

HEYL ROYSTER WORKERS' COMPENSATION NEWSLETTER

A Newsletter for Employers and Claims Professionals

Fall/Winter 2006

A WORD FROM THE PRACTICE GROUP CHAIR

On behalf of our firm's Workers' Compensation Practice Group, I am pleased to present our Fall/Winter 2006 review of recent workers' compensation cases.

This issue contains an excellent article by Kevin Luther outlining the requirements from recent case law for an employer to preserve and not waive its section 5(b) lien rights. Brad Peterson brings us up to date on the Medicare Secondary Payer in Workers' Compensation Settlement Agreement Act of 2006, and Gary Borah reviews a recent decision suggesting a change in the issuance of settlement checks or payments of an award. Brad Antonacci reviews the latest attempt by the Supreme Court to define "manifestation date" of a repetitive trauma case. We have another article by Kevin Luther dealing with post-judgment petitions under section 19(h).

In addition, as always, we have Jim Voelker's timely case law update, and I have attempted to bring you up to date with recent developments at the Illinois Workers' Compensation Commission. Finally, we include the second installment of our regular feature containing practice pointers which we hope are of use to our clients and carriers.

We are happy to provide seminars to groups small and large with respect to the handling of workers' compensation matters as well as the effects of the recent changes to the Workers' Compensation Act. If you would like a presentation, please do not hesitate to contact me.

We are in the process of updating and confirming our newsletter/seminar database. Please be sure to complete the enclosed card and send or e-mail the information to us as indicated.

Finally, as we approach the end of the year, we would like to extend best wishes for a healthy holiday season and a prosperous new year from all of your friends at Heyl, Royster, Voelker & Allen.



Bruce L. Bonds

WC Practice Group Chair

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EMPLOYER ENTITLED TO SECTION 5 WORKERS' COMPENSATION LIEN – BORROWMAN REJECTED

By Kevin J. Luther, Rockford

In a previous *IDC Quarterly* issue, the appellate court opinion of *Borrowman v. Prastein*, 356 Ill. App. 3d 546, 826 N.E.2d 600, 292 Ill. Dec. 459 (4th Dist. 2005) was reported. In *Borrowman*, the employer settled its workers' compensation claim, but it did not specifically use language in the workers' compensation settlement contract stating that it was preserving, and not waiving, its section 5(b) lien that would attach to any third-party recovery. The plaintiff and defendants in *Borrowman* argued that by not specifically preserving the section 5 workers' compensation lien in the Lump Sum Settlement Contract, the employer waived its lien. The Fourth Appellate District agreed. As a result of the *Borrowman* decision, workers' compensation practitioners have been specifically preserving their section 5(b) lien in settlement contracts that are presented to the Illinois Workers' Compensation Commission.

Most commentators, as well as trial courts, have suggested that the *Borrowman* decision was incorrect. In *Gallagher v. Lenart*, 854 N.E.2d 800, 305 Ill. Dec. 208 (1st Dist. 2006), the First District specifically rejected the holding in *Borrowman*.

In *Gallagher*, the genesis of the plaintiff's injury was an industrial accident which gave rise to a compensable workers' compensation claim. Following the accident, a workers' compensation claim was filed, and it was eventually settled for the sum of \$150,000. The settlement contract in the workers' compensation claim did not specifically state that the employer was preserving its section 5(b) lien against any third-party recovery. The injured employee also had a personal injury action pending against certain defendants. Those defendants, following the workers' compensation

settlement, filed a third-party action against the employer seeking contribution.

During the pendency of the lawsuit, the defendants filed a motion to adjudicate any third-party claims and to issue a settlement draft. Citing the *Borrowman* decision, the defendants argued that in the settlement of the workers' compensation claim, the employer waived its workers' compensation lien. The employer filed a petition to intervene, which was granted by the trial court. The trial court granted the defendants' motion to adjudicate any third-party liens, and found that the employer did not have a lien pursuant to *Borrowman*.

The First District in *Gallagher* conducted a detailed discussion of *Borrowman*. In doing so, the First District held that the *Borrowman* decision was unsupported by case law, contrary to several principles behind the Workers' Compensation Act, and was also at odds with general contract law. The First District emphasized that waiver is the voluntary and intentional relinquishment of a known right by conduct inconsistent with an intent to force that right. The absence of any reference to an employer's lien in a workers' compensation settlement, without more, cannot constitute such a voluntary and intentional relinquishment of that section 5(b) right. In sum, the First District rejected *Borrowman* and declined to follow it.

The *Gallagher* decision is a welcome decision by workers' compensation practitioners. However, because there is a split between appellate districts on this particular issue, it is recommended that all workers' compensation settlements contain specific language preserving the employer's section 5(b) lien.

THE MEDICARE SECONDARY PAYER AND WORKERS' COMPENSATION SETTLEMENT AGREEMENTS ACT OF 2006

By Bradford J. Peterson, Urbana

Since the Center for Medicare Services (CMS) began enforcement of the Medicare Secondary Payer Act, (MSPA) 42 U.S.C. §1395y(b), *et seq.*, considerable ambiguity and uncertainty has existed regarding the parties' duties and obligations under the Act. Workers' compensation claimants, attorneys, insurers and employers have faced untenable delays in securing CMS approval of Medicare Set-Aside (MSA) accounts. In addition, delays exceeding 90 days are common place when attempting to determine whether Medicare has made conditional payments of the claimant's medical bills. Pronouncements from CMS as to the regulatory scheme have slowly provided some clarity to their enforcement of the Act. However, continuing frustration with the Center for Medicare Services led the American Bar Association House of Delegates to pass a resolution on February 14, 2005, calling for significant amendments to the MSPA. Many of the ABA's proposals have become a part of House Bill 5309. House Bill 5309 was introduced in the House of Representatives on May 4, 2006. The Bill has since been referred to the House Committees on Ways and Means and Energy and Commerce.

If enacted into law, the Bill would provide practitioners with significantly more certainty in handling Medicare Set-Aside issues. As a whole, the statute limits the scope of the MSPA and requires CMS to decide cases in a timely manner.

Exempt Settlements

The Bill sets forth five categories of workers' compensation settlements that would become exempt from the MSPA. Those categories include:

1. Settlement with a present cash value of less than \$250,000.
2. Compromise settlements where the present cash value of the settlement is not more than 20 percent of the total amount that could have been payable under the Workers' Compensation Statute.
3. The claimant is not currently receiving Medicare benefits and is unlikely to become eligible within 30 months after settlement.
4. Settlements where the claimant is not eligible for future medical expenses.
5. Any settlement that does not close future medical expenses.

Clearly, the first exemption would significantly reduce the number of cases in which the MSPA would apply. It would exempt all cases with a value of less than \$250,000. Currently the \$250,000 threshold only applies where claimants are reasonably likely to become Medicare eligible. In addition, the second exemption would apply to those cases where there is a significant compromise as to the value of the claim. On whole, fewer claims would fall within the realm of the MSPA, making disposition easier.

Qualified Medicare Set-Aside

The Bill defines a qualified Medicare Set-Aside as one that "reasonably takes into account the full payment obligation" for future medical expenses considering the following:

1. The illness or injury giving rise to the workers' compensation claim involved.
2. The age and life expectancy of the claimant involved.
3. The reasonableness and necessity of future medical expenses for treatment of the illness where injury involved.
4. The duration of and limitation on benefits payable under the workers' compensation law or plan involved.

Where the Medicare Set-Aside allocation satisfies this standard, the allocation will be deemed “qualified” and the parties will have satisfied their obligations under the MSPA. Pursuant to House Bill 5309, the parties will not need to submit such MSAs to CMS for approval. Rather, submission for approval will become optional.

The MSA allocation must reasonably protect Medicare’s interests. “Reasonableness” is evaluated based upon the following criteria:

- The claimant’s illness or injuries;
- The claimant’s life expectancy;
- The need for future claim-related medical expenses;
- The duration of and limitation on benefits payable under the workers’ compensation law or plan.

The Bill significantly alters how the Set-Aside will be calculated. The MSA would be based upon applicable work comp fee schedules and would be calculated based upon present cash value. Furthermore, the costs associated with creating and administering the MSA are subtracted from the qualified MSA amount.

Discounted Settlements

HR 5309 would recognize “compromise” settlements. The Act would provide for a proportionate reduction in MSA funding based upon the percentage that the disputed workers’ compensation claim is discounted. The Act identifies *deep discount compromise agreements* as workers’ compensation settlements in which the present cash value of the denied or contested portion of the claim is more than 20 percent and less than 90 percent of the present cash value of the claim’s full value if it had not been denied or contested. In other words, if the settlement is partially denied or contested and the settlement is compromised by more than 20 percent and less than 90 percent of the claim’s total potential value, the settlement will be deemed a deep discount compromise

settlement. In such cases, the percentage discount of the workers’ compensation claim would also be applied to the amount necessary to fund the MSA in order for it to become a *qualified* Medicare Set-Aside.

Safe Harbor Provision

The Act creates a *safe harbor amount* wherein Medicare Set-Aside amounts will be deemed *qualified* where the Set-Aside amount is the greater of:

1. The amount that is 10 percent of the present cash value of the agreement or,
2. The amount that is 15 percent of the payments provided by the agreement for medical expenses, including payments for items and services that are covered under the Secondary Payor Act and also such expenses that are not covered under the MSPA.

Accordingly, settlements would be deemed qualified (even if not approved by CMS) where the MSA amount equals or exceeds the greater of 10 percent of the total settlement or 15 percent of the total medical benefits including both Medicare and non-Medicare covered amounts.

Direct Payments to CMS

The Bill provides parties with an election to submit the MSA amount directly to CMS for their administration of the account. Where a qualified Medicare Set-Aside amount is paid to CMS the payment shall satisfy the parties’ obligations under the Medicare Secondary Payer Act and the *secretary shall have no further recourse, directly or indirectly, upon a workers’ compensation claimant or workers’ compensation payer to the agreement.*

Criticism has already arisen with regard to this provision. Commentators have suggested that a substantial bureaucracy would need to be created in order for CMS to meet its statutory obligation. As with current CMS procedures and Medicare coverage, it is

anticipated that a third-party vendor would be retained to administer the direct payment MSAs.

Deadlines

The Act imposes long overdue deadlines on CMS to render decisions regarding the MSA as well as respond to inquiries regarding prior conditional payments. Under the Act, CMS would have a 60-day deadline in which to approve or reject the MSA. Where rejected, the specific basis of the rejection must be set forth in writing. If CMS fails to meet the 60-day deadline, the MSA would automatically be deemed a *qualified* MSA satisfying the parties' obligations. In addition, CMS would also have a duty to respond to inquiries as to conditional payments within 60 days. If CMS fails to provide the conditional payment information within 60 days, then neither the claimant nor the payer shall be liable for reimbursement.

Appeals

HR 5309 institutes an appeals process which is currently non-existent. Parties would be allowed to request reconsideration of a MSA denial within 60 days of the Notice of Determination. CMS would then have 30 days to rule upon the Request for Reconsideration. Further appeal may then be had to an Administrative Law Judge (ALJ) for a full hearing. The parties would be subject to a 30-day deadline in which to file a request for a hearing. The Administrative Law Judge would then be under a 90-day deadline in which to complete the hearing and issue their ruling. Further judicial review of the administrative ruling is also provided for under the proposal. In instances where the ALJ fails to render a ruling within the 90-day deadline, the parties are then allowed to proceed with judicial review.

Termination and Modification

The Bill sets forth standards for claimants or their beneficiaries seeking termination or modification of an MSA. Upon death of the claimant, a beneficiary to the funds may request termination of the account. Claimants may also seek modification or termination of the MSA where the MSA has been in effect for at least five years and a change in circumstance or medical condition justifies a reduction in the amount of the MSA by at least 25 percent. CMS will be under an obligation to render a decision as to the request within 60 days of notice of the request. Where CMS fails to respond within 60 days, the request would be deemed granted.

Conclusion

Amendments to the Medicare Secondary Payer Act are long overdue. While HR 5309 enjoys strong support from the Bar as well as claimants, employers and insurers, it has yet to be seen whether the Bill will receive a hearing in committee and reach the floor of the House of Representatives. The Workers' Compensation Section Counsel will continue to follow the progress of HR 5309 and update readers of developments in the future.

INCLUSION OF MEDICAL PROVIDER ON PETITIONER'S CHECK MAY WARRANT SANCTIONS

By Gary L. Borah, Springfield and Brad A. Elward, Peoria

A new Illinois Workers' Compensation Commission decision handed down in late June signals a possible change in practice for the issuance of settlement checks or payment of an award. In *Carreno v. Cambridge Homes*, No. 06 I.W.C.C. 0531, 2006 WL 1968954, Ill. Workers' Comp. Comm'n., June 30, 2006,

the Commission (Commissioner's Sherman, Rink, and Ulrich) unanimously awarded section 19(k) penalties and section 16 attorneys' fees against an employer whose carrier issued a payment check for medical benefits that included both the petitioner and the name of the providers.

Following an unsuccessful appeal process, the employer sought to pay the Commission's award and issued a series of checks, payable to petitioner and his attorney. Two checks were issued, payable to petitioner and his counsel, representing the awards of TTD and of PPD benefits. Sixteen other checks were issued, purporting to represent the Commission's award of medical expenses, in the total amount of \$113,779.85. Each check was made payable to petitioner, his attorney, and the particular provider for whose services the employer was held liable to by the Commission.

Petitioner rejected the medical expense checks and filed a section 19(k) and section 16 petition arguing an improper and incomplete tender of the medical expenses. The Commission agreed and awarded penalties of \$56,889.93 under section 19(k) and \$34,133.96 in attorneys' fees under section 16. According to the Commission, "we find that Respondent's inclusion of medical providers as payees . . . was unreasonable and vexatious. It was an improper tender which is properly treated as no tender at all." *Id.*

The Commission observed that section 21's proscription against awards being subject or held liable to any lien or debt applied directly to the employer's conduct. "It is undoubtedly true that Petitioner has an obligation to pay his medical providers for their services. However, Respondent has no right to interfere with Petitioner's determination of how he distributes the proceeds of his award." *Id.*

"The entire award is payable to the Petitioner." *Id.*

CARPAL TUNNEL CLAIM NOT BARRED BY STATUTE OF LIMITATIONS

By Brad A. Antonacci, Rockford

As we reported in our Summer 2006 edition of the newsletter, in *Durand v. Industrial Comm'n*, 358 Ill. App. 3d 239, 831 N.E.2d 665, 294 Ill. Dec. 715 (3d Dist. 2005), the appellate court denied petitioner's carpal tunnel syndrome claim because the claim was held to be time-barred by the three-year statute of limitations. Petition for leave to the Illinois Supreme Court was allowed on December 1, 2005. The Illinois Supreme Court recently wrote a decision reversing the appellate court. *Durand v. Industrial Comm'n*, No. 101109, 2006 WL 2975584 (Ill. Oct. 19, 2006).

In this case, the claimant suffered from pain in her hands and wrists in 1997. However, the petitioner continued to work and did not seek treatment for this pain until August of 2000. Claimant's testimony at arbitration contained four admissions that in September or October of 1997, she was aware of her injury and its causal relationship to her employment, at which time she reported her hand and wrist problems to her supervisor. The Supreme Court noted that the "accident date" in a repetitive trauma claim is the date on which an injury manifests itself. The manifestation date is the date on which the fact of the injury and its causal relation to work becomes plainly apparent to a reasonable person. The Illinois Supreme Court held that the petitioner's manifestation date was the date on which she necessitated medical treatment in 2000, and thus her claim was not barred by the statute of limitations. The majority held that prior to that date, the petitioner had a sketchy understanding of her hand and wrist pain. In 1997, her pain was not constant or severe enough so as to require medical treatment or reassignment to other work. There was indication of doubt of an injury until 2000, when the petitioner's pain finally necessitated medical treatment. The Supreme Court also noted that an employee should not be

punished for diligently working through progressive pain until it affects his or her ability to work and requires medical treatment.

The decision can be found at the following web site address: <http://www.state.il.us/court/Opinions/SupremeCourt/2006/October/Opinions/Html/101109.htm>.

WHAT'S NEW AT THE ILLINOIS WORKERS' COMPENSATION COMMISSION

By Bruce L. Bonds, Urbana

Concern remains over the implementation of the medical fee schedule. Preliminary studies suggest the medical fee schedule may not result in the level of savings business groups hoped to receive in exchange for the significant benefit increases. It will probably take a year or two to get more dispositive numbers. Hopefully, with their current generous level of funding, the Illinois Workers' Compensation Act (IWCC) will fund studies by entities such as the Workers' Compensation Research Institute (WCRI) or National Council on Compensation Insurance (NCCI) that will track the savings or lack thereof from the medical fee schedule.

The first priority at present must be to bring **all** medical services within the purview of the medical fee schedule. At a recent seminar hosted by the Illinois Self Insured's Association, Chairman Ruth stated that the current medical fee schedule covers only approximately 71 percent of all medical services. Ambulatory surgical center services, out-patient hospital services, emergency room services and dental services are currently not covered. These charges, along with most out-of-state medical charges, are paid at 76 percent of the charge without any limit on the amount charged.

Chairman Ruth told the Self Insured's Association that the data to bring dental charges within the medical

fee schedules is available, but there is a dispute with the dentists over the use of their codes, which are copyrighted. However, dental charges probably are not a significant component of workers' compensation medical outlets. The chairman hopes that emergency room and out-patient hospital services will be brought within the medical fee schedule by the early part of 2007. Once that has been accomplished, Chairman Ruth says that 90 percent of medical procedures will then be covered. It may be another year or more before out-patient surgical treatment center surgeon charges are brought within the medical fee schedule.

Effective January 1, 2007, the medical fee schedule will increase 3.8 percent to reflect the consumer price index (CPI-U) from the past year. If the increases had been based on the consumer price index for medical services, known as the "CPI-M," these increases would have been in the 8 percent to 10 percent range.

Chairman Ruth says that the Illinois Medical Fee Schedule is the most "consumer friendly medical fee schedule in the country." That may be true, unless one is trying to determine anesthesia charges which cannot be done without outside help or purchasing outside reference materials.

At Heyl Royster, we continue to closely monitor the ongoing implementation of the new medical fee schedule as well as all developments of the Illinois Workers' Compensation Commission so as to better serve you. We are active at the Coalition of Employers and Insurance Groups monitoring workers' compensation issues known as the "Tuesday Working Group" as well as the Illinois Chamber of Commerce, the Chicagoland Chamber of Commerce and the Illinois Self Insured's Association.

Please do not hesitate to contact me or any of our attorneys with any questions.

MULTIPLE POST-JUDGMENT 19(h) PETITIONS CAN BE FILED IN CERTAIN CIRCUMSTANCES

By Kevin J. Luther, Rockford

Section 19(h) of the Workers' Compensation Act provides that an award may be reviewed by the Illinois Workers' Compensation Commission at the request of either the employer or the employee on the ground that the disability of the employee has subsequently recurred, increased, diminished, or ended, so long as the 19(h) petition is filed within 30 months of the award. *See* 820 ILCS 305, 19(h). The appellate court recently entertained a question as to whether it is possible to file multiple 19(h) petitions.

In *Behe v. Industrial Comm'n*, 365 Ill. App. 3d 463, 848 N.E.2d 611, 302 Ill. Dec. 312 (2d Dist. 2006), the petitioner filed a 19(h) petition within 30 months of a workers' compensation decision. After hearing evidence on the petitioner's 19(h) petition, it was denied by the Illinois Workers' Compensation Commission. Within 30 months of the Illinois Workers' Compensation Commission's denial of that first 19(h) decision, the attorney for the petitioner filed a second 19(h) petition arguing that the disability had increased.

The appellate court determined that when a 19(h) petition is filed within 30 months of a final award from the Illinois Workers' Compensation Commission, and that 19(h) petition results in a change of the award, a party has an additional 30 months from the date of the 19(h) award in which to file another 19(h) petition. The Illinois Workers' Compensation Commission retains jurisdiction for 30 months after each 19(h) decision that results in a change in the amount of disability awarded. However, in *Behe*, the first 19(h) petition resulted in no change in the award. Therefore, neither party had the opportunity to file another 19(h) petition within the 30-month period after the denial of the first 19(h) petition. To hold otherwise, the court felt that claimants and employers could simply file successive 19(h) petitions

regardless of their merit and, in essence, extend the 19(h) period beyond 30 months to an indefinite period of time.

In conclusion, if there has been a 19(h) award that either increases or decreases the prior award, then the Illinois Workers' Compensation Commission retains jurisdiction for another 30 months. If another 19(h) petition results in an award that changes the prior award, then the 30-month limitation period runs again.

CASE SUMMARY

By James M. Voelker, Peoria

Contract Waiving Jurisdiction in Illinois Not Binding on Claimant. Recovery in Two States Allowed.

PI & I Motor Exp., Inc./For U, LLC v. Industrial Comm'n, No. 5-05-0450 WC, 2006 WL 2847898 (5th Dist., September 21, 2006). At the time petitioner was hired in Illinois, he executed a contract by which he agreed to be bound by the Workers' Compensation Act of Ohio and waived all provisions of the Illinois Workers' Compensation Act. The claimant was injured in Pennsylvania while driving a truck. He filed claims in both Ohio and Illinois and received an award in Ohio. The employer sought dismissal of the Illinois claim, arguing (1) the employment contract waived jurisdiction in Illinois and (2) the recovery in Ohio precluded recovery in Illinois. The Illinois Appellate Court ruled that section 23 of the Illinois Workers' Compensation Act prohibits the employer and the employee from entering into any kind of agreement depriving Illinois of jurisdiction. Thus, the employment contract was held invalid to the extent that it was asserted as a waiver of jurisdiction in Illinois. The court further held that the receipt of benefits in one state does not bar a subsequent award in another state with concurrent jurisdiction. Finally, it held that the

employer's argument, that the Ohio award acted as *res judicata*, failed based on a lack of proof.

**Respondent's Failure to Pay Award Justified
\$6,000.00 in Attorney's Fees
Rather than 20 Percent under Section 19(g)**

Radosevich v. Industrial Comm'n, 367 Ill. App. 3d 769, 846 N.E.2d 1, 305 Ill. Dec. 469 (4th Dist. 2006). Petitioner received an award on September 17, 2002, and neither party appealed. Respondent's attorney wrote to petitioner's attorney on October 25, 2002, requesting the petitioner's Social Security number and inquiring as to whether the petitioner was interested in a lump sum settlement. On November 19, 2002, the petitioner's attorney confirmed in writing that the petitioner was not interested in a lump sum settlement and wanted the award paid within one week. Next, on December 13, 2002, the petitioner filed an Application for Entry of Judgment pursuant to section 19(g). On January 2, 2003, the respondent paid the award in full. Then, on April 3, 2003, the petitioner sought attorney's fees of \$32,310.35, representing 20 percent of the amount awarded in circuit court under section 19(g). The circuit court awarded \$6,000.00 in attorney's fees and \$847.20 in interest. The petitioner appealed, contending entitlement to 20 percent of the gross award under section 19(g); the respondent cross appealed arguing the evidence was insufficient to support the circuit court's finding that the respondent's conduct amounted to a refusal to pay under section 19(g). The appellate court affirmed the circuit court's finding that the respondent's conduct amounted to refusal to pay and also affirmed the circuit court's award of \$6,000.00 in fees and interest. It held that section 19(g) does not require attorney fees of 20 percent, but only that the attorney's fees not exceed 20 percent of the award. It ruled that it was within the circuit court's discretion to weigh the conduct of the parties and arrive at a fair assessment of attorney's fees. The fees in this case,

\$6,000.00, were not against the manifest weight of the evidence.

**Illinois Workers' Compensation Commission
Reversed - Fall on Non-defective Bathroom
Floor Not Compensable**

First Cash Financial v. Illinois, 853 N.E.2d 799, 304 Ill. Dec. 722 (1st Dist. 2006). Claimant slipped and fell on a bathroom floor on the employer's premises injuring his left arm. The petitioner admitted at trial that he did not observe any foreign objects on the floor or any defects in the floor. Moreover, he did not know what caused his fall. An engineering consultant testified for the respondent that the slip resistance of the floor was within national safety standards. The arbitrator and Illinois Workers' Compensation Commission found the case compensable based on the fact that the bathroom floor had not been cleaned recently. The appellate court reversed and reviewed the case on a *de novo* basis because there were no disputes of fact in the underlying case. Thus, the manifest weight standard did not apply. The appellate court ruled that the claimant failed to show that the fall arose out of and in the course of his employment because claimant failed to present any evidence as to the cause of the fall. It is important to note that the court did not strain to find compensability by following the unexplained fall doctrine, which was not mentioned in the decision.

**Injury During Company Picnic
Not Compensable Since Claimant
Not Ordered or Assigned to Attend**

William Gooden v. Industrial Comm'n, 366 Ill. App. 3d 1064, 853 N.E.2d 37, 304 Ill. Dec. 505 (1st Dist. 2006). The petitioner was injured while playing volleyball at a company picnic and sustained a back injury. He was paid his regular salary the entire day, but

was not ordered or assigned to attend the picnic. He was diagnosed with a herniation and underwent low back surgery.

The arbitrator found the case not compensable and the Illinois Workers' Compensation Commission affirmed. The appellate court affirmed the Commission ruling that his injuries were not compensable because he was not ordered or assigned to attend the picnic. The court distinguished the *Woodrum* case by noting that the petitioner did not face the prospect of a loss of pay or vacation/personal days as a consequence of foregoing the picnic. If he had not gone to the picnic he could have worked the entire day just like any other.

Wage Differential Affirmed Even Though There Was No Direct Evidence of Current Earnings Potential at Former Occupation

Morton's of Chicago v. Industrial Comm'n, 366 Ill. App. 3d 1056, 853 N.E.2d 40, 304 Ill. Dec. 508 (1st Dist. 2006). The petitioner sustained a knee injury when she slipped and fell on a floor while working for the respondent. She underwent surgery and following her recovery was told by her treating doctor that she was physically unable to perform her former job as a waitress. In May of 2000, she eventually accepted a job as a paralegal paying \$34,000.00 per year. Two years prior to that, she had earned \$44,000.00 with respondent, as had a co-employee. In 2000, the same co-employee earned \$50,000.00 and another co-employee earned \$54,000.00. The arbitrator awarded a period of disability and 60 percent loss of the use of the left leg. The Illinois Workers' Compensation Commission awarded a wage differential commencing on the date that she began working as a paralegal.

The respondent appealed, claiming that the Illinois Workers' Compensation Commission erred in awarding a wage differential. The respondent did not make any arguments regarding the petitioner's incapacity to return to her former employment, but

simply argued that the claimant failed to sustain her burden of proof regarding an impairment of earnings. The appellate court affirmed the decision of the Commission, and held that the Commission's reliance on the wages of co-employees to show the current earning capacity at her former occupation reasonable and reliable.

Denial of First 19(h) Petition Does Not Extend Time for Filing Second 19(h) Petition

Behe v. Industrial Comm'n, 365 Ill. App. 3d 463, 848 N.E.2d 611, 302 Ill. Dec. 312 (2d Dist. 2006). The parties tried this matter in April of 1997, and the petitioner received an award. Neither party appealed. In April 1999, the petitioner filed a 19(h) Petition which was denied by the Commission. In July 2002, the claimant again filed a 19(h) Petition and the employer moved to dismiss it as being filed outside the 30-month period described by the statute. The Commission granted the petitioner's Motion to Dismiss, and the claimant appealed.

The claimant argued that the 30-month limitations period began to run after the date of the Commission's denial of the petitioner's first section 19(h) Petition, relying on *Harden v. Industrial Comm'n*, 154 Ill. App. 3d 390 (1987). The appellate court distinguished *Harden* because in this case the original 19(h) Petition was denied. In *Harden*, the first 19(h) Petition was allowed and additional benefits were awarded. In *Harden*, the court allowed a second 19(h) Petition after the 30-month period, but within the 30-month period following the first 19(h) award. The basis for the *Harden* decision was that it alleviated the inherent problem of speculative awards that must account for anticipated increases and decreases in a claimant's disability. Since the first 19(h) decision in this case was denied, no additional 19(h) filings would be allowed after the 30-month period from the date of the accident. To do so would preserve the petitioner's right of review

in perpetuity so long as a successive 19(h) Petitions were filed within 30 months of the previous denial.

Fall on Parking Garage Door Threshold Held Compensable

University of Illinois v. Industrial Comm'n, 365 Ill. App. 3d 906, 851 N.E.2d 72, 303 Ill. Dec. 174 (1st Dist. 2006). The petitioner was employed at the University of Illinois as a midwife. In 1999, she suffered a right knee injury with a torn medial meniscus and underwent arthroscopic surgery. In December 2000, she was attending a mandatory, monthly midwife service meeting. She parked her car on the third floor of the University of Illinois parking structure in an area designated for employees. As she passed through a doorway, between the parking garage and the walkway, she tripped over a metal threshold and twisted her right knee. She attended the meeting and then went to the emergency room where it was recorded that she injured her right knee after slipping on ice. The claimant denied ever giving a history of slipping on ice. She reported the incident to a University police officer while in the emergency room. The police report stated that she gave a history of tripping over a metal floor plate that separated the parking garage from the walkway.

The arbitrator denied the case, but the Illinois Workers' Compensation Commission reversed and found that the petitioner sustained accidental injuries which arose out of and in the course of her employment. The University appealed, arguing that the decision of the Commission was against the manifest weight of the evidence because at the time of the injury, the claimant was not exposed to a risk greater than that to which the general public was exposed. The appellate court rejected the University's argument and held that the case did not merely involve the risks inherent in walking across a threshold as the University asserted. It ruled that when an injury to an employee arriving for

work takes place in an area on the employer's premises which constitutes a usual access route for employees, and is caused by some special risk or hazard located thereon, the "arising out of" requirement of the Act is satisfied.

Cerebral Hemorrhage During Speech Held Compensable

Pinckneyville Community Hospital v. Industrial Comm'n, 365 Ill. App. 3d 1062, 851 N.E.2d 595, 303 Ill. Dec. 408 (5th Dist. 2006). The petitioner suffered an intracerebral hemorrhage and stroke while giving a speech at a dinner. The claimant testified that she was nervous about her speech because it was being given on such short notice and she wanted everything to be "just right." As she stood up to give her speech, her head hurt and she heard a roaring sound in her ears. About halfway through the speech, she lost sight in one of her eyes and then lost consciousness. The claimant's family physician personally witnessed the incident and testified that the stress of the petitioner's job duties and the stress of giving the speech caused the claimant's hemorrhage. The respondent presented testimony from two physicians, one an internist and one a neurologist, both of whom opined that the hemorrhage was not caused by the stress of any unusual work activities. The arbitrator rejected the findings of the petitioner's treating physician and adopted the findings of the respondent's medical experts. The Commission reversed and ordered medical expenses exceeding \$277,000.00 and awarded permanent and total disability.

The employer argued first, that the speech at the dinner was a voluntary recreational activity that was specifically excluded from the Act under section 11. The appellate court rejected that argument because there was evidence in the record to support a finding that the claimant was "ordered or assigned" not only to attend the event, but to speak. Next, the employer

argued that the treating physician lacked the expertise of both of respondent's experts. The appellate court ruled that the Commission was forced to weigh the competing expert testimony and the fact that it adopted the treating family physician over the respondent's more specialized experts did not warrant a reversal under the manifest weight standard. The Commission was presented with conflicting expert testimony, its assessment of the weight and credibility of that evidence would not be disturbed under the manifest weight standard.

19(g) Award of \$41,375.00 in Attorney's Fees Based on a \$300.00 Per Hour Rate Affirmed

Aurora East School District v. Don Dover, 363 Ill. App. 3d 1048, 846 N.E.2d 623, 301 Ill. Dec. 298 (2d Dist. 2006). In December 2000, a 19(b) was awarded in favor of the petitioner in the amount of \$85,000.00 in TTD benefits. Respondent filed a Petition for Review, and in August of 2000 the Commission affirmed and adopted the arbitrator's decision. The respondent appealed to the circuit court and appellate court which affirmed the Commission's decision. In February of 2004, the appellate court denied the employer's Petitions for Rehearing and Certification.

In March 2004, the employer filed a motion with the Commission seeking to adjudicate payment of the award and medical bills. It contended that \$29,000.00 in TTD benefits awarded had already been paid along with interest. He also argued that at the time of the original hearing, all the medical bills were unpaid but since the hearing, the defendant's group carrier, HMO of Illinois, satisfied four of the outstanding bills. It further alleged that it paid 100 percent of the petitioner's group insurance premiums. In May 2004, the petitioner filed a 19(g) motion in circuit court seeking to reduce his award to a judgment. The court allowed the motion and awarded \$41,375.00 in attorney's fees. The circuit court further found that the employer was not entitled to a credit, and the

Commission was without jurisdiction to determine whether respondent was entitled to a credit.

In the appellate court, the employer argued that the trial court lacked jurisdiction because the matter was remanded to the Commission. The appellate court rejected that argument, as the cause was remanded for only a permanency determination. The TTD award was final. The court further noted that only tender of full payment of the final award is a defense to a 19(g) Petition. The employer conceded that it only made partial payment due to the credit issue.

The court further noted that the Commission's decision became final in February 2004, and nearly three months passed before the 19(g) hearing in which the employer could have satisfied its obligation. The appellate court rejected the employer's argument that it made a good faith offer of settlement, and agreed to hold the petitioner harmless regarding any claims brought by his medical providers. It held that the argument ignored the Commission's directive to pay \$85,000.00 in medical expenses.

Although a partial payment had been made at the time of the 19(g) award, the appellate court held that only a tender of full payment of the final award is a defense to a 19(g) Petition. The fact that the employer had made a substantial payment on the award did not negate the court's authority to enter a fee award based on the entire award from the Commission. At the time of the hearing only \$88,756.00 was due, but despite that the court's award of \$41,375.00 in fees was affirmed.

PRACTICE POINTERS

By Bruce L. Bonds, Urbana

1. Look Out for "Zip-Gaming"

The medical fee schedule contains 29 separate three-digit "geo zips." Reimbursement levels vary from one geo zip to another, sometimes dramatically. In

essence, there are 29 different medical fee schedules in Illinois. As a result, medical providers may be involved in “zip-gaming.” Zip-gaming can manifest itself in various ways. Some doctors may elect to perform procedures in areas where the highest reimbursements may be obtained. We have heard that for some shoulder surgeries there is a \$2,000 difference in reimbursement between Northbrook and Evanston. A local physician advises me that he can receive 35 percent more for identical treatment performed in Champaign versus Decatur. This may effect where doctors choose to perform procedures.

Similarly, when you receive a bill for medical services, confirm the charges based on the geo zip where the procedure took place, **NOT** the location of the billing office which may be different.

2. What’s the Difference Between Utilization Review and an Independent Medical Evaluation?

Utilization review will focus primarily on the reasonableness and necessity of treatment, including “frequency.” An IME will focus typically on causation and work-relatedness. In addition, the IME will often address impairment and disability (PPD) as well as return to work issues. An IME doctor can still address the reasonableness and necessity of treatment, but if a non-URAC utilization review procedure is followed, the conclusions of your evaluating doctor will be considered along with all other admissible evidence, and will not create a “rebuttable presumption” against 19(l) penalties.

3. Are Charges from IME Doctors Subject to the Medical Fee Schedule?

No.

4. Don’t Rely on the Petitioner to Provide X-Rays and Films to Your IME Doctor

Many insurance carriers arrange section 12 IMEs in house and forward the petitioner a letter advising them to bring copies of their X-rays and films for review by the examining doctor. More often than not, the petitioner does not undertake the effort necessary to obtain these films, films collected are incomplete or the petitioner’s attorney instructs his or her client not to perform this task. A better practice is to obtain all X-rays and MRI films yourself and forward them to the examining doctor. If surgery has already taken place and photographs were made of the surgical findings (such as the slides often taken of arthroscopic findings) copies of these should be obtained as well. If multiple MRI and/or CT scans have been taken of the same body part, be sure to obtain all films for comparison. You will not be subpoenaing the records but will be, in essence, subpoenaing the purchase of copies of those records. In our experience, the cost associated with obtaining these copies is not prohibitive (perhaps \$4.00 to \$6.00 per copy per film). Making sure your examining physician has these copies at the time of the examination may be important to the defense of your case.

Although many carriers prefer to have adjusters arrange medical evaluations and correspond with the examining doctor outlining the issues to reduce legal expenses, you will have a better chance of getting a good, more legally useful report if defense counsel performs these tasks.

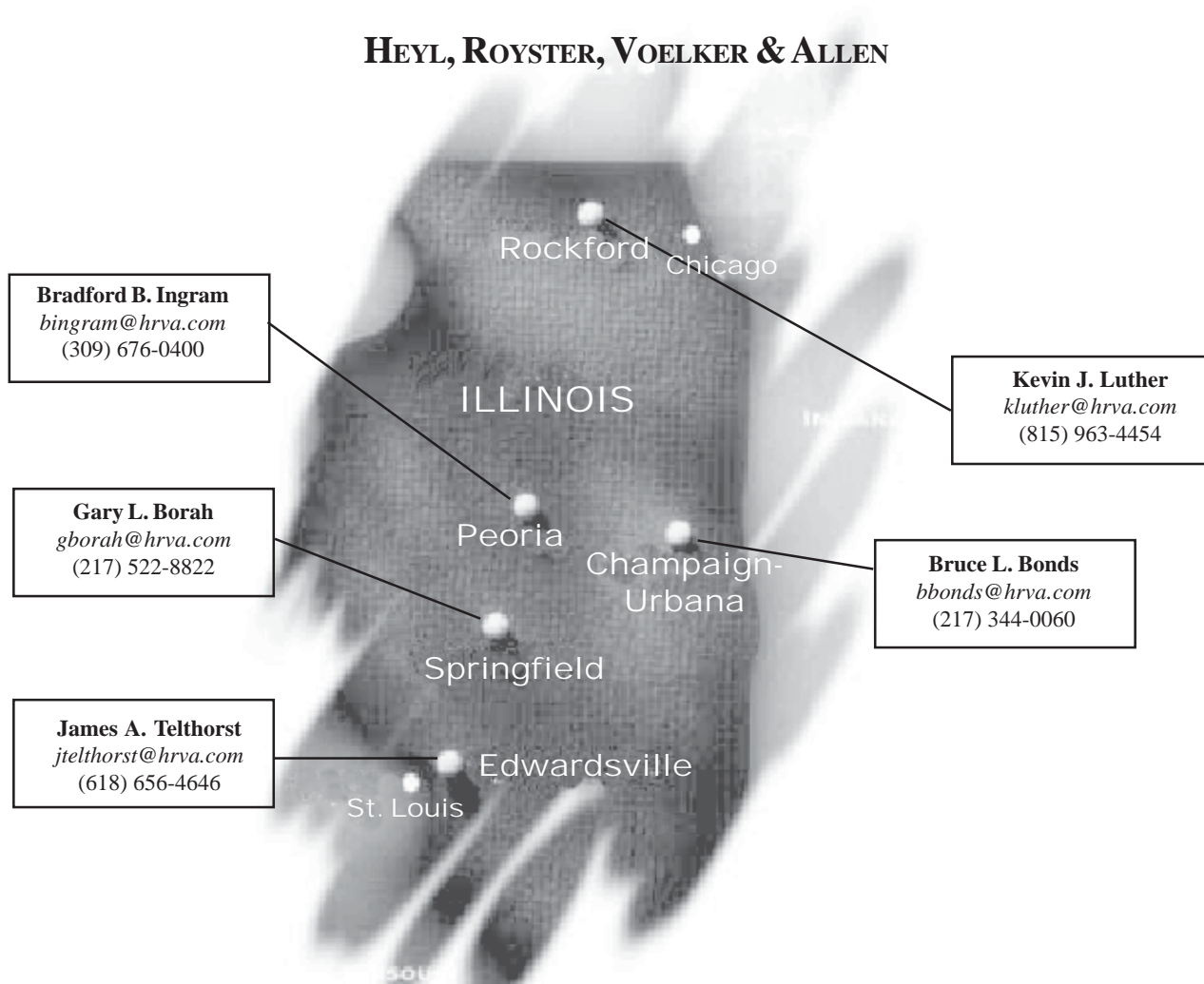
5. Why Do I Receive “Subrogation Notices” from the IDPA and What Should I Do with Them? I Thought There Were No Liens on Workers’ Compensation Payments?

If the Illinois Department of Public Aid (IDPA) has paid medical bills on behalf of a worker who has a

pending workers' compensation case, they will forward a "subrogation notice" to the parties and their attorneys. The IDPA has a "super-lien" and these must be honored. However, rarely does the notice contain the amount claimed or an itemization of the bills on which the lien is based. Always respond to receipt of a subrogation notice with a written request for an itemization. Often the IDPA will respond that the notice was sent in error (for example payments were made for unrelated treatment) and advise that the lien is null and void. Otherwise they will send an itemization and you can verify whether the charges were for treatment related to the work injury.

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We recommend the entire opinion be read and counsel consulted concerning the effect these decisions may have upon your claims.

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