

**NOTICE:** This order was filed under Supreme Court Rule 23(b) and is not precedent except in the limited circumstances allowed under Rule 23(e)(1).

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IN THE  
APPELLATE COURT OF ILLINOIS  
FIRST DISTRICT

WORKERS' COMPENSATION COMMISSION DIVISION

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REGINALD B. WILLIAMS, SR.,	)	Appeal from the Circuit
	)	Court of Cook County
Appellant,	)	
	)	
v.	)	No. 24 L 50337
	)	
THE ILLINOIS WORKERS' COMPENSATION	)	
COMMISSION, <i>et al.</i>	)	Honorable
	)	Daniel P. Duffy,
(The City of Chicago, a municipal corporation, Appellee).	)	Judge, presiding.

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JUSTICE ROCHFORD delivered the judgment of the court.  
Presiding Justice Holdridge and Justices Mullen, Cavanagh, and Barberis concurred in the judgment.

**ORDER**

- ¶ 1 *Held:* Where claimant's arguments on appeal are unsupported by the record, barred by the law of the case doctrine, or forfeited, we affirm the judgment of the circuit court which confirmed the decision of the Illinois Workers' Compensation Commission, awarding the claimant certain benefits pursuant to the Workers' Compensation Act.
- ¶ 2 The claimant, Reginald B. Williams, Sr., filed an application for adjustment of claim under the Illinois Workers' Compensation Act (Act) (820 ILCS 305/1 *et seq.* (West 2012)), seeking benefits for an automobile accident that occurred while the claimant was employed by appellee, The City of Chicago, a municipal corporation (City). The Illinois Workers' Compensation Commission (Commission) ultimately granted this application in part, the circuit court affirmed, and the claimant has now appealed *pro se* to this court from certain aspects of the final award. For

the following reasons, we affirm the judgment of the circuit court which confirmed the decision of the Commission.

¶ 3 The record reflects that claimant was employed by the City, and while at work on January 7, 2013, he was a passenger in a City-owned truck. The truck collided with a viaduct and as a result of the collision claimant experienced immediate pain in his lower back on the right side down to his right leg, and that night he experienced pain in his neck and right shoulder and his lower back. Thereafter, claimant sought treatment and diagnosis for his pain throughout 2013 and 2014. For purposes of resolving this appeal, we need not detail all his medical history. It is sufficient to note the following.

¶ 4 The day after the incident claimant was treated by Dr. Homer Diadula at Mercy Hospital and Medical Center. An X-ray of claimant's lumbar spine was performed, which showed mild degenerative changes but no evidence of fracture. Dr. Diadula diagnosed claimant with a "[c]ontusion, mid-back, right upper back and lower back," prescribed medication for the pain, and determined that claimant should remain off work and return for reevaluation on January 15, 2013. Claimant followed up with Dr. Diadula on that date. There was no swelling in his lumbar spine, but claimant reported that he was still in pain. Dr. Diadula recommended physical therapy three times a week and determined that claimant should remain off work. Claimant continued to be treated by Dr. Diadula through May 2013. An MRI of claimant's lumbar spine taken during this time showed degenerative disc changes, arthritis, and degenerative bulging. Claimant remained off work during this time.

¶ 5 Thereafter, claimant sought treatment and diagnosis from Dr. Adam LaBore, Dr. Matt Lambert, and Dr. Lukas Zebala. During that time, claimant underwent an X-ray, additional MRI examinations, and a CT scan, as well as receiving several therapeutic injections for pain. The test

results all generally revealed arthritis and mild degenerative disc disease. Dr. Zebala reported a “predominant finding[ ] of degenerative disk disease at L4-L5,” and noted that he could “not make [claimant’s] pain better with surgery.” He further noted that “a lumbar fusion for this type of condition, in my opinion, will not improve [claimant’s] pain.” Dr. Zebala reported having “concern that there are underlying nonsomatic causes for his pain,” and stated that he had “no further treatment options” for claimant.

¶ 6 Dr. Jay Levin saw claimant for an independent medical examination on December 3, 2014. Claimant reported having tenderness and discomfort on the right side of his back, in his neck, and in his right shoulder. Dr. Levin reviewed the MRI and CT examinations of claimant’s lumbar spine. He also ordered an MRI of claimant’s shoulder so that he could “review that [MRI] in concert with the imaging studies of the cervical and lumbar spine” that he had in his possession. Taken together, these test results showed degenerative disc changes in claimant’s cervical spine, arthritis in his right shoulder, phleboliths in his pelvis with spurring of the iliac crest, and degenerative disc changes in his lumbar spine.

¶ 7 After reviewing claimant’s medical records, Dr. Levin issued a report on December 16, 2014, concluding that claimant sustained a “contusion/lumbar myofascial strain” because of the accident. He further determined that claimant had sustained no injury to his right shoulder or cervical spine during the accident. He opined that claimant had reached maximum medical improvement “at 4-6 weeks post-injury,” and was able to return to work without restrictions. Finally, he concluded that “the permanent impairment rating for [claimant’s] lumbar spine is 2% whole person impairment.” Based on Dr. Levin’s report, the City contacted claimant on January 14, 2015, to coordinate his reinstatement. Claimant elected not to return to his position with the City, and his temporary total disability (TTD) benefits terminated on January 31, 2015.

¶ 8 Claimant thereafter continued to visit various doctors and emergency rooms with complaints of back pain. On April 8, 2015, he visited Dr. Charles Slack at Illinois Bone and Joint Institute. Dr. Slack diagnosed claimant with “persistent severe lumbar radiculopathy with L4-L5 disc protrusion with nerve compression and a grade I spondylolisthesis.” He noted that claimant was “a candidate for surgical intervention,” and recommended that claimant speak with his associate, Dr. Theodore Fisher, regarding surgery. Claimant visited Dr. Fisher on August 13, 2015. Dr. Fisher obtained radiographs of claimant’s lumbar spine, which showed “disk space narrowing at L4-L5.” He diagnosed claimant with “L4-L5 degenerative disk disease, disk herniation, discogenic pain, and recurrent bilateral lower extremity radiculopathy.” Claimant told Dr. Fisher that he wanted to proceed with surgery, and Dr. Fisher stated that he would schedule the surgery once claimant’s insurance approved it.

¶ 9 Dr. Levin thereafter reviewed the records of claimant’s visits with Dr. Slack and Dr. Fisher. In a letter dated February 18, 2016, Dr. Levin maintained his opinion that the degenerative changes in claimant’s lumbar spine “predated the occurrence of January 7, 2013,” and “were not anatomically changed by [that] event.” He agreed with Dr. Zebala’s opinion that surgery “would not improve [claimant’s] pain.”

¶ 10 As to the procedural history of this matter, on January 25, 2013, claimant filed an initial application for adjustment of claim. After a hearing on claimant’s application, an arbitrator issued a written decision on August 8, 2016. The arbitrator found that claimant’s condition of ill-being was related to the work accident, that the City was required to pay claimant’s past medical expenses, and that the City was required to pay for claimant’s future medical treatment. The arbitrator also awarded claimant TTD benefits for the period of January 8, 2014, through April 28, 2016.

¶ 11 The City sought review by the Commission. On April 18, 2018, the Commission reversed the arbitrator's decision regarding causation. It found that claimant had reached maximum medical improvement on December 16, 2014, and that his condition of ill-being after that date was not causally connected to the accident. As a result, the Commission ruled that claimant's TTD benefits should have terminated as of December 16, 2014, and awarded claimant \$91,189.39 in TTD pay. The Commission also denied claimant's petition for prospective medical expenses. In addition, the Commission found that claimant had "exceed[ed] the number of permissible providers under the Act" when he visited Dr. Slack and Dr. Fisher; it therefore denied claimant's medical expenses for those visits. Moreover, the Commission found that claimant visited emergency rooms "approximately twenty" times, displaying "pain seeking behavior" and complaining about "body parts in addition to [claimant's] low back," that there was "no evidence these visits constituted *bona fide* medical emergencies," and that the emergency room visits were neither reasonable nor necessary. The Commission remanded the matter to the arbitrator "for further proceedings consistent with [its] Decision."

¶ 12 Claimant sought administrative review in the circuit court. On December 4, 2018, the circuit court confirmed the Commission's ruling, holding that claimant had not established a causal connection between his condition of ill-being and the accident. Specifically, it held that claimant's "lack of credible testimony matched with inconsistent complaints and numerous ER visits make[s] it impossible to determine what, if anything, is causally related to the incident of January 7, 2013." Moreover, the court ruled that "Dr. Slack [was claimant's] third choice [of physicians] and therefore Defendant does not have liability for any expenses incurred through Dr. Slack or any of his referrals, including Dr. Fisher." On January 14, 2019, claimant filed a notice of appeal from

No. 1-25-0639WC

the circuit court's December 4, 2018, decision, but this court dismissed the appeal for lack of jurisdiction due to an untimely notice of appeal and remanded the case to the Commission.

¶ 13 The case then returned to the arbitrator pursuant to the Commission's April 18, 2018, order. Claimant argued that he was entitled to permanent partial disability (PPD) benefits. On August 26, 2020, the arbitrator determined that claimant was not entitled to PPD benefits because the circuit court had previously ruled that claimant's current condition of ill-being was not causally related to the accident, and that ruling was now the law of the case.

¶ 14 Claimant then filed a petition for review with the Commission. On July 2, 2021, the Commission reversed the arbitrator's ruling. It held that nothing in the circuit court's order precluded a PPD award and ordered the arbitrator to conduct an evidentiary hearing to determine whether claimant was entitled to PPD benefits. Separately, the City argued that it should receive a credit for overpayment of TTD benefits because it had paid claimant \$97,120.57 between 2013 and 2016, and according to the Commission's April 18, 2018, ruling, claimant was entitled to only \$91,189.39. The Commission ruled that the arbitrator should address this issue on remand.

¶ 15 On remand, on August 24, 2022, the arbitrator conducted a hearing regarding claimant's PPD benefits. At the hearing, claimant claimed that, in addition to PPD benefits, he was also entitled to TTD benefits from January 8, 2013, through August 24, 2022. The arbitrator found that claimant's current condition of ill-being was not causally related to the accident. The arbitrator also found that claimant had sustained permanent partial disability to the extent of 2% loss of use of the person as a whole, which corresponded to ten weeks of PPD benefits at a weekly rate of \$712.55, totaling \$7,125.50. Next, the arbitrator ruled that claimant was not entitled to TTD benefits after December 16, 2014. Pursuant to the Commission's April 18, 2018, decision, which was confirmed by the circuit court, claimant had reached maximum medical improvement on

December 16, 2014, and that decision was now the law of the case. Finally, the arbitrator determined that the City had overpaid TTD benefits and was entitled to a credit of \$5,931.23, “which may be applied to the award on permanency.”

¶ 16 Claimant again sought review by the Commission. On May 29, 2024, the Commission affirmed and adopted the arbitrator’s decision with slight modifications. Claimant sought administrative review, the circuit court confirmed the Commission’s decision, and claimant timely appealed.

¶ 17 On appeal, claimant first contends that it was error for the Commission to rely upon the opinion of Dr. Levin, where he identified “the right shoulder as the alleged injured area. The actual injured part of [the] body is [claimant’s] lower back \*\*\* [claimant] never mentioned his right shoulder as being injured.” The record belies this argument.

¶ 18 First, the record does in fact include evidence that claimant had complained of right shoulder pain after the incident. The record also shows that Dr. Levin specifically ordered and reviewed an additional MRI of claimant’s right shoulder in response to those complaints. However, the record is also clear that in his opinion letter issued December 16, 2014, Dr. Levin specifically concluded that the claimant “did not sustain an injury to his right shoulder or cervical spine from the occurrence of January 7, 2013.” Dr. Levin then went on to discuss claimant’s other complaints along with his medical history and various diagnostic results before ultimately concluding that claimant’s sole injury resulting from the incident was a contusion and strain of the lower back. The entire rest of Dr. Levin’s discussion and opinions were based upon a discussion of the lower back injury resulting from the accident. At no point did Dr. Levin base his analysis and opinions solely on any injury to claimant’s right shoulder, and we therefore reject this argument on appeal.

¶ 19 Claimant next contends that the City “failed to prove that [he] had a pre-existing condition of his lower back,” and even if claimant did have such a pre-existing condition the incident at issue did not need to be the sole causative factor of his current state of ill-being. We reject these arguments for two reasons.

¶ 20 First, as the appellant claimant “has the burden of presenting a sufficiently complete record of the proceedings \*\*\* to support a claim of error.” *Midstate Siding & Window Co. v. Rogers*, 204 Ill. 2d 314, 319 (2003) (citing *Foutch v. O’Bryant*, 99 Ill. 2d 389, 391-92 (1984)). In the absence of a complete record, a reviewing court presumes that the order entered below was in conformity with the law and had a sufficient factual basis. *Foutch*, 99 Ill. 2d at 392. “In fact, when the record on appeal is incomplete, a reviewing court should actually ‘indulge in every reasonable presumption favorable to the judgment from which the appeal is taken.’ ” *Smolinski v. Vojta*, 363 Ill. App. 3d 752, 757-58 (2006) (quoting *People v. Majer*, 131 Ill. App. 3d 80, 84 (1985)). Here, the record on appeal does not contain all the medical records reviewed by the Commission in the various proceedings below, nor does it contain a complete record of the proceedings leading to the Commission’s decision in April 2018. We are simply unable to adequately evaluate the Commission’s exercise of discretion on such a record, and we must therefore presume the Commission’s actions were in conformity with the law and had a sufficient factual basis. *Foutch*, 99 Ill. 2d at 392.

¶ 21 Second, and the state of the record aside, 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. *Miller v. Lockport Realty Group, Inc.*, 377 Ill. App. 3d 369, 374 (2007). The principles underlying the doctrine apply to matters resolved in proceedings before the Commission. *Weyer v. Workers’ Compensation Comm’n*, 387 Ill. App. 3d 297, 307 (2008);

No. 1-25-0639WC

*Irizarry v. Industrial Comm'n*, 337 Ill. App. 3d 598, 606–07 (2003); *Help At Home v. Illinois Workers' Compensation Comm'n*, 405 Ill. App. 3d 1150, 1151 (2010). Where an award of benefits based on a finding as to the causal connection between the claimant's work accident and the claimed injuries is not challenged as set forth in the Act, it becomes final and conclusive and cannot be challenged in a permanency hearing. *Irizarry*, 337 Ill. App. 3d at 605-06; see also *Ming Auto Body/Ming of Decatur, Inc. v. Industrial Comm'n*, 387 Ill. App. 3d 244, 255 (2008) (the Act does “not permit the Commission to generally reconsider the evidentiary basis or factual finding underlying an award that has become final”). Once the causation finding becomes a final judgment, it becomes the law of the case and is not subject to further review. *Ming Auto Body*, 387 Ill. App. 3d at 252.

¶ 22 Here, these issues were resolved in the Commission's April 2018 decision, where it determined that that claimant had reached maximum medical improvement on December 16, 2014, and that his condition of ill-being after that date was not causally connected to the accident. The circuit court confirmed that decision in December 2018, and claimant's appeal from that decision was dismissed by this court for lack of jurisdiction in August 2019. These issues are therefore now finally determined for this litigation, under the law of the case doctrine.

¶ 23 Even if there were any further doubt as to this issue, we note that the arbitrator and the Commission specifically relied upon the law of the case doctrine in deciding this matter below. And the City relies upon this doctrine on appeal. Nevertheless, claimant has not addressed this issue in any way on appeal, either in his opening or reply briefs. Points not argued in an opening appellate brief “are forfeited and shall not be raised in the reply brief, in oral argument, or on petition for rehearing.” Ill. S. Ct. R. 341(h)(7) (eff. Oct. 1, 2020).

¶ 24 Claimant finally contends that the Commission improperly failed to provide him reimbursement for certain medical expenses. However, the record reflects that claimant did not raise this issue before the Commission below, and indeed explicitly acknowledged at the hearing before the arbitrator that he had no unpaid medical bills to place at issue. It is axiomatic that arguments not raised below are forfeited and cannot be raised for the first time on appeal. *U.S. Bank National Ass'n. v. Prabhakaran*, 2013 IL App (1st) 111224, ¶ 24; *Parks v. Kownacki*, 193 Ill. 2d 164, 180 (2000).

¶ 25 Lastly, we recognize that claimant is representing himself *pro se* in this appeal. However, a *pro se* litigant is not relieved of following the procedural rules of the court. *Tannenbaum v. Lincoln National Bank*, 143 Ill. App. 3d 572, 574 (1986). “Although his right to appear *pro se* is well established, it is equally well established that when he does appear *pro se*, he must comply with the established rules of procedure.” *Id.* Similarly, a *pro se* litigant is not entitled to more lenient treatment than attorneys. In Illinois, parties choosing to represent themselves without a lawyer must comply with the same rules and are held to the same standards as licensed attorneys. *Holzrichter v. Yorath*, 2013 IL App (1st) 110287, ¶ 78.

¶ 26 For the foregoing reasons, we affirm the judgment of the circuit court which confirmed the decision of the Commission.

¶ 27 Affirmed.