USE OF AMA IMPAIRMENT RATINGS: SEIZE THE MOMENT TO REDUCE PPD AWARDS!

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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.
USE OF AMA IMPAIRMENT RATINGS: 
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I. EVALUATING THE PERMANENT PARTIAL DISABILITY UNDER THE 2011 AMENDMENTS TO THE ILLINOIS WORKERS’ COMPENSATION ACT

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 305/8.1(b), 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
A. What Is the Difference Between “Disability” and “Impairment?”

It is important to differentiate between the concepts of “disability” and “impairment.” The *AMA Guides to the Evaluation of Permanent Impairment*, Sixth Edition (the second printing of which is the most recent edition) indicates that:

1. “Impairment” is a significant deviation, or loss of use of any body structure or body function in an individual with a health condition, disorder, or disease.

2. “Disability” has been defined as activity limitations and/or participation restrictions in an individual with a health condition, disorder, or disease.

3. “Impairment rating” has been defined as a 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 (“ADL’s”).

4. “ADL’s” Basic self-care activities performed in one’s personal life such as feeding, bathing, hygiene and dressing.

Impairment and disability as used in the 2011 amendments are separate concepts. The AMA impairment rating is a component of the PPD percentage loss of use assessment, but there is not an “equal sign” between the impairment rating and PPD.

Example:

Both a lawyer and a pianist sustain an amputation of the non-dominant little finger.

- Both have the same “impairment” under the AMA Guides: 100% of the digit, 10% of the hand, 9% of the upper extremity or 5% of the whole person.
- The lawyer has no “disability.”
- The pianist is unable to perform his/her occupation and is therefore totally disabled from his occupation, although fully capable of many other jobs.

The AMA Guides Sixth Edition clearly indicates that disability (or PPD) is a determination made by an administrative law judge and may or may not have a relationship to an impairment. All editions of the AMA Guides state that an impairment rating is not equal to a disability rating and is not intended to be a measure of disability since disability has to do with limitations or restrictions in job functions rather than the actual anatomic limitation. Nonetheless the fact that an AMA impairment rating will usually be significantly lower than the customary PPD award for the same injury should, if properly presented by knowledgeable counsel, reduce PPD awards going forward. All players in the WC system, including the Chairman of the IWCC and the most rabid plaintiffs’ attorneys, acknowledge this and anticipate lower PPD awards.
B. Why Were the AMA Guides Included In the 2011 Amendments?

1. To provide greater uniformity in PPD awards.
2. To reduce the value of awards as AMA ratings are typically much lower than the typical PPD award for the same injury.

C. Who Can Prepare an AMA Rating Report?

1. Section 8.1(b) of the Act requires that the 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. The Act does not, however, require that the physician be certified to perform an AMA rating.

Note that the AMA Guidelines themselves do permit impairment evaluations from “medical doctors who are qualified in allopathic or osteopathic medicine or chiropractic medicine.” The Guides 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 pursuant to the 2011 amendments.

2. Presumably an impairment rating by a “certified” physician will carry more weight than one by a “non-certified” individual, although the certification is not required by either the AMA Guides or the Illinois statute. A physician can obtain certification by attending a two-day class which costs between $800 - $1,000.

D. Can a Treating Physician Perform an AMA Rating?

1. An AMA impairment rating is customarily provided by treating physicians in other jurisdictions, including our nearby neighbor Indiana where the treating physician who is chosen by the employer may use AMA Guidelines to determine the injured worker’s permanency.

2. The Guides themselves indicate that treating doctors should not be doing AMA impairment ratings as they are not independent, and therefore, their determinations “may be subject to greater scrutiny,” because they are considered biased in favor of the patient. The AMA Guides emphasize that 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.

The Guides’ explicit acknowledgment of the bias of treating physicians in favor of their patients brings a refreshing dose of common sense to a 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. Ample case law, including *International Vermiculite v. The Industrial Comm’n*, 77 Ill. 2d 1, 394 N.E.2d 1166, 31 Ill. Dec. 789 (1979), have articulated this conclusion. Examining physicians have often been considered “hired guns,” expressing opinions they were retained to
give by the insurance carrier while the obvious financial gain the treating physician stands to reap from causally connecting the injury to the work incident (thus guaranteeing payment by workers’ compensation carrier), and recommending various modalities of treatment (for which the treating physician expects to be paid at a rate higher than health insurance or Medicare) have been ignored.

E. Can/Should the Workers’ Compensation Insurance Carrier or Plaintiff’s Attorney Request an AMA Rating From the Treating Physician (Where They Are Qualified to Render One)?

1. **Respondent/WC Carrier:** Not without prior written approval from the petitioner or his/her attorney. If a treating physician chooses to provide an AMA rating, he/she may do so but the respondent’s attorney or insurance carrier cannot contact the petitioner’s treating physician to request an impairment rating. To do so would be a violation of the physician-patient privilege which has been applied to workers’ compensation cases in the case of *Hydraulics, Inc. v. The Industrial Comm’n*, 329 Ill. App. 3d 166, 768 N.E.2d 760, 263 Ill. Dec. 679 (2d Dist. 2002).

2. **Petitioners’ Attorney:** They can request a rating from the treating physician (if the physician is qualified to perform one), but it is unclear whether the petitioner’s attorney will routinely do so. If the petitioner’s attorney does request a rating from the treating physician, practically speaking, who pays for it? The Act does not assign responsibility for paying for the rating and clearly the impairment rating does nothing to “cure or relieve from the effects of the accidental injury” which would trigger the respondent’s responsibility to pay under section 8(a). If a petitioner needs to pay for the rating or obtain an IME to provide a rating, that might make smaller cases not worth pursuing.

3. **Petitioners’ Strategies:** Some petitioners’ attorneys advise that they will: (1) never request an AMA rating from a treating physician; (2) always object to any request by the respondent for an AMA rating by the treating physician; (3) seek sanctions under *Petrillo* and *Hydraulics* for any attempt by respondent to request an AMA rating from a treating physician without petitioner’s agreement; and (4) object to any AMA rating provided by a physician retained for that purpose by the respondent as a means of increasing the costs of the respondent which would include both the cost of obtaining the report and the cost of a subsequent deposition; and (5) they will never fight an AMA rating with their own rating but will emphasize evidence of disability corroborated by medical records.

F. Admissibility of AMA Ratings

While an AMA rating is provided for by statute, there is no provision for the automatic admissibility of these ratings. Thus, any report containing an AMA rating would be considered hearsay and almost certainly 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 will likely be required. It seems equally
likely that the petitioner's counsel will not agree to phone depositions and thus, these individuals will need to be deposed in person which will dictate the use of physicians for ratings in or near the state of Illinois.

G. Can a Physician Performing an IME Pursuant to Section 12 of the WC Act Provide an AMA Rating?

An IME physician can provide an impairment rating. Where a rating is performed by an IME physician or any other physician retained for that purpose, it is important that they be provided with the requirements of the statute and specifically address not only the AMA rating but the other factors specified, including 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.

H. How Much Does an AMA Rating Cost?

This number will vary from physician to physician but based on the seminars I have attended, the range which I have heard is that the AMA rating report will cost between $300 and $900 and a deposition between $1,000 and $1,500 for the doctor's testimony, if required.

I. When Is It Appropriate to Obtain an AMA Rating?

An AMA rating is appropriate once the patient reaches maximum medical improvement. This has been defined by the AMA 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. The Guides, does not permit the rating of future impairment.” Robert D. Rondinelli, Guides to the Evaluation of Permanent Impairment 26 (2008).

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. The Industrial Comm'n, 309 Ill. App. 3d 616, 722 N.E.2d 703, 242 Ill. Dec. 919 (3d Dist. 2000). Contrary to common belief, an injured worker can receive medical treatment after a physician has determined that maximum medical improvement has been reached but that is not typical.

J. Can AMA Guides Be Used to Establish Work Restrictions?

No. The Guides indicate that they are “not intended to be used for direct estimates of work participation restrictions.” Impairment percentages derived according to the Guides criteria do not directly measure work participation restrictions.
II. HOW ARE AMA IMPAIRMENT RATINGS DETERMINED?

A. Diagnosis:

1. The Sixth Edition of the AMA Guides bases ratings initially on a diagnosis or what is known as a diagnosis based impairment or “DBI.” The impairment class is determined by the diagnosis as the “key” factor and then adjusted by other “non-key” factors referred to as “modifiers.”

2. Do not stack diagnosis to the same body part; the AMA rating is based one per “region.” Subsequent to the diagnosis, determination must be made as to whether the condition at MMI is no problem, a mild problem, a moderate problem, a severe problem, or a complete problem. These categories are assigned a number from 0 to 4. Most conditions at the time of maximum medical improvement are categorized as “mild” which the AMA Guides defines as symptoms with strenuous activity; no symptoms with normal activity in a completely independent person.

3. Disputes over the proper diagnosis may significantly impact the AMA impairment rating.

B. Modifiers:

Once a diagnosis has been made, the rating is adjusted by certain modifiers as follows:

1. Functional history: The functional history is based on subjective reports attributable to impairment. This can be determined by an oral history given by the injured worker or through the use of forms provided in the AMA Guides.

   a. The evaluating physician may use forms/questionnaires provided in the AMA Guides to establish the functional history.

      i. Quick DASH – for upper extremity
      ii. Lower Limb Questionnaire
      iii. Pain Disability Questionnaire for spine

   b. Subjective complaints that are not clinically verifiable are generally not ratable under the Guides.

2. Physical exam: Greater weight is given to objective findings. The factors to be evaluated include, but are not limited to, stability, alignment, range of motion, muscle atrophy and deformity.

3. Clinical studies or objective test results.
C. What Are Typical AMA Ratings for Common Workers’ Compensation Injuries?

Spine Rating – Typical Case Examples (WPI%)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Sixth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-specific cervical (neck) pain</td>
<td>1% - 3% WPI</td>
</tr>
<tr>
<td>Cervical radiculopathy with fusion (resolved radiculopathy)</td>
<td>4% - 8% WPI</td>
</tr>
<tr>
<td>Lumbar radiculopathy (single level, persistent)</td>
<td>10% - 14% WPI</td>
</tr>
<tr>
<td>Lumbar pain with single level fusion (no radiculopathy)</td>
<td>5% - 9% WPI</td>
</tr>
<tr>
<td>Lumbar pain with single-level fusion (with persistent single level radiculopathy)</td>
<td>10% - 14% WPI</td>
</tr>
<tr>
<td>Lumbar pain with multi-level fusion (no radiculopathy)</td>
<td>5% - 9% WPI</td>
</tr>
<tr>
<td>Lumbar radiculopathy with fusion (persistent single level radiculopathy)</td>
<td>10% - 14% WPI</td>
</tr>
</tbody>
</table>

Extremity Rating – Typical Case Examples

UEI – Arm, LEI – Leg (To convert UEI to Hand Divide by 0.9)

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

D. Conversions

1. An injury to a thumb is 40% of an impairment rating to a hand, while an index-middle finger is 20% loss of use of a hand impairment, and a ring-little finger is 10% of a hand impairment.
2. A hand impairment is determined by multiplying 0.9 times the upper extremity rating.

3. An upper extremity rating can be multiplied by 0.6 to obtain a whole person impairment rating.

4. A lower extremity rating can be multiplied by 0.4 to obtain a whole person impairment rating.

E. Anomalies Between Illinois Workers’ Compensation Law and the AMA Guides?

1. The Guides treat a wrist fracture as an injury to the forearm (upper extremity).
   - Illinois law treats an injury to the wrist as involving the hand.

2. The Guides treat a rotator cuff injury as an injury to the shoulder and assign of loss of use on the upper extremity.
   - Illinois law may now treat shoulder injuries as a person as a whole.

3. The Guides treat carpal tunnel syndrome as an injury to the upper extremity.
   - Illinois law treats it as an injury to the hand.

4. Successful surgery significantly reduces impairment under AMA Guides (the problem has been resolved).
   - In Illinois, surgery or any invasive procedure significantly increases a PPD award even if the medical problem/injury is completely cured.

III. IS SUBMISSION OF AN IMPAIRMENT RATING INTO EVIDENCE REQUIRED BEFORE AN ARBITRATOR CAN AWARD PPD BENEFITS?

A. Statutory Requirement

The plain language of section 8.1(b) mandates that PPD awards be established at least in part using impairment ratings. Specifically it states:

- “Permanent 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.”

“In determining the level of disability, the relevance in weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.”

The word “shall” is defined by Meriam Webster’s Collegiate Dictionary Tenth Edition as meaning “will have to,” “must,” and is used in laws, regulations or directives to express what is “mandatory.” Such as “it shall be unlawful to carry firearms.”

B. IWCC Interpretations (or It Depends on the Definition of What “Is” Is!)

Notwithstanding what appears to be an unambiguous statutory requirement that the Commission consider an AMA rating in any permanency award (as well as the common dictionary definition of the word “shall”), the Commission voted “unanimously” to provide the following recommendations to the arbitrators regarding impairment ratings:

- An impairment report is not required to be submitted by the parties with a settlement contract.

- If an impairment rating is not entered into evidence, the arbitrator is not precluded from entering a finding of disability.

C. Practical Considerations and Petitioners’ Anticipated Strategies

1. The practical effect of the Commission’s conclusion will embolden many petitioners’ attorneys to object to the introduction of AMA ratings into evidence in hopes that the cost of obtaining the rating and securing its admission into evidence via evidence deposition (subsequent to a hearsay objection) will drive the cost of obtaining the AMA ratings up to a level that many carriers will not wish to incur in routine cases. Nonetheless the burden of proving all of the elements of a workers’ compensation claim remains on the injured worker and those elements must be proven by a preponderance of the evidence. Martin v. Industrial Comm’n, 91 Ill. 2d 288, 437 N.E.2d 650 (1982). A petitioner who fails to submit an AMA rating into evidence runs the risk of a court determination that they have failed to meet this burden of proof, and thus, has not established any entitlement to PPD benefits.

2. As the directive that “shall” does not mean “shall” came from an “unanimous” Commission, it is likely that a case where permanent partial disability is awarded without consideration of an AMA rating would need to go to the circuit or appellate court in order to obtain a “legal” ruling on the appropriate compliance with statutory requirements.
3. Petitioners are well aware of the fact that a typical AMA rating is dramatically lower than the typical permanent partial disability award and should be expected to exert a significant amount of energy in diluting, if not eliminating, their impact.

4. Absent an AMA award, the Commission, as noted by the Chairman in a recent speech, will decide cases based on the evidence that is before them, in light of the other four factors which include the occupation of the injured worker, the worker’s age at the time of the accident, the injured worker’s future earnings capacity, and the evidence of disability corroborated by the medical records of the treating physician. Practically speaking, there are only three rather than four of these factors to be considered, as in most instances where there is a significant impact on a petitioner’s future earnings capacity, a wage differential award under section 8(d)(1) would be sought rather than a PPD award. The impact of the “occupation” and “age” of the injured worker on a PPD award is not entirely clear. Presumably the petitioner’s attorney will argue that a young worker with a significant injury and a heavy job with many years left to perform should be entitled to a higher award, perhaps than an older worker with a similar injury, although this is by no means clear.

5. The factor which all petitioners’ counsel will be using whether an AMA rating is in evidence or not will be the “evidence of disability corroborated by the medical records of the treating physician.”

   a. Petitioners intend to satisfy this element via petitioners’ testimony at arbitration of what they notice about themselves at the time of arbitration that did not exist prior to that time and via introduction into evidence of the treating medical records.

   b. Whether or not similar “subjective complaints” contained in the records constitutes “corroboration” is anyone’s guess.

   c. The reality is that in most instances after an individual has reached maximum medical improvement and is released to return to work at full duty with no restrictions, the medical records do not and have not historically “corroborated” permanent partial disability in any significant sense. That fact has not stopped the Commission from significant awards for relatively minor injuries (e.g.; 20% to 25% loss of use of a hand for an operated carpal tunnel with a full duty return to work).

IV. LET’S CREATE THE “NEW” Q-DEX: HOW TO “SEIZE THE MOMENT” TO REDUCE PPD AWARDS!

   A. Don’t be distracted by the petitioner’s claim that nothing has changed!

   1. The petitioner’s bar wants to pretend that AMA Guides do not exist and are not a statutory requirement.
2. The petitioner’s bar will argue that at most, AMA Guides are one element of five, not the primary element and consideration of them according to the Commission guidance is not required.

3. If an AMA rating is not entered into evidence, the petitioner’s bar will argue that the determination of PPD awards is the same as it has always been; “business as usual.”

4. Even if AMA Guides are entered into evidence, the petitioner’s bar will also argue that the key element in determination of PPD is the fifth element, to wit, evidence of disability corroborated by the medical records.

B. Insist that “shall” means “shall,” and that an AMA rating is required in all cases. Petitioner’s failure to submit an AMA rating into evidence represents a failure of meeting the burden of proof that the injured worker incurred a compensable injury and therefore no PPD award can be entered. Be willing to appeal if necessary! The AMA ratings were put into the statute for a reason and that reason was to decrease PPD awards.

C. Argue that the petitioner’s age and occupation are irrelevant where the petitioner is at MMI and has returned to full duty work with no restrictions, and where no further treatment is necessary. Petitioner’s “evidence of disability as corroborated by treating medical records” is in the typical case, neither “evidence of disability” or “corroborated by medical records.” It is a legal fiction. Wage loss is also irrelevant; if there was a significant reduction in earnings petitioner would elect a wage differential under 8(d)(1). Absent concrete evidence of disability there is no basis for an award in excess of the AMA rating.

D. Obtain an AMA rating from a physician qualified to perform one, preferably one who is certified (although that is not required). This is especially true now as we try to “create a new Q-Dex,” of dramatically reduced PPD values. While this will necessitate increased expense upfront, once the new customary values are understood there is the potential for significant cost savings from reduced disability awards.

E. Until the evidentiary issues are clarified, obtain AMA ratings from physicians who are available to give evidence depositions.

F. Provide any physician, IME or otherwise, from whom you have requested an AMA rating, with the specific terms of the statute so that not only is the AMA rating provided with the other items, but the additional provisions of section 8.1(b) referencing appropriate measurements, including, but not limited to, loss of range of motion, loss of strength, measured atrophy of tissue mass consistent with the injury, and other relevant measurements be included. Failure to do so may subject the impairment report to lacking appropriate foundation and therefore, inadmissible.
G. Use AMA impairment ratings in *pro se* cases, especially in injuries which traditionally result in significant awards, as a means of showing the *pro se* petitioner the impairment rating, and challenge the arbitrator to state a basis for a higher award.

H. Retain knowledgeable counsel who have studied the amendments and the strategies of the petitioner’s bar and are prepared to aggressively and creatively advocate the significance of AMA ratings in reducing PPD awards.
Bruce L. Bonds
- Partner

Bruce 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 Illinois Workers’ Compensation Act.

Bruce was appointed by Mitch Weiss, 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.

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.

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.


Bruce is a frequent speaker on workers’ compensation issues at bar association and industry-sponsored seminars.

Bruce 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 by Chicago magazine named Bruce one of the “Best Lawyers in Illinois” for 2008.

Professional Recognition
- Martindale-Hubbell AV Rated
- Selected as a Leading Lawyer in Illinois. Only five percent of lawyers in the state are named as Leading Lawyers.
- Named to the 2012 Illinois Super Lawyers list. The Super Lawyers selection process is based on peer recognition and professional achievement. Only five percent of the lawyers in each state earn this designation.

Professional Associations
- American Bar Association (Past Vice-Chair of Employment Law Committee)
- Illinois State Bar Association (Past Chair Workers’ Compensation Law Section Council)
- Champaign County Bar Association
- Illinois Association of Defense Trial Counsel (Member, Workers’ Compensation Committee)
- Defense Research Institute
- Illinois Self-Insurers Association

Court Admissions
- State Courts of Illinois
- United States District Court, Central District of Illinois
- United States Court of Appeals, Seventh Circuit
- United States Supreme Court

Education
- Juris Doctor, Washington University School of Law, 1982
- Bachelor of Arts-Finance, University of Illinois, 1979