Below the Red Line

HEYL ROYSTER

Workers' Compensation Update

"We've Got the State Covered!"

A Newsletter for Employers and Claims Professionals — *September 2012*

A Word From The Practice Group Chair

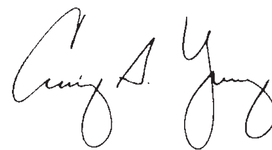
We are pleased to offer the September edition of *Below the Red Line*. We hope you appreciate our new look, and our ongoing effort to keep you updated on trends and issues concerning the defense of workers' compensation cases. We constantly strive to meet the needs of our clients in the never-ending effort to control workers' compensation costs, and we hope this newsletter will continue to be a helpful tool for you in that effort.

As the Commission begins to release decisions addressing the 2011 amendments, and as we deal daily around the state with Arbitrators and Commissioners, certain trends are emerging as to how these statutory changes may impact the defense of our cases. This month's feature article by Bruce Bonds is the most up-to-date and comprehensive analysis of the AMA *Guides* you will find, and we hope it is helpful. There remains work to be done in aggressively using the AMA *Guides* to control costs, and I am sure you will find some helpful information in Bruce's article. We will continue to update you regularly as we see additional developments.

Our firm has always prided itself on the relationship we have with our clients. Given our emphasis on a teamwork approach to effectively resolve claims, we want you to know our attorneys and how we view claims handling. To further this understanding, you will find in this newsletter an expanded biography on Bruce Bonds, our featured author. Many of you know Bruce well; he is a past chair of our Workers' Compensation Practice Group and a regular speaker at our firm's annual Spring seminar. Bruce has outlined some of his philosophies for handling claims, and our firm's approach to making sure we are working closely with our clients to accomplish your goals and objectives. We will try to include this type of information and comment from other attorneys in future editions.

As many of you know, we made ourselves available for in-house presentations at the end of 2011 for discussions on the potential impact of the 2011 amendments. We enjoyed meeting personally with many of you to discuss those changes, and we believe it is now time to do so again. Given our firm's extensive practice in every venue around the state, we are able to compile information on a near-daily basis regarding how Arbitrators and Commissioners are interpreting the statutory changes. We want to make sure you and our clients have this information and I invite you to contact me if an in-house presentation on the status of the 2011 amendments would be beneficial.

I hope you find this newsletter helpful and, as always, if we can be of help in any way in defense of your claims, please do not hesitate to contact us.



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Evaluating Permanent Partial Disability Under The 2011 Amendments To The Illinois Workers' Compensation Act

by Bruce Bonds - Urbana Office

The 2011 amendments changed the criteria for evaluating permanent partial disability for injuries that occur on or after September 1, 2011. Pursuant to 820 ILCS 305/8.1b, permanent partial disability for accidental injuries that occurred on or after that date shall be established using the following criteria:

> (a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.
>
> (b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors:
>
> (i) the reported level of impairment pursuant to subsection (a) (e.g., the AMA rating)
>
> (ii) the occupation of the injured employee
>
> (iii) the age of the employee at the time of the injury
>
> (iv) the employee's future earning capacity
>
> (v) evidence of disability corroborated by the treating medical records.
>
> No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

820 ILCS 305/8.1b

What Are The AMA *Guides To The Evaluation of Permanent Impairment*?

The AMA *Guides* provide physicians with a method of calculating a number that corresponds to each individual's level of impairment. This is called the impairment rating or "AMA rating." The *Guides* define "impairment rating" as "consensus-derived percentage estimate of loss of activity reflecting severity for a given health condition, and the degree of associated limitations in terms of activities of daily living." This is not, however, a direct estimate of work restrictions like the conclusions of a functional capacity evaluation.

What Version Of The AMA *Guides To The Evaluation Of Permanent Impairment* Should Be Used In Evaluating Illinois Injuries?

Section 8.1b of the 2011 Amendments to the Illinois Workers' Compensation Act provides that the most current edition of the American Medical Association's *Guides to the Evaluation of Permanent Impairment* shall be used by a physician in determining the level of impairment. At present, the Sixth Edition, second printing is the most current edition. The criteria for determination of an impairment rating in the Sixth Edition differs significantly from prior editions.

How Are "AMA Ratings" Determined Under The *Guides*?

AMA impairment ratings are based on diagnosis based impairments ("DBI") where the impairment class is determined by the diagnosis as the "key factor." A rating based on an incorrect or questionable diagnosis will lack credibility. This key factor is then adjusted by "non-key" factors also known as "grade modifiers," which are the functional history, the physical exam and the results of clinical studies.

The functional history can be determined via an oral history given by the injured worker or by the use of forms specified in the AMA *Guides.* These forms are the QuickDASH for the upper extremity, the lower limb questionnaire and the pain disability questionnaire for the spine. These forms are not, however, required to establish functional history, and the evaluating physician can verbally obtain this information

from the injured worker. An issue may arise as to whether the injured worker is required to fill out these forms if the AMA rating is obtained pursuant to an IME under Section 12.

The physical exam would include, but not limit itself to factors such as stability, alignment, range of motion, muscle atrophy and deformity. According to the AMA *Guides*, greater weight is to be given to objective findings.

Clinical studies refers to diagnostic tests and their interpretations.

Why Were The AMA *Guides* Included In The 2011 Amendments?

During the negotiations which culminated in the passage of the 2011 amendments, business interests sought to have permanency awards based solely and entirely on AMA ratings to both reduce and provide greater uniformity in PPD awards. AMA ratings are typically much lower than a PPD award for the same injury.

Spine Rating – Typical AMA Ratings (WPI%)

	Sixth
Non-specific cervical (neck) pain	1% - 3% WPI
Cervical radiculopathy with fusion (resolved radiculopathy)	4% - 8% WPI
Lumbar radiculopathy (single level, persistent)	10% - 14% WPI
Lumbar pain with single level fusion (no radiculopathy)	5% - 9% WPI
Lumbar pain with single-level fusion (with persistent single level radiculopathy)	10% - 14% WPI
Lumbar pain with multi-level fusion (no radiculopathy)	5% - 9% WPI
Lumbar radiculopathy with fusion (persistent single level radiculopathy)	10% - 14% WPI

Extremity Rating – Typical AMA Ratings UEI – Arm, LEI – Leg (To convert UEI to Hand Divide by 0.9)

	Sixth
Digit Amputation – Index at DIP joint	45% Digit
Wrist Fracture – residual symptoms and objective findings and/or functional loss with normal motion	1% - 5% UEI
Wrist Fracture – lack of 20 degrees flexion and of 20 degrees extension	6% UEI
Lateral Epicondylitis – residual symptoms without consistent objective findings (without surgery)	0% - 2% UEI
Impingement Syndrome – residual loss, functional with normal motion	0% - 2% UEI
Carpal Tunnel Syndrome – confirmed, s/p release, symptoms and no objective findings	2% - 5% Hand
Partial Medial Meniscectomy – symptoms, normal exam	1% - 3% LEI
Cruciate Ligament Laxity – moderate laxity (at MMI)	14% - 18% LEI
Knee Arthritis – moderate, 2 mm cartilage interval	16% - 24% LEI
s/p Total Knee Replacement – fair result	31% - 43% LEI

The negotiations resulted in a compromise, wherein AMA ratings are to be considered in the assessment of PPD, but only as one factor along with the employee's occupation, age, future earning capacity and evidence of disability corroborated by the treating medical records.

It is therefore important to understand that while the AMA impairment rating is a component of the PPD percentage loss of use assessment, there is not an "equal sign" between the impairment rating and the PPD in the eyes of the Commission at this time.

Our experience at Heyl Royster to date has made clear that the arbitrators will not always rubberstamp a global *pro se* agreement based on an AMA rating. The author has personally heard the Chairman speak at public events, wherein he has

indicated that he anticipates that PPD awards may come down some, but no more than 10 percent to 20 percent overall.

Who Can Perform An AMA Rating?

Section 8.1b of the Act requires that the AMA rating report be prepared by a physician licensed to practice medicine in all of its branches. Thus, in Illinois, non-physicians such as chiropractors are not permitted to provide impairment ratings. Note that the AMA *Guides* themselves do permit impairment evaluations from "medical doctors who are qualified in allopathic or osteopathic medicine or chiropractic medicine." They also permit non-physician evaluators to analyze an impairment evaluation to determine if it was performed in accordance with the Guides. This will not be the case in Illinois, however, pursuant to the 2011 amendments.

The Act does not require that a physician be certified to perform an AMA rating in Illinois. Presumably, an impairment rating by a "certified" physician will carry more weight than one performed by a "non-certified" individual. Our recommendation would be to use only "certified" evaluators unless extraordinary circumstances dictate otherwise.

Can A Treating Physician Perform An AMA Rating?

According to the *Guides,* the physician's role in performing an impairment evaluation is to provide an independent, unbiased assessment of the individual's medical condition, including its effect on function and of limitations to the performance of Activities of Daily Living, or "ADL." Accordingly, while the *Guides* permit a treating physician to perform impairment ratings, they specifically note that treating physicians are not considered independent and their determinations may therefore be subject to greater scrutiny. This observation injects a refreshing dose of common sense to our workers' compensation system which has traditionally accorded greater weight to medical opinions expressed by an injured employee's treating physician, including issues of causal connection, work restrictions and the need for medical treatment. In the real world, the treating medical provider is often not unbiased. A desire to be paid, and a desire to "please" the patient based on the personal relationship developed during the treatment with the employee/patient (and/or their family) can create a significant bias in the employer's favor. On the flipside, it is possible that a treating physician, happy to emphasize their successful treatment might minimize the AMA rating.

When Is An AMA Rating Appropriate?

An AMA rating is appropriate once the patient reaches maximum medical improvement. This is defined by the *Guides* as a "status where patients are as good as they are going to be from the medical and surgical treatment available to them. It can also be conceptualized as a date from which further recovery or deterioration is not anticipated, although over time (beyond 12 months) there may be some expected change." Robert D. Rondinelli, *Guides to the Evaluation of Permanent Impairment*, 26 (6th ed. 2008). The *Guides* do not permit the rating of a future impairment.

This is similar to the case law definition of maximum medical improvement in Illinois, which is defined as "the time at which the injured worker's injuries stabilizes or the injured worker has recovered as far as the permanent character of the injury will permit." *Mobil Oil Corp. v. Industrial Comm'n*, 309 Ill. App. 3d 616, 722 N.E.2d 703 (3d Dist. 2000).

Can The *Guides* Be Used For Determinations Of The Need For And Nature Of Work Restrictions?

No, the *Guides* are not intended to be used for the imposition of or estimates of work participation restrictions. Physicians requested to perform AMA ratings should not be requested to comment on the need for restrictions.

Can A Physician Performing An IME Pursuant To Section 12 Of The Act Perform An AMA Rating?

Yes. But if an AMA impairment rating is requested from a non-treating physician, the request should be made pursuant to Section 8.1b, and not Section 12 which authorizes independent medical examinations so as not to lose your opportunity for an evaluation on other issues, including causation, future treatment and permanent restrictions. The request should be confined to the impairment rating alone.

Can The Employer's Representative Request An AMA Rating From The Petitioner's Treating Doctor?

Yes, but an employer's representative should not contact the treating physician to request an AMA rating without written prior approval from petitioner and/or his or her attorney.

To do so could be a violation of the physician-patient privilege which has been applied to workers' compensation cases in the case of *Hydraulics, Inc. v. Industrial Comm'n*, 329 Ill. App. 3d 166, 768 N.E.2d 760 (2d Dist. 2002). Don't give petitioner's attorney a chance to play "gotcha."

How Much Does An AMA Rating Cost?

This number will vary from physician to physician but based on our experience to date, they will range from $750 to approximately $1,500 for the rating and report.

Will AMA Ratings Be Admissible In Proceedings Held Before The Commission?

Not necessarily. While an AMA rating is specifically provided for by statute, there is no provision for the automatic admissibility of these ratings. Thus, any report containing an AMA rating could be considered hearsay and most likely would not be considered a "medical record" under Section 16 of the Act which governs the automatic admissibility of certain treatment records. Thus, the deposition of the physician providing the AMA rating may, under the current law, be required. Unlike the recent amendments to Section 8.7 dealing with admissibility of utilization review reports, 8.1b does not provide for phone depositions or other cooperative means of completing the evaluator's deposition. Until this portion of the law is changed or clarified, it is prudent to obtain ratings from doctors who are both available and willing to testify via deposition if necessary.

Is An AMA Rating Required For PPD Assessments In Every Case?

Section 8.1b of the 2011 amendments unambiguously requires an AMA rating be considered in the determination of any permanency award. The plain language of 8.1b mandates this usage. Specifically, the statute states:

- "[P]ermanent partial disability **shall** be established using the following criteria:"
- "In determining the level of permanent partial disability, the Commission shall base its determination on the following factors:"

Among these factors which the statute mandates can be considered is an AMA rating.

The word "shall" is defined by Merriam Webster's Collegiate Dictionary as meaning, "will have to," "must," and is used in laws, regulations, or directives to express what is "mandatory." The example given in the dictionary is that, "it shall be unlawful to carry firearms."

Notwithstanding the unambiguous statutory requirement that the Commission consider an AMA rating in any permanency award, the Commission issued a memorandum dated November 28, 2011, indicating that it had voted unanimously to provide the following recommendations to arbitrators:

1. An impairment report is **not** required to be submitted by the parties with a settlement contract;
2. If an impairment rating is not entered into evidence, the Arbitrator is not precluded from entering a finding of disability.

The memorandum concludes by stating, "[t]he preceding two statements are simply provided as guidance of the Commission's review of the new law and some current relevant arguments and interpretations and are not a rule of general applicability. Each Commissioner and Arbitrator should issue a decision that responds to the factual situation on review before them." www.iwcc.il.gov/amamemo.pdf

It is possible that this "recommendation" was based on "practical" concerns with respect to the costs and effort which would be required to secure an AMA rating in each and every case. No doubt in small cases, an AMA rating could cost as much as the case is worth. Nonetheless, this "recommendation" renders the statutory requirement null. We at Heyl Royster recommend that in any litigated case employers' representatives should vigorously advocate that "shall means shall," and that absent the admission into evidence of an AMA rating, the petitioner has failed in his or her burden of proof. Presumably the appellate court will ultimately determine this issue.

Anticipated Strategies By The Petitioner's Bar

We anticipate the petitioners' counsel will take one of three approaches with respect to AMA ratings. The more aggressive petitioners' counsel will attempt to keep AMA ratings out of evidence entirely, secure in their knowledge that

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the Commission has indicated that it is not precluded from entering a finding of disability when an impairment rating is not entered into evidence. The second group of petitioners' counsel will enter an AMA rating into evidence out of concern that failure to do so may result in an appellate court decision that they had not met their burden of proof, but will argue that the other four factors and most particularly the "evidence of disability corroborated by the medical records," are more significant than the AMA rating in an effort to obtain a PPD award at or near pre-2011 levels. The third group of petitioners' counsel which may represent a significant number, are those who are not well versed in the statutory changes and may not be sure what to do one way or the other.

It is important for the employer's representative to determine in advance of arbitration whether the petitioner's counsel has obtained an AMA rating. If they have, it should be reviewed and a determination made as to whether a deposition will be necessary to attack its credibility. If the employee has not obtained an AMA rating, the employer must then determine whether they wish to secure one of their own. In most cases, the answer to that question would be "yes."

Practical Considerations: What Are The Employer/Carrier's Options If An Arbitrator Refuses To Approve A *Pro Se* Settlement At Or Near The AMA Rating?

First, did your settlement offer take into account factors other than the AMA rating as mandated by the statute? Was there any potential significance to the employee's occupation, their age, the impact of the injury on future earnings capacity? Most importantly, is there any "evidence of disability corroborated by the treating medical records," which will often be cited by the arbitrator in support of a recommendation for a PPD amount greater than the AMA rating? This is understood to be petitioners' current complaints of problems corroborated by the medical records. Thus, if a petitioner claims they have difficulty lifting or reduced range of motion and that is confirmed by the doctor's notes, that may influence the arbitrator to assign a greater PPD value.

But what is corroboration? Are subjective complaints to the arbitrator corroborated by subjective complaints documented in the medical records? We assert that the use of the word "corroboration" is referring to objective corroboration documented in the medical records of subjective complaints. Absent the presence of both, the significance of this so-called "fifth factor" is a legal fiction.

Where the four factors apart from the AMA rating are benign or non-existent, a decision to insist on arbitration becomes an economic decision for the carrier. The insurance carrier's choices will be to either: (1) obtain the additional PPD amounts recommended by the arbitrator in order to close the file expeditiously; or (2) refuse and litigate the permanency. No doubt, in many cases it will be tempting to pay the additional amount to close the file. The Commission may be banking on that occurring for an appeal. Unless a case is forced to arbitration, however, the arbitrator will not be required to explain the relevance and the weight of the factors used in the PPD determination as mandated by the 2011 Amendments. We need this written record of the basis for the determination.

Practical Considerations: When Should A Case Be Tried?

The considerations as to when to try a case are largely similar to those outlined above in evaluating whether to accept an arbitrator's recommendation on a *pro se* contract. If the AMA rating is low and the "other four factors" are benign or insignificant, strong consideration should be given to arbitrating the matter if the petitioner's counsel is demanding an amount at or near pre-2011 levels. At this point it is hard to say how much less we should insist upon than was paid for similar injuries in the past, but certainly for an individual with a full duty release, no restrictions, no significant complaints, and no need for future treatment, the settlement amount should in most instances be closer to the AMA rating than to the pre-2011 permanency awards as documented in the current Q-Dex.

If there are significant restrictions and you anticipate that the petitioner's age, occupation, loss of earnings capacity, or other evidence of disability corroborated by the medical records, might be significant, then it is likely the case would have significantly more value than an AMA rating. It will take time and experience for all of us to get a handle on potential case values going forward. What we do know, however, is if we permit the Commission and the petitioners' bar to ignore or minimize the AMA rating, we will have effectively surrendered the benefits to the employer community negotiated in the 2011 Amendments.

Consideration should also be given to litigating any case where the parties cannot agree on the PPD amount and the petitioner's counsel has not obtained an AMA rating. At that point, you need to determine whether: (1) you want to obtain an AMA rating of your own to protect your downside

(which you often will); or (2) whether you wish to litigate the case without an AMA rating with a view toward appealing an excessive PPD award on the basis the petitioner has failed to meet their burden of proof. The statute mandates an AMA rating be placed into evidence in each case. This will obviously present the carrier with a very difficult decision; one which you will wish to consult counsel before making a determination.

Examples Of PPD Awards/Arbitrator Recommendations Involving AMA Ratings To Date

We at Heyl Royster are tracking arbitrator recommendations, pre-trial conferences, arbitrator decisions and approval of *pro se* contracts to track the impact of AMA ratings on the PPD determinations.

1. Zone 3 – *pro se*:

A 28 year old *pro se* electrician with a surgically repaired medial meniscus tear with no residual problems. AMA rating from the treating physician was 5 percent loss of use of a lower extremity. The arbitrator indicated she would not approve less than 10 percent of the affected leg, notwithstanding the AMA rating.

2. Zone 2 – *pro se*:

40 year old *pro se* maintenance man with a surgically repaired medial meniscus tear. Two separate AMA ratings of 2 percent loss of a lower extremity. After repeated questioning from the arbitrator, the petitioner indicated that at times he experienced some difficulty in doing a full squat with the right leg but was otherwise fine. The arbitrator (different than above) indicated she would not approve less than 10 percent loss of use of the affected leg.

Question: Is it a coincidence that two separate arbitrators came up with the same amount for a torn medical meniscus with different AMA ratings?

3. Zone 2 – *pro se*:

58 year old male school maintenance supervisor with right trigger thumb with surgical release. One month of temporary total disability and 2½ months of temporary partial disability with a full duty release. AMA rating was 0 percent loss of use of the affected thumb. The case was settled pro se for 4 percent loss of use of a right thumb. *Pro se* settlement was approved.

Interesting fact: This petitioner had previously experienced the exact same injury and treatment to the left thumb and had received a settlement of 25 percent loss of use of a left thumb based on the pre-2011 Amendments.

4. Chicago Arbitration:

45 year old right hand dominant welder with surgically repaired right distal biceps tendon rupture. Released to return to work at full duty after five months of treatment with no restrictions. Only objective finding at MMI was lack of 5 to 10 degrees of supination in the right forearm. The petitioner testified at arbitration that contrary to the medical records, he was capable of lifting only 25 pounds and had ongoing pain and numbness. It was also noted that the employer did not take him back to work. AMA rating of 5 percent loss of a right arm which equated to 4 percent of a person. The arbitrator awarded 30 percent loss of use of a right arm based on the significance of the four factors other than the AMA rating. In this author's opinion, that award would have been high even before the 2011 Amendments!

5. Chicago Arbitration:

28 year old truck driver incurs a closed right small finger metacarpal fracture treated conservatively and released to full duty eight weeks after the injury. The petitioner returned to the regular job and shortly thereafter changed jobs, having obtained a higher paying job as a truck driver. At MMI it was noted that he had some cold weather susceptibility but all other objective testing was normal and functional difficulties were noted to be "minimal." Range of motion was normal. AMA rating of 1 percent loss of use of a right hand was entered into evidence by the respondent. No rating was en-

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tered by the petitioner. The arbitrator concluded that the injury justified a "minimal" PPD award and awarded 10 percent loss of use of a right hand. Again, in the view of this author, that would be an excessive award prior to the 2011 Amendments!

Conclusion:

AMA ratings were included in the determination of permanency by the 2011 Amendments to reduce and provide greater uniformity to PPD awards. It is ironic that at present there is little, if any, uniformity; no one has any real idea what effect an AMA rating is going to have on a typical PPD decision, and the recommended PPD amounts seem to vary by arbitration.

We do know, however, that there is significant push back from the petitioners' bar, and perhaps even from the Commission, against reducing PPD awards from their pre-2011 levels. The organized petitioners' bars' mantra is that "nothing has changed." Unfortunately there are signs that the Commission's approach might be that "very little has changed."

In order to make the change "real and meaningful," that is to say in order to obtain significant reductions in PPD awards from the 2011 Amendment levels, employers, carriers, and their counsel must work closely together in the aggressive handling of these cases. Effective, aggressive and creative advocacy is more important than ever if we are to create together a "new" Q-Dex. We at Heyl Royster have the knowledge and the experience to assist you in evaluating the appropriate PPD value under the 2011 Amendments. When a case needs to be tried, the attorneys at the Heyl Royster Workers' Compensation Practice Group can aggressively represent your interests at every venue in the State of Illinois. If appeal is necessary, our Appellate Department provides unmatched experience and success before the Workers' Compensation Division of the Illinois Appellate Court.

Working together we can reduce your workers' compensation costs!

Bruce Bonds is a past Chair of our state-wide workers' compensation practice group and has spent his entire legal career with Heyl Royster beginning in 1982 in the Peoria office. He concentrates his expertise in the area of workers' compensation, third-party defense of employers, and employment law. He served as a technical advisor to the combined employers group in the negotiations which culminated in the 2005 revisions to the Illinois Workers' Compensation Act. More recently, Bruce worked as a technical advisor to the Illinois Chamber of Commerce as well as a number of Illinois legislators and State agencies in the process that resulted in the 2011 Amendments to the Act.

Bruce was appointed by Mitch Weisz, Chairman of the Illinois Workers' Compensation Commission, to a committee of attorneys who reviewed and made recommendations for revisions to the Rules Governing Practice before the Workers' Compensation Commission. He has served as Vice-Chair of the ABA Committee on Employment, Chair of the Illinois State Bar Association Section Council on Workers' Compensation, and currently serves on the Employment Law Committee of the Chicagoland Chamber of Commerce and the Illinois Chamber of Commerce Workers' Compensation Committee. He has been designated as one of the "Leading Lawyers" in Illinois as a result of a survey of Illinois attorneys conducted by the *Chicago Daily Law Bulletin*; another survey published recently by *Chicago Magazine* named Bruce one of the "Best Lawyers in Illinois" for 2008. He has also been designated as an Illinois Super Lawyer by *Chicago Magazine.*

With extensive experience before the Illinois Workers' Compensation Commission, Bruce has defended employers in thousands of cases during the course of his career. As a result of his experience and success, his services are sought by self-insureds, insurance carriers, and TPAs. "I strive to handle all claims in an aggressive but fair and cost effective manner while strictly adhering to the philosophy and guidelines of the individual clients for whom we have the privilege to represent." Bruce believes that "cases must be promptly evaluated, a game plan mutually agreed to, and every attempt made to resolve the case as quickly and efficiently as possible."

Bruce says there are several things which distinguish his handling of claims from attorneys of other law firms.

"I always look for practical ways to resolve cases, especially complicated matters. I seek the answers to questions such as "*what motivates this petitioner or this petitioner's attorney*?" I often recommend the "carrot and stick" approach to case resolution which means coupling a fair but not overly generous offer with a less desirable consequence such as suspension of benefits for non-cooperation, intensive vocational rehabilitation (including regular meetings with a counselor), an IME in Chicago, or a simple "if that's not acceptable, let's try it and in a couple of years we will see where we are." I strive to return e-mails and phone calls as soon as possible, whether or not I am physically in the office. Hopefully the level of service

that I and the other attorneys in our Practice Group deliver sets us apart from the attorneys in other law firms.

Bruce also believes that his representation is enhanced by the strength of the firms' overall practice group. "The extraordinary quality of our attorneys from youngest to oldest, and the fact that we have more than 20 attorneys engaged primarily in the defense of workers' compensation cases, sets us apart from other firms in that we can effectively and efficiently represent our clients at every workers' compensation venue in Illinois. As we like to say, 'Heyl Royster has the State covered.'"

Bruce is an adjunct professor of law at the University of Illinois College of Law where he has taught workers' compensation law to upper-level students since 1998. "My teaching at the College of Law over the past 15 years, authoring two editions of a treatise on Illinois Workers' Compensation Law, as well as consulting for business interests, has kept me on top of new developments in the law, including nationwide trends, placed me in a position to give input as legislation and rules affecting workers' compensation are crafted in Springfield, and kept me young! While service is key in keeping and retaining good clients, legal knowledge, sound judgment and experience are the foundation upon which high quality service is built and delivered.

Bruce has co-authored a book with Kevin Luther of the firm's Rockford office entitled *Illinois Workers' Compensation Law, 2009-2010 Edition*, which was published by West. The book provides a comprehensive, up-to-date assessment of workers' compensation law in Illinois. The Second Edition of this treatise is due for publication in the Spring of 2012. He is a frequent speaker on workers' compensation issues at bar association and industry-sponsored seminars.

Amputations

by Joe Guyette

A workplace accident involving an amputation requires special handling. The Act specifically dictates the awards to be made in the case of an amputation of a digit or a limb. If these awards are not timely paid, the respondent is subject to significant penalties. These benefits may be demanded only weeks after an accident, long before the petitioner reaches maximum medical improvement. Often, cases involving the amputation of a digit or limb may be ultimately settled on the basis of a partial loss of use of a hand or foot, or as a wage differential or permanent total disability award. In those instances, the question often arises, what happens to the benefits paid pursuant to the statutory provisions regarding amputations? Also, if you get a credit, is it based upon the money paid to the petitioner, or the number of weeks of disability benefits?

This issue is further complicated by the different minimums required for amputation benefits versus permanent partial disability benefits. For an accident occurring on July 1, 2012, an employee with an average weekly wage of $500.00 would have a PPD rate of only $300.00. In the case of an amputation, the minimum PPD rate is increased to $483.36. The minimum amputation rate is dictated by Section 8(b)4.1 of the Act, and the difference can be very significant in the case of a low wage earner. Because the amputation rate is higher, the money paid for amputation benefits can be much higher than the amount paid for the same number of weeks of regular PPD benefits.

In *Payetta v. Industrial Comm'n*, 339 Ill. App. 3d 718, 791 N.E.2d 682 (2d Dist. 2003), the Appellate Court, Second District, Industrial Commission Division, addressed this exact issue. The holding in that case establishes that a respondent is entitled to a credit for the amputation benefits previously paid, based on the money paid to the petitioner. *Id*. at 723. The court noted that "The rationale for penalizing an employer who does not promptly pay a scheduled award is based on the fact that the employer would be entitled to a credit if the employee later seeks" a non-amputation award. *Id.* Since the *Payetta* case was decided, the Commission has repeated this reasoning in allowing the respondent to take a credit for amputation benefits where a petitioner later seeks a wage differential, permanent total disability award, or an award based on a loss of use of a hand, foot or limb.

A petitioner's attorney may not always volunteer that this credit should be based upon dollars, instead a number of weeks of disability. The *Payetta* case is an important tool for maximizing the credit available to a respondent in the case of an amputation. If you ever have any questions regarding the special handling necessitated by an amputation claim, or the credits available for benefits previously paid to a petitioner, please feel free to contact any of our workers' compensation attorneys.

Joe Guyette began his career with Heyl Royster, clerking in the Urbana office. Following graduation from law school, he joined the firm's Urbana office as an associate in August of 2004. During law school, he served as Articles Editor for the University of Illinois Journal of Law, Technology & Policy.

Joe concentrates his practice in the areas of workers' compensation defense, professional liability and employment matters. Joe devotes a portion of his practice to representing the firm's clients at depositions of plaintiffs and fact witnesses in asbestos personal injury matters.

Joe has taken several bench and jury trials to verdict, and has drafted and argued numerous dispositive motions. Joe has handled workers' compensation arbitration hearings at venues throughout the state, and has argued multiple cases before the Workers' Compensation Commission. Joe regularly handles depositions of expert witnesses and treating physicians in both civil and workers' compensation matters.

Practice Pointer

by Bruce Bonds

The 2011 Amendments to the Illinois Workers' Compensation Act contain two provisions that affect the determination of permanent partial disability of repetitive trauma carpal tunnel syndrome cases. It is important to keep in mind, however, that the two provisions have different effective dates.

Section 8(e)(9) limits the recovery for carpal tunnel syndrome due to repetitive or cumulative trauma to 15 percent loss of use of the hand, except for cause shown by clear and convincing evidence in which case the award shall not exceed 30 percent loss of use of the hand, and bases that percentage on 190 weeks. Those provisions became effective when the Governor signed the law into effect on June 28, 2011.

Section 8.1b provides for the consideration of an AMA rating in all determinations of permanency, which includes repetitive trauma carpal tunnel claims. It applies only to those cases which occurred on or after September 1, 2011. An AMA rating on a typical carpal tunnel claim status post surgical release with resolution of symptoms and no objective findings is 2 percent to 5 percent of a hand, according to the Sixth Edition of the *Guides to the Evaluation of Permanent Impairment*. These ratings will **not**, however, apply to repetitive trauma carpal tunnel cases that took place between June 28, 2011 and August 31, 2011.

Recent Case

On September 26, 2012, the Illinois Supreme Court granted leave to appeal in the case of *Gruszecka v. Workers' Compensation Comm'n*, No. 114212 (formerly 2012 IL App (2d) 101049WC). This is the decision we reported on in our March 2012 issue, where the appellate court, in a 3-2 decision, held that the mailbox rule did not apply to circuit court judicial review filings under section 19(f) of the Act. The case will be briefed over the course of the fall and oral arguments should be scheduled in early-to-mid 2013. We will continue to monitor this case as it moves towards disposition.

The cases and materials presented here are in summary and outline form. To be certain of their applicability and use for specific claims, we recommend the entire opinions and statutes be read and counsel consulted.

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