulge out when he attempts to lift anything. Claimant also has symptoms in his neck radiating down his arms into his hands. In addition, claimant continues to experience pain in the right shoulder which causes problems with lifting items. Claimant also has symptoms in his low back that radiate down his right leg and numbness and a burning sensation of the foot.

¶ 17 Claimant also provided additional testimony regarding his business, TJS Home Repair. Claimant stated that he started the business approximately 10 years earlier. While working for respondent, TJS Home Repair became "inactive," and he did no work for it. However, he occasionally received inquiries from potential clients and, in June 2008, began accepting jobs. Claimant testified that as a result of his injury, he was unable to perform any physical labor associated with the jobs. As a result, he fielded calls, prepared estimates, and subcontracted out the physical work to an entity known as Reese and Rich's Home Improvement Company. Occasionally,

claimant would also travel to the work site to make sure that the job was being done properly and bring the workers supplies and lunches.

¶ 18 Claimant provided a chart of each of the jobs that he had accepted and copies of bids for the completed jobs. Claimant testified that for each job he had to pay labor expenses to Reese and Rich's Home Improvement Company. Claimant would retain any proceeds that were left over. Claimant noted that traditionally, he would have performed the physical labor himself and would not have had to pay any of the labor costs out of the contract.

¶ 19 Richard Sumner testified that he is claimant's older brother and one of the proprietors of Reese and Rich's Home Improvement Company. Sumner testified that Reese and Rich's Home Improvement Company would obtain job referrals from TJS Home Repair and would perform the physical labor associated with the referrals. Sumner testified that while claimant would occasionally visit the work sites, he would never perform any of the physical labor associated with the projects. Sumner did note, however, that claimant would sometimes obtain supplies or lunch for the crew. Reese Hendrickson testified that he was also a proprietor of Reese and Rich's Home Improvement Company. The testimony provided by Hendrickson was similar to that of Sumner.

¶ 20 Based on the foregoing evidence, the arbitrator determined that claimant's condition of ill-being remained causally related to his work injury of July 5, 2007. The arbitrator gave no weight to the opinion of Dr. Mirkin on the basis that "the issues addressed by him were previously addressed by this arbitrator and the Commission on Review." Noting that Dr. Van Ryn continues to advise claimant to remain off work, the arbitrator awarded claimant TTD benefits from July 25, 2008, through November 19, 2009, a period of 69 weeks. See 820 ILCS 305/8(b) (West 2006). The

arbitrator awarded \$7,011.46 in medical expenses incurred since the initial hearing. See 820 ILCS 305/8(a) (West 2006). The arbitrator noted that claimant has continued to seek medical treatment from Dr. Van Ryn, who has prescribed further testing, and that claimant has personally paid for some of this testing. The arbitrator admonished respondent for failing to provide the prescribed medical treatment following the Commission's earlier decision, and the arbitrator again ordered respondent to authorize the medical care prescribed by Dr. Van Ryn as well as any referrals for future care.

¶ 21 The arbitrator also ordered respondent to pay claimant penalties pursuant to section 19(k) of the Act (820 ILCS 305/19(k) (West 2006)) in the amount of \$3,505.73 plus an amount to be determined for 50% of the prospective medical expenses which were ordered in the prior decision.

The arbitrator explained:

“Respondent has unreasonably and vexatiously refused to provide medical treatment in spite of the Commission decision ordering them [*sic*] to provide such treatment. Instead, Respondent has chosen to unreasonably rely on the conclusions of their independent medical examiner even though those issues were addressed in the earlier hearing and Award. Respondent's conduct is a slap in the face to the Commission and is reprehensible! Respondent did not schedule its medical evaluation until 10/9/09 [*sic*]. In spite of this delay, Respondent failed to authorize any further medical benefits or lost time benefits without any form of justification leading up to this evaluation. Respondent did not provide any explanation for non-payments of benefits until after it received its examiner's report of 10/9/09. Such actions by Respondent are reprehensible, unreasonable and vexatious \*\*\*.”

The arbitrator also awarded additional compensation in the amount of \$10,000 under section 19(l)

of the Act (820 ILCS 305/19(l) (West 2006)) for respondent's failure to pay "lost time benefits past the date of the first trial in spite of the fact that Respondent had no counter opinions that [claimant] might be employable until 10/9/09 [sic]." Finally, the arbitrator concluded that respondent's "continued refusal to provide benefits in spite of the Commission's decision lead [sic] to the need for a second trial." Accordingly, he awarded attorney fees in the amount of \$18,823.48 pursuant to section 16 of the Act (820 ILCS 305/16 (West 2006)). The Commission affirmed and adopted the arbitrator's decision and remanded the cause for further proceedings pursuant to *Thomas*. Thereafter, the circuit court of Madison County confirmed the decision of the Commission. This appeal followed.

¶ 22

## II. ANALYSIS

¶ 23

### A. TTD Benefits

¶ 24 On appeal, respondent first challenges the Commission's award of TTD benefits for the period from July 25, 2008, through November 19, 2009. According to respondent, between June 2008 and August 2009, claimant "actively participated" in the TJS Home Repair business, earning more than \$16,000. Thus, respondent reasons, claimant failed to establish that he was physically incapable of returning to work and claimant is not entitled to TTD benefits during this period. Claimant responds that his "passive income" from TJS Home Repair did not negate his temporary total disability status as he did not perform any of the physical labor associated with these jobs.

¶ 25 To establish temporary total disability, an employee must demonstrate not only that he did not work, but also that he was unable to work. *Schmidgall v. Industrial Comm'n*, 268 Ill. App. 3d 845, 848 (1994). However, evidence that an employee has been or is able to earn occasional wages

or perform certain useful services does not preclude a finding of total disability. *Dolce v. Industrial Comm'n*, 286 Ill. App. 3d 117, 121 (1996). It is the employee's burden to show that income earned while he is disabled was only occasional wages and not income from employment in the labor market. *Dolce*, 286 Ill. App. 3d at 121. Whether the employee is entitled to compensation for temporary total disability is a question of fact for the Commission. *Archer Daniels Midland Co. v. Industrial Comm'n*, 138 Ill. 2d 107, 118-19 (1990). The Commission's determination on a factual matter will not be disturbed on appeal unless it is against the manifest weight of the evidence. *Whitney Productions, Inc. v. Industrial Comm'n*, 274 Ill. App. 3d 28, 30 (1995). For a finding to be against the manifest weight of the evidence, an opposite conclusion must be clearly apparent. *Dolce*, 286 Ill. App. 3d at 120.

¶ 26 In support of its assertion that claimant is not entitled to TTD benefits for the period from July 24, 2008, through November 19, 2009, respondent relies on *Dolce*. In that case, the employee worked as a deliveryman. He also sold real estate on a part-time basis. After the employee injured his knee during a delivery, he continued to sell real estate. In 1987, prior to his injury, the employee completed nine real-estate transactions. Thereafter, his sales progressed yearly as did his income. In 1988, the employee completed 14 sales, earning \$22,155.31. In 1989, the employee completed 26 sales, earning \$36,534.09. Between January 1990 and July 1990, the employee completed 19 sales, earning \$28,220.18. At the arbitration hearing, the employer argued that although the employee was unable to work as a deliveryman, he was not temporarily totally disabled because he earned income as a real estate agent. The Commission agreed. This court affirmed, holding that the employee was not entitled to TTD benefits because his post-injury income as a real estate agent was

“regular and continuous, and not occasional.” *Dolce*, 286 Ill. App. 3d at 120-22.

¶ 27 We find the present case and *Dolce* to be factually dissimilar. In *Dolce*, the employee regularly completed sales throughout the year, and throughout the entire period that he was unable to work for the employer. *Dolce*, 286 Ill. App. 3d at 121. In this case, claimant testified that he established his business, TJS Home Repair, years before his injury. However, the business became inactive after he began working for respondent. TJS Home Repair began booking jobs again in June 2008, about one year after the injury at issue. Traditionally, claimant would perform the physical labor himself. However, as a result of the injuries claimant sustained while working for respondent, his role in the business was limited to light-duty work such as fielding calls from clients, preparing estimates, purchasing supplies, and visiting the job sites to check on the progress of work. Claimant subcontracted the physical labor to a business owned in part by his brother. Admitted into evidence was a summary prepared by claimant of the jobs completed by TJS Home Repair and copies of the bids claimant prepared for those jobs. These documents establish that between June 2008 and August 2009, TJS Home Repair completed 10 jobs.<sup>1</sup> The bid sheets show that TJS Home Repair bid on three of the ten jobs in June 2008, three of the jobs in September 2008, two of the jobs in October 2008, one of the jobs in July 2009, and one of the jobs in August 2009.<sup>2</sup> The job summary also

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<sup>1</sup>The summary sheet prepared by claimant actually lists 11 individual jobs. However, our review of the bid sheets upon which the summary is based indicates that the fourth entry and the eleventh entry on the summary sheet are duplicates.

<sup>2</sup>Although one of the bid sheets is not dated, it is for work on a home for which a June 2008 bid was also prepared. Therefore, we categorize it as a June 2008 bid.

shows that after paying Reese and Rich's Home Improvement for labor costs, claimant netted a total of \$13,786 for these 10 jobs.

¶ 28 Based on this evidence, the Commission could have reasonably concluded that claimant's work for TJS Home Repair was occasional and not regular and continuous. TJS Home Repair was hired for a total of 10 jobs over a course of 15 months. This averages out to less than one job per month. Moreover, there was an eight-month gap between October 2008 and July 2009, during which TJS Home Repair was not hired for any jobs. Similarly, claimant's income from his work for TJS Home Repair was occasional and not regular and continuous. The summary sheet indicates that after paying out labor costs to Reese and Rich's Home Improvement, claimant's net profit averaged \$1,378 per job. However, the profit per job varied widely from a low of zero dollars to a high of \$3,256. Accordingly, we cannot say that a conclusion opposite to the one reached by the Commission is clearly apparent. Therefore, we affirm the Commission's award to claimant of TTD benefits for the period from July 25, 2008, through November 19, 2009.

¶ 29 **B. Medical Expenses**

¶ 30 Respondent next argues that the Commission erred in awarding claimant \$7,011.46 in medical expenses and ordering it to authorize and pay for medical treatment recommended by Dr. Van Ryn. Respondent's argument is twofold. First, respondent contends that it was against the manifest weight of the evidence and contrary to law for the Commission to award medical expenses and order it to authorize the treatment recommended by Dr. Van Ryn because Dr. Van Ryn did not comply with the procedure for billing an employer for medical expenses. See 820 ILCS 305/8.2(d) (West 2006). Second, respondent disputes liability for charges incurred after September 9, 2009,

based on the opinion of Dr. Mirkin that claimant had reached MMI by that date. Claimant responds that the Commission's award of \$7,011.46 in medical expenses and prospective medical treatment is not against the manifest weight of the evidence because "this medical treatment had previously been ordered by the Commission."

¶31 Following the section 19(b) hearing held in July 2008, the arbitrator determined that claimant sustained a work-related accident on July 5, 2007. At that time, the arbitrator ordered respondent to pay the \$4,161.15 in medical bills submitted up to that point and also ordered respondent "to authorize and pay for the recommended diagnostic testing and surgeries, specifically the hernia repair surgery, and others if applicable." The Commission affirmed and adopted these findings, and respondent took no further appeals. As such, this became the law of the case. See *Ming Auto Body/Ming of Decatur, Inc. v. Industrial Comm'n*, 387 Ill. App. 3d 244, 253 (2008) ("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."); see also *Help at Home v. Illinois Workers' Compensation Comm'n*, 405 Ill. App. 3d 1150, 1151 (2010) (noting that the "principles underlying the [law-of-the-case] doctrine apply to matters resolved in proceedings before the Commission."). While respondent asserts that it has "satisfied the prior awarded medical bills," the record suggests that it has not authorized any of the prospective testing and treatment previously ordered by the Commission. Thus, to the extent respondent is challenging the award of diagnostic testing and prospective medical treatment recommended by Dr. Van Ryn and awarded by the Commission as a result of the section 19(b) hearing held in July 2008, it is barred from doing so. See *Irizarry v. Industrial Comm'n*, 337 Ill. App. 3d 598, 605-07 (2003). However, respondent is not

barred from challenging the propriety of any medical expenses incurred following the date of the section 19(b) hearing in July 2008 as those expenses were not and could not have been addressed 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).

¶ 32 With respect to respondent's dispute to liability for those medical expenses incurred following the initial arbitration hearing, we find respondent's arguments unpersuasive. Respondent relies on section 8.2(d) of the Act (820 ILCS 305/8.2(d) (West 2006)), which provides as follows:

*“When a patient notifies a provider that the treatment, procedure, or service being sought is for a work-related illness or injury and furnishes the provider the name and address of the responsible employer, the provider shall bill the employer directly. The employer shall make payment and providers shall submit bills and records in accordance with the provisions of this Section. All payments to providers for treatment provided pursuant to this Act shall be made within 60 days of receipt of the bills as long as the claim contains substantially all the required data elements necessary to adjudicate the bills. In the case of nonpayment to a provider within 60 days of receipt of the bill which contained substantially all of the required data elements necessary to adjudicate the bill or nonpayment to a provider of a portion of such a bill up to the lesser of the actual charge or the payment level set by the Commission in the fee schedule established in this Section, the bill, or portion of the bill, shall incur interest at a rate of 1% per month payable to the provider.”*

(Emphasis added.) 820 ILCS 305/8.2(d) (West 2006).

Relying on the portion of the statute italicized above, respondent claims that it should not be required to pay claimant's medical bills because Dr. Van Ryn did not follow the billing procedure set forth in the statute. In support of its claim that Dr. Van Ryn failed to comply with the statute, respondent relies on testimony from Dr. Van Ryn's October 9, 2009, deposition.

¶ 33 During that deposition, Dr. Van Ryn testified on direct examination that respondent's workers' compensation carrier had neither authorized any of the treatment he recommended nor paid any of his bills. On cross-examination, the following exchange occurred between Dr. Van Ryn, Martin Spiegel (respondent's attorney), and David Jerome (claimant's attorney):

“Q [by Spiegel]. Okay. Now, you're not sending [claimant's medical] records on to the insurance company, are you, the workers' compensation carrier?”

A [by Dr. Van Ryn]. I've not been appraised [*sic*] that the workers' compensation carrier will accept or pay the bills.

Q. Okay. Let's talk about the bills. You have the bills in your chart—in a section of your chart; correct Doctor?

A. Yeah. We have the face sheets. These are our billing forms.

Q. Okay. Are any of them directed to the insurance company?

A. No, they are not.

Q. They're directed to [claimant] and David Jerome?

A. That is correct.

Q. Okay. So they've never been submitted to the insurance company, have they?

MR. JEROME: Objection. They have been. I've sent them directly to your office with each report.

MR. SPIEGEL: You're not testifying counsel. I'm asking the Doctor—

MR. JEROME: I'm the one telling you.

MR. SPIEGEL: I'm asking the Doctor if his office has ever submitted the bills to the workers' compensation carrier.

MR. JEROME: And I'm telling you it's a non-issue because I'm the one that submitted them to the insurance company.

MR. SPIEGEL: You're not testifying. I'm asking the Doctor. Thank you, Doctor.

A [Dr. Van Ryn]: My new office here has not directed the bills to his workers' compensation carrier because in the old office we were instructed that the workers' compensation carrier was not paying the bills.

Q. (By MR. SPIEGEL) And you were instructed by Mr. Jerome?

A. Yes."<sup>3</sup>

According to respondent, the foregoing testimony demonstrates that Dr. Van Ryn failed to submit the medical bills associated with claimant's treatment in accordance with the procedure set forth in section 8.2(d). As such, respondent insists that the Commission's award of medical expenses is against the manifest weight of the evidence.

¶ 34 Respondent's argument is not well taken. Respondent does not assert that it never received copies of Dr. Van Ryn's records or medical bills, only that it did not receive them *directly from Dr.*

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<sup>3</sup>The arbitrator, upon reviewing the deposition, sustained the objection of claimant's attorney.

*Van Ryn*. However, respondent does not cite any language in section 8.2(d), or, for that matter, any other provision of the Act, for the proposition that the statute was intended to absolve an employer of responsibility for medical expenses if the claimant's medical provider fails to comply with the procedure set forth in section 8.2(d). Indeed, respondent focuses on just the first sentence of the statute to the exclusion of the statute's remaining language. In *Vulcan Materials Co. v. Industrial Comm'n*, 362 Ill. App. 3d 1147, 1152 (2005), we noted that the purpose of section 8.2(d) is to compensate a medical provider for an employer's delay paying undisputed medical bills. The statute simply is not intended to provide the employer with an excuse for not paying medical bills.

¶ 35 In any event, we find that respondent has forfeited this argument by failing to raise it before the Commission. *Jacobo v. Illinois Workers' Compensation Comm'n*, 2011 IL App (3d) 100807WC, ¶ 40. In its statement of exceptions before the Commission following the second arbitration hearing, respondent never asserted that Dr. Van Ryn's failure to comply with the provisions of section 8.2(d) required reversal of the award of medical expenses and prospective medical care. Instead, respondent merely contended that Dr. Van Ryn's failure to comply with section 8.2(d) "was the reason for Respondent's carrier inability [*sic*] to satisfy those expenses." Respondent went on to "acknowledge the previous award and agree[d] to satisfy those bills regarding the [claimant's] care prior to September 9, 2009, the date of the examination by Dr. Mirkin." Thus, any contention that Dr. Van Ryn's failure to comply with section 8.2(d) absolved respondent of liability for medical expenses has been forfeited.

¶ 36 Respondent also disputes liability for any medical expenses incurred after September 9, 2009, when Dr. Mirkin examined claimant and opined that claimant had reached MMI. Dr. Mirkin

diagnosed a resolved cervical strain as a result of the work accident. He then concluded that claimant was not in need of any additional medical care or surgery related to the incident at work and that claimant was at MMI on September 9, 2009, the date of his examination. In contrast, Dr. Van Ryn's diagnosis and treatment recommendations remained essentially unchanged between the time of his initial examination of claimant in May 2008 and the second arbitration hearing. Respondent insists that Dr. Mirkin's opinion is "clearly more credible than that of Dr. Van Ryn" because Dr. Mirkin, having reviewed claimant's medical records prior to his examination, "was not left to merely rely on [claimant's] subjective complaints and inaccurate medical history." However, questions as to the reasonableness, necessity, and causal relationship of medical expenses are factual matters to be resolved by the Commission, and its resolution of such matters will not be disturbed on review unless they are against the manifest weight of the evidence. *Westin Hotel v. Industrial Comm'n*, 372 Ill. App. 3d 527, 546 (2007). Given the conflicting medical opinions presented, the fact that Dr. Van Ryn is claimant's long-standing physician, and the timing and abbreviated nature of Dr. Mirkin's examination, we cannot say that a conclusion opposite to the one reached by the Commission is clearly apparent. Accordingly, the Commission's award of medical expenses is not against the manifest weight of the evidence.

¶ 37

#### C. Penalties and Attorney Fees

¶ 38 Finally, respondent challenges the award of penalties pursuant to section 19(k) of the Act (820 ILCS 305/19(k) (West 2006)), additional compensation pursuant to section 19(l) of the Act (820 ILCS 305/19(l) (West 2006)), and attorney fees pursuant to section 16 of the Act (820 ILCS 305/16 (West 2006)). Respondent argues that its conduct in regard to the payment of TTD benefits

and medical expenses has not been unreasonable and vexatious.

¶ 39 The Act's penalty provisions are not intended to inhibit contests of liability or appeals by employers who honestly believe that an employee is not entitled to compensation. *Avon Products, Inc. v. Industrial Comm'n*, 82 Ill. 2d 297, 301 (1980). Additional compensation under section 19(l) of the Act (820 ILCS 305/19(l) (West 2006)) is appropriate where an employer fails, neglects, or refuses to make payments or unreasonably delays payment of workers' compensation benefits without good and just cause. *McMahan v. Industrial Comm'n*, 183 Ill. 2d 499, 515 (1998). Penalties under section 19(k) of the Act (820 ILCS 305/19(k) (West 2006)) and attorney fees under section 16 of the Act (820 ILCS 305/16 (West 2006)) are appropriate where a delay in payment or the termination of benefits is "deliberate or the result of bad faith or improper purpose." *McMahan*, 183 Ill. 2d at 515. The standard is one of objective reasonableness (*Board of Education of the City of Chicago v. Industrial Comm'n*, 93 Ill. 2d 1, 9 (1982)), and the employer bears the burden of justifying the delay in the payment of compensation (*Zitzka v. Industrial Comm'n*, 328 Ill. App. 3d 844, 848 (2002)). Whether the employer's conduct justifies the imposition of penalties, additional compensation, and attorney fees is a question of fact for the Commission, and the Commission's decision will not be disturbed on appeal unless it is against the manifest weight of the evidence. *Anders v. Industrial Comm'n*, 332 Ill. App. 3d 501, 508-09 (2002).

¶ 40 We first address the Commission's assessment of additional compensation under section 19(l) of the Act (820 ILCS 305/19(l) (West 2006)). In affirming and adopting the decision of the arbitrator, the Commission ordered respondent to pay claimant \$10,000 pursuant to section 19(l) for respondent's failure to pay claimant "lost time benefits past the date of the first trial in spite of the

fact that Respondent had no counter opinions that [claimant] might be employable until 10/9/09 [sic].” Respondent argues that it had a good-faith challenge to liability for TTD benefits following the first hearing on the basis that claimant was operating and earning income from his own business, TJS Home Repair, during the period of time TTD benefits were awarded. We agree. As this court has noted, “[e]ach section 19(b) proceeding is a separate proceeding, limited to a determination of temporary total disability up to the date of the hearing, and each 19(b) decision is a separate and appealable order.” *Weyer*, 387 Ill. App. 3d at 307, quoting *R.D. Masonry, Inc. v. Industrial Comm’n*, 215 Ill. 2d 397, 408 (2005). In this case, following the second section 19(b) hearing, the Commission awarded TTD benefits for the period from July 25, 2008 (the day after the first section 19(b) hearing) until November 19, 2009 (the date of the second section 19(b) hearing). Although Dr. Mirkin did not examine claimant until September 9, 2009, at which time he found that claimant could return to work, respondent also possessed evidence that claimant performed work for and earned income from his own business, TJS Home Repair, during the time for which he was awarded TTD benefits. While we have already concluded that the Commission did not err in awarding claimant TTD benefits following the first arbitration hearing, we cannot say that respondent’s reliance on claimant’s work for TJS Home Repair for its failure to provide TTD benefits during this period did not constitute good and just cause. As such, the Commission’s finding to the contrary is against the manifest weight of the evidence, and we vacate the \$10,000 penalty imposed pursuant to section 19(l) of the Act (820 ILCS 305/19(l) (West 2006)).

¶ 41 The Commission also assessed penalties pursuant to section 19(k) of the Act (820 ILCS 305/19(k) (West 2006)) in the amount of \$3,505.73 (representing 50% of the medical expenses

awarded) plus a to-be-determined amount for 50% of the prospective medical expenses which were ordered in the prior award. In *Hollywood Casino-Aurora, Inc. v. Illinois Workers' Compensation Comm'n*, 2012 IL App (2d) 110426WC, ¶¶ 15-19, we held that the plain language of section 19(k) does not provide for the assessment of penalties for an employer's delay in authorizing medical treatment. Thus, while we admonish respondent for not authorizing in a timely manner the medical treatment previously ordered, we are compelled to vacate the penalties assessed on the "to-be-determined" prospective medical expenses ordered in the prior award which have yet to be authorized by respondent.

¶ 42 With regard to respondent's failure to pay for the remaining medical expenses, we note that one of the ways that an employer may show an objectively reasonable belief that an employee is no longer entitled to workers' compensation benefits is through an employer-requested medical examination. *R.D. Masonry, Inc.*, 215 Ill. 2d at 409. The relevant inquiry is whether the employer's conduct in relying on the opinion of its medical experts is reasonable under all of the circumstances presented. *Continental Distributing Co. v. Industrial Comm'n*, 98 Ill. 2d 407, 415-16 (1983). Differing medical opinions "must be weighed carefully, considering such factors as the length and thoroughness of the examination, the extent of the observation and testing performed, the specialty of the doctor, whether the doctor is the treating physician, and whether the doctor possessed all available information before rendering the opinion." *Ford Motor Co. v. Industrial Comm'n*, 140 Ill. App. 3d 401, 406 (1986). The employer may not rely on its qualified medical opinion to the exclusion of other medical opinions. *Ford Motor Co.*, 140 Ill. App. 3d at 406.

¶ 43 In awarding penalties under section 19(k), the Commission indicated that respondent chose

to unreasonably rely on the conclusions of Dr. Mirkin “even though those issues were addressed in the earlier hearing and Award.” However, as noted above, each proceeding on a workers’ compensation claim for TTD benefits is a separate proceeding, limited to a determination of benefits up to the date of the respective hearing. *Weyer*, 387 Ill. App. 3d at 307. Thus, the first arbitration hearing addressed claimant’s entitlement to benefits from the date of the work accident until July 24, 2008, the date of the first arbitration hearing, while the second arbitration hearing addressed claimant’s entitlement to compensation after the first arbitration hearing. *Weyer*, 387 Ill. App. 3d at 307. As a result, we conclude that it was not unreasonable for respondent to obtain a medical opinion after the first arbitration hearing to determine if claimant’s condition of ill-being was still related to his work accident and whether he was therefore entitled to continuing benefits, including medical expenses. Therefore, we conclude that the Commission’s assessment of penalties pursuant to section 19(k) and attorney fees pursuant to section 16 are contrary to the manifest weight of the evidence.

¶ 44

### III. CONCLUSION

¶ 45 For the reasons set forth above, we affirm the Commission’s award of TTD benefits and medical expenses. We vacate the awards of penalties pursuant to section 19(k), additional compensation pursuant to section 19(l), and attorney fees pursuant to section 16. Thus, the judgment of the circuit court of Madison County, which confirmed the decision of the Commission, is affirmed in part and vacated in part. The cause is remanded for further proceedings pursuant to *Thomas*.

¶ 46 Affirmed in part, vacated in part, and remanded.