AMA IMPAIRMENT RATINGS

Things Are Looking Up
(Since the 2011 Amendments)

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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.
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”** are 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 percent of the digit, 10 percent of the hand, 9 percent of the upper extremity or 5 percent 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 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 workers’ compensation system, including the Chairman of the IWCC and most plaintiffs’ attorneys, acknowledge this fact 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 Co. v. Industrial Comm’n,
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. Industrial Comm’n*, 329 Ill. App. 3d 166, 768 N.E.2d 760 (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).

3. **Petitioners’ Strategies:** Some petitioners’ attorneys maintain 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; 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.
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 “such time as the employee’s condition has stabilized or the employee 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). 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 Range</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 Range</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 percent of an impairment rating to a hand, while an index-middle finger is 20 percent loss of use of a hand impairment, and a ring-little finger is 10 percent 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 loss of use on the upper extremity.
   - Illinois law now treats 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 Merriam 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.

The directive from the Commission that “shall” does not mean “shall” came from a unanimous Commission, and it is likely that the issue of whether an AMA impairment rating is required as a part of the petitioner’s burden of proof will be addressed by circuit and appellate courts in the future. Where an AMA impairment rating is not introduced into evidence, the arbitrator/Commission will decide the case based upon the evidence before them in light of the four other factors including the occupation of the injured worker, the worker’s age at the time of accident, the injured worker’s future earnings capacity, and the evidence of disability corroborated by the medical records of a treating physician. Practically speaking, only three of these factors will be considered in the majority of cases as instances where there is a diminution of future earning capacity will most likely be decided on a wage differential award under Section (d)(1), rather than a permanent partial disability award. Currently decisions are ambiguous, if not contradictory, with regard to what impact the petitioner’s age will have on the PPD award.

The requirement that the Commission consider the “evidence of disability corroborated by the medical records of the treating physician” raises additional issues to be decided by the arbitrator/Commission. Will the petitioner’s subjective complaints contained in the records be considered “corroboration?” In reality, most cases are resolved after the petitioner reaches MMI and the petitioner is released to return to work without restrictions. When a petitioner is
released without restrictions, can the medical records really corroborate permanent partial disability in any significant sense? Practically speaking, the Commission has always awarded permanency in cases where there is a clear injury, although relatively minor. For example, the arbitrator/Commission will always award permanency to a claimant with an operated carpal tunnel syndrome even if they have complete resolution of symptoms and are released without restriction. Essentially, the element that the arbitrator/Commission consider evidence of a disability “corroborated” by the medical records is a highly subjective standard for the arbitrator/Commission to apply, and it is not anticipated that a lack of corroboration will significantly impact the amount of the PPD award.

IV. PRACTICE TIPS AND ADVICE FROM THE TRENCHES

One of the more critical decisions an employer faces in handling the claim is determining whether to obtain an AMA report/rating. At the outset, it is generally true that an AMA evaluation is an important tool in the defense of your case. Therefore, it is usually a good idea to obtain an AMA report. A strong AMA report/rating can lead to monetary savings on permanency at settlement. The expense of obtaining a report is typically at or below the cost you would expect to pay for an independent medical examination, so it can be a good investment. To obtain the AMA report, you simply need to set up a medical examination, pay for the petitioner’s travel/expenses to attend the exam, pay your AMA expert, and then disclose the report to opposing counsel. It most cases it will be worth your time, money, and effort when the time comes to discuss settlement.

The decision of whether to obtain an AMA report has several considerations. One of the first steps is to confirm the petitioner is at maximum medical improvement. If you have a credible medical opinion stating that the petitioner is at maximum medical improvement, then you can rely upon that opinion and arrange for the employee’s AMA exam. Conversely, if you are confident your claim will involve a wage differential or permanent total disability claim, we do not recommend spending the time, money or effort in getting an AMA opinion. Instead, that money may be better spent on vocational rehabilitation or settlement efforts.

Also, take a close look at the average weekly wage and how that would impact the total value of the claim for settlement purposes. If the claim is so de minimus that the expense of obtaining the AMA rating would be cost prohibitive, then you are better off in foregoing the AMA rating report and putting that money towards settlement of the case.

Another consideration is the claimants’ bar’s tactic of trying to make this defense strategy (using AMA opinion reports) overly expensive or cost-prohibitive for the claims handler. Petitioner’s counsel will often object to the report on foundational grounds and force an evidence deposition of the reporting physician. Do not fall for this tactic. Be strong, set up the deposition, and move forward with your AMA report. Do not let the injured worker’s attorney strong-arm you into giving up your right to obtain such a report/rating.
Other factors you should take into account include the identity of opposing counsel, whether the petitioner is pro se, the arbitrator/venue of your case, and how quickly you want to move this case forward.

If you are dealing with a pro se petitioner, and you want to move this case along as quickly as possible, and you have a low average weekly wage rate, you may want to delay obtaining an AMA rating. The rationale here is as follows: some arbitrators will take into account an AMA rating “assumption” based upon that arbitrator’s past practices and procedures. Because the pro se petitioner is willing to accept your current pro se settlement offer, and you do not want to spend the added time and expense of obtaining an AMA rating, it may be advisable to simply move forward with your pro se settlement. In this scenario, your attorney can then convince the arbitrator the “nature and extent” of the injury is exactly what is being offered to the pro se employee and educate the arbitrator as to what the AMA rating would be if you had sent the petitioner for an exam. Typically, an attorney can highlight for the arbitrator the potential cost savings that could be passed along to the pro se petitioner. Instead of paying an expert to issue an AMA rating, the money could be applied to the settlement funds. At the same time, the attorney can express to the arbitrator that based upon the facts of the case the AMA rating would be “X percent.”

Along these same lines, where the employee is represented and the opposing attorney is willing to engage in a pretrial hearing concerning the “nature and extent” of the injury, and that attorney will allow you to argue respondent could easily obtain an AMA rating and based upon the reasonable hypothesis that rating would be “X percent,” then it would be advisable to move forward with that pretrial hearing without the expense in getting the actual AMA rating/report. You can still make your AMA argument on behalf of respondent, but you save the time of setting up the exam and having it take place, and you actually save money which you can then turn around and invest in resolving the case amicably. Again, we have to take into consideration whether the arbitrator will allow such a course of conduct. There are some arbitrators who will not allow counsel to make any AMA rating arguments unless he or she actually has a valid report in hand. In each of these scenarios, an attorney can help you determine the best course of action suited to the facts of your case, taking into account the venue, arbitrator, and opposing counsel.

As we have all heard before, each case is unique and will rise and fall on its own set of factual circumstances. Therefore, it is important for you to consult with an attorney so that a reasonable, educated discussion can take place regarding these various elements and, based upon this information, you can determine the best course of action from a claims management standpoint moving forward. We should always be looking out for what is the best course of action for the client. Generally speaking, that course involves obtaining an AMA rating report. While not every circumstance warrants that course of action, it is important to make that final determination only when all pieces of vital information are available.
V. CASE ILLUSTRATIONS

A. Johnson v. Central Transport

In Johnson v. Central Transport, 11 WC 41328 (2012), the petitioner was a right-hand dominant truck driver who suffered a right small finger metacarpal fracture with angulations when a truck door fell onto his right hand on October 17, 2011. He treated conservatively, and eight weeks following the accident was released to return to work full duty with no restrictions. The petitioner had not received any medical treatment since December of 2011. He continued working his regular duties and actually took another job working as an over the road truck driver earning more money. The petitioner made subjective complaints of right hand stiffness in cold weather and experiencing periodic pain throughout the day.

Pursuant to section 8.1b, the arbitrator noted the following:

1. **AMA impairment rating:** 1 percent of the right hand per Dr. Vendor, who was apparently hired by respondent. Petitioner did not offer an AMA impairment rating.
2. **Occupation:** The arbitrator noted that the petitioner was still employed as a truck driver following his treatment.
3. **Age:** The arbitrator noted that the petitioner was 28 years old. Because he was younger, the arbitrator reasoned that his PPD may not be as extensive as that of an older individual.
4. **Future earning capacity:** No evidence of the diminished future earning capacity.
5. **Evidence of disability corroborated by medical records:** Arbitrator spent the most time discussing this. She noted respondent's IME doctor felt petitioner's susceptibility to cold would resolve over time, his grip strength was relatively symmetrical and functional difficulties associated with this type of injury are minimal. Dr. Vendor, who completed the AMA impairment rating, noted complaints of sporadic numbness in petitioner's right palm and sporadic soreness in the ulnar aspect of his right hand. Petitioner also was noted to have normal range of motion of his right small finger.

Surprisingly, the arbitrator noted that prior commission decisions lend support to the conclusion that a minimal PPD award was appropriate. She cited a 2007 commission decision with a similar injury, but the petitioner in that claim suffered 50 percent strength loss in the hand. In that case the petitioner was awarded 7.5 percent loss of use of the left hand. The petitioner in the case at hand had no loss of strength, as noted by the arbitrator.

The arbitrator then awarded 10 percent loss of use of the right hand, which is a higher percentage than was awarded in the case she cited which illustrated evidence of 50 percent loss.
of use of the hand strength. This would be approximately 93.2 percent loss of use of the right small finger.

**B. ** *Williams v. Flexible Staffing, Inc.*

In *Williams v. Flexible Staffing, Inc.*, 11 WC 46390 (2012), the petitioner was right-hand dominant and suffered an accident on October 7, 2011. He was performing welding on a rail which slipped off a house. The petitioner tried to catch the rail with his right hand and injured his right arm. He was diagnosed with a distal biceps tendon rupture. Surgery was performed on November 7, 2011 which included a repair of the right elbow distal biceps tendon rupture. The petitioner underwent physical therapy following surgery and was placed at MMI on March 7, 2012 by the treating physician. The treating physician noted a lack of range of motion of approximately 5 to 10 degrees in supination of the forearm.

Pursuant to section 8.1(b), the arbitrator noted the following:

1. **AMA impairment rating:** Respondent’s IME physician, Dr. Mark Levin provided an AMA disability rating noted to be four percent of the whole person or six percent upper extremity impairment. The arbitrator was critical of Dr. Levin’s AMA rating. She claimed he did not include loss of range of motion or any other measurements that establish the nature and extremity of the impairment pursuant to section 8.1b. She noted that Dr. Levin did not consider a grade modifier for clinical studies and also failed to include documentation regarding how he determined the functional history modifier.

2. **Occupation:** The arbitrator noted that the petitioner was a welder/fabricator, which she took judicial notice to be medium to heavy work. She concluded that the petitioner’s permanent partial disability will be greater than that of someone who performs lighter work.

3. **Age:** The petitioner was 44 years old at the time of the accident. Since the arbitrator concluded that he was somewhat younger, she felt that his disability would be more extensive than that of an older individual because the petitioner will have to live with his condition longer.

4. **Future earning capacity:** The arbitrator noted the petitioner’s future earning capacity appeared to be undiminished as a result of his injuries because he was medically returned to his full-time duties. However, when petitioner attempted to return to work he was told they no longer had a job. The arbitrator concluded that this may negatively affect his future earning capacity, despite the fact that it did not appear that his job loss had any relationship to his injury.

5. **Evidence of disability corroborated by medical records:** The arbitrator concluded that the petitioner credibly testified that he currently experiences pain, numbness or tingling and loss of range of motion.
because his complaints regarding his right arm were corroborated by the treating medical records.

The arbitrator then awarded 30 percent loss of use of the right arm.

On May 29, 2013, the Workers’ Compensation Commission issued their Decision and Opinion on Review of the permanent partial disability award. The Commission modified the arbitrator’s decision decreasing the petitioner’s permanent partial disability award from 30 percent to 25 percent loss of use of the right arm. Williams v. Flexible Staffing, Inc., 11 IL.W.C. 46390, 13 I.W.C.C. 0557, 2013 WL 3381128 (May 29, 2013). The Commission did not provide any explanation or opinion as to the basis of their reducing the PPD award.

C. Dorris v. Continental Tire

In Dorris v. Continental Tire, 11 WC 46624 (2012), the petitioner hurt his left forearm and wrist while attempting to pull a stuck tire from a mold on September 18, 2011. An MRI of the left wrist revealed a peripheral TFCC tear. On December 1, 2011, the petitioner underwent a left wrist arthroscopy with repair of the peripheral TFCC tear. The petitioner returned to work with restrictions on December 12, 2011, and began a course of physical therapy shortly thereafter. The petitioner was released by his surgeon on May 7, 2012. At that time, the petitioner estimated he was only 80 percent better, but he exhibited good range of motion and grip strength.

At arbitration, the petitioner testified that he continued to have left wrist and forearm pain. Further, the petitioner explained that he had lost strength and range of motion in his hand and wrist. The petitioner acknowledged that he was able to return to his regular position, but claimed he had to alter his work activities to compensate for his left hand.

Pursuant to section 8.1b, the arbitrator noted the following:

1. **AMA impairment rating:** Six percent upper extremity impairment, per the treating surgeon, Dr. David Brown. The AMA rating was performed at the request of the respondent, and there is no indication an AMA rating was presented by the petitioner.

2. **Occupation:** The arbitrator noted the petitioner returned to his regular position, and also that he held a “labor intensive job.” The arbitrator found “that petitioner’s permanent partial disability will be greater based on this regard than an individual who performs lighter work.”

3. **Age:** The arbitrator noted the petitioner was 38 years old at the time of his injury. The arbitrator found the petitioner “to be a somewhat younger individual and conclude[d] that petitioner’s permanent partial disability will be more extensive than that of an older individual because he will have to live with the permanent partial disability longer.”
4. **Future earning capacity:** There was no evidence of diminished future earning capacity, so the arbitrator did not place any weight on that factor.

5. **Evidence of disability corroborated by medical records:** The arbitrator noted the petitioner’s medical records established a loss of grip strength and limited range of motion. Further, the petitioner testified that he continued to have left wrist and forearm pain.

Ultimately, the arbitrator awarded the petitioner 13 percent loss of use of his left hand.

**D. Arscott v. Con-Way Freight, Inc.**

In *Arscott v. Con-Way Freight, Inc.*, 12 WC 3876 (2013), the petitioner was a truck driver who injured his left knee while exiting his tractor. An MRI scan shortly after the accident revealed a torn left meniscus. The meniscus was arthroscopically repaired on May 22, 2012, and the petitioner returned to work at full duty on July 2, 2012. The petitioner was fully released at maximum medical improvement on August 7, 2012. At arbitration, the petitioner testified that he was able to return to all his regular job duties, and continued to perform a home exercise program. The petitioner explained that he occasionally had to take over-the-counter pain medication, but did not need a knee brace.

Pursuant to section 8.1b, the arbitrator noted the following:

1. **AMA impairment rating:** 20 percent impairment to the lower extremity, or eight percent disability to the person, per Dr. Sanjay Patari, who was hired by the respondent. The decision does not mention any impairment rating offered by the petitioner.
2. **Occupation:** The arbitrator noted the petitioner had returned to his usual employment.
3. **Age:** The arbitrator noted the petitioner was 57 years old as of the date of the loss, but did not indicate the impact of this finding on the arbitration decision.
4. **Future earning capacity:** There was no evidence of diminished future earning capacity.
5. **Evidence of disability corroborated by medical records:** The arbitrator noted the petitioner “describes some residual symptoms in the knee, which are generally consistent with the surgery performed.”

The arbitrator ultimately agreed with the respondent’s doctor’s impairment rating, awarding 20 percent loss of use of the leg.

**E. Garwood v. Lake Land College**

In *Garwood v. Lake Land College*, 12 WC 4194 (2014), the petitioner injured his left knee when he tripped and fell while walking to his vehicle on September 12, 2011. An MRI of the left knee
taken about a month later revealed mild chondromalacia and arthritis involving the patellar femoral compartment and a complete tear of the posterior horn of the lateral meniscus. After conservative treatment failed to resolve his symptoms, the petitioner underwent arthroscopic surgery on December 2, 2011. Following additional physical therapy, the petitioner was released at maximum medical improvement on May 7, 2012. At that time, the treating surgeon noted, “improved range of motion and good strength” in the petitioner’s knee. In addition, there was no tenderness, effusion or swelling noted.

At arbitration, the petitioner testified that he was able to return to his regular job, but sits down whenever he can. The petitioner explained that he occasionally takes Aleve for residual knee pain, and has difficulty walking long distances.

Pursuant to section 8.1b, the arbitrator noted the following:

1. **AMA impairment rating:** Eight percent loss of the lower extremity, which translated to three percent whole person impairment, per Dr. Joseph T. Monaco. The impairment rating was performed by Dr. Monaco at the request of the respondent. There is no indication that the petitioner presented an AMA rating at the time of arbitration.
2. **Occupation:** At the time of arbitration, the petitioner had a different job than he held at the time of his accident. The arbitrator did not indicate how this factored into the decision.
3. **Age:** The arbitrator noted the petitioner was 53 years old at the time of his accident. According to the arbitrator, “no evidence was presented as to how petitioner’s age might affect his disability.”
4. **Future earning capacity:** No evidence was presented to show a diminishment in the petitioner’s future earning capacity as a result of this injury.
5. **Evidence of disability corroborated by medical records:** The arbitrator noted the petitioner complained of ongoing problems with pain and stiffness in his injured left knee, which limits his ability to stand and walk. Further, the arbitrator found that these complaints were corroborated by the petitioner’s medical records.

The arbitrator awarded the petitioner 20 percent loss of use of his left leg.

**F. Brown v. Con-Way Freight**

In *Brown v. Con-Way Freight, Inc.*, 12 WC 4657 (2013), the petitioner was a freight truck driver who hurt his left shoulder on October 8, 2011, while moving some cargo. An MRI scan shortly after the accident revealed a full thickness rotator cuff tear. The petitioner underwent surgery to repair the rotator cuff on December 16, 2011. The surgeon released the petitioner to return to work at full duty on April 11, 2012, noting only minor ache, excellent range of motion, and strength against resistance.
At arbitration, the petitioner testified that he had some concerns about the strength and endurance of his shoulder, but acknowledged that he was able to do his regular job.

Pursuant to section 8.1b, the arbitrator noted the following:

1. **AMA impairment rating**: Six percent of the upper extremity, which translated to four percent of a person as a whole per Dr. Fedder, who was retained by the respondent. The decision does not reference any AMA rating presented by the petitioner.

2. **Occupation**: The arbitrator noted the petitioner returned to his usual employment.

3. **Age**: The arbitrator noted the petitioner was 51 years old as of the date of the accident, but did not indicate how this impacted the permanency award.

4. **Future earning capacity**: There was no evidence of diminished future earning capacity.

5. **Evidence of disability corroborated by medical records**: The arbitrator indicated the petitioner continued to complain of weakness and fatigue in the shoulder, with occasional swelling and pain. According to the arbitrator, “While the weakness is not well borne out in the records, the occasional discomfort described is consistent with the undisputed surgery.”

The arbitrator ultimately awarded ten percent loss of use of a person as a whole, which would be equivalent to approximately 19.8 percent loss of use of the arm.

**G. Riley v. Con-Way Freight, Inc.**

In *Riley v. Con-Way Freight, Inc.*, 12 WC 11083 (2013), the petitioner injured his right knee when he slipped off a forklift in the course and scope of his employment as a freight truck driver on December 5, 2011. X-rays taken shortly after the accident revealed an acute closed comminuted fracture of the proximal end of the right fibula. Subsequent imaging studies revealed the petitioner also had a right ACL tear, which would require reconstruction. On February 27, 2012, the petitioner underwent arthroscopic ACL repair. Following a course of work hardening, the petitioner’s surgeon released the petitioner to full duty as of July 9, 2012. On August 7, 2012, the petitioner was released at maximum medical improvement, with full range of motion.

Pursuant to section 8.1b, the arbitrator noted the following:

1. **AMA impairment rating**: Seven percent of the lower extremity, which translated to three percent of a person as a whole, per the petitioner’s surgeon, Dr. McIntosh. The arbitrator’s decision indicated the rating was requested by the petitioner’s attorney. It does not appear the respondent presented an AMA rating at trial.
2. **Occupation:** The arbitrator noted the petitioner returned to his regular job as a driver/sales representative.

3. **Age:** The arbitrator noted the petitioner was 46 years old as of the date of the accident, but did not indicate that it affected the permanency award.

4. **Future earning capacity:** There was no evidence of diminished future earning capacity.

5. **Evidence of disability corroborated by medical records:** The arbitrator noted that the petitioner claimed some stiffness and achiness in his right knee, along with some weather sensitivity and difficulty climbing ladders. According to the arbitrator, “These complaints are generally consistent with the surgery reflected in the medical records of Dr. McIntosh.”

The arbitrator awarded the petitioner 27.5 percent loss of use of the right leg.

**H. Oltmann v. Continental Tire of the Americas, LLC**

In *Oltmann v. Continental Tire of the Americas, LLC*, 12 WC 11777 (2013), the petitioner injured his left wrist when he tripped and fell over a guard railing on January 31, 2012. X-rays taken shortly after the accident revealed a non-displaced fracture. The fracture was splinted, but surgery was not necessary. On February 29, 2012, the petitioner reported to his treating physician that he was feeling “a lot better” and he was released to return to full duty at maximum medical improvement. At that time, the treating physician indicated the petitioner had good range of motion, and suggested that any residual symptoms would improve over time.

The treating physician, Dr. David Brown, prepared an AMA rating report finding that the petitioner had a zero percent impairment at the left wrist. The parties took Dr. Brown’s deposition, in support of his findings and treatment course, as well as the basis for his impairment rating. At arbitration, the petitioner testified that he had returned to his regular position, but still had some discomfort in his left wrist.

Pursuant to section 8.1b, the arbitrator noted the following:

1. **AMA impairment rating:** Zero percent of the left wrist, per the treating physician, Dr. Brown. The decision does not indicate whether the rating was requested by either party.

2. **Occupation:** The petitioner returned to his regular job.

3. **Age:** The arbitrator noted the petitioner was 49 years old as of the date of the accident, but did not indicate how this impacted the permanency award.

4. **Future earning capacity:** There was no evidence of diminished future earning capacity.

5. **Evidence of disability corroborated by medical records:** The arbitrator noted the petitioner continued to complain of “minor residual symptoms
in the wrist.” There is no indication these complaints were substantiated by medical records.

The arbitrator ultimately awarded the petitioner five percent loss of use of his left hand.

1. Mansfield v. Ball Chatham Community School District #5

In Mansfield v. Ball Chatham Community School District #5, 12 WC 14648 (2013), the petitioner injured her left knee while picking up some paper in the course and scope of her employment as a school custodian on November 3, 2011. An MRI taken approximately a month after the accident revealed small knee effusion and medial meniscal tear with an associated parameniscal cyst. On March 6, 2012, the petitioner underwent an arthroscopic partial medial meniscectomy and cyst decompression.

On June 12, 2012, the petitioner was released to return to work without restrictions. At that time, the petitioner continued to complain of difficulty going down steps, and occasional sharp pains in her knee. Further, the petitioner reported ongoing slight stiffness of the knee.

Pursuant to section 8.1b, the arbitrator noted the following:

1. **AMA impairment rating:** One percent of a lower extremity, which converted to a one percent impairment of a person as a whole, per Dr. Michael Lewis. The AMA rating was performed at the request of the respondent, by a doctor chosen by the respondent.
2. **Occupation:** The petitioner returned to her regular position.
3. **Age:** The arbitrator noted the petitioner was 58 years old at the time of her injury. The arbitrator’s decision specifically noted that there was “no testimony concerning how long she expected to continue to work.”
4. **Future earning capacity:** The arbitrator found the petitioner’s future earning capacity was “relatively undiminished as a result of the injuries.”
5. **Evidence of disability corroborated by medical records:** The arbitrator noted that the physical therapy records prior to the petitioner’s release indicated she continued to complain of pain, stiffness and difficulty walking up and down steps. The arbitrator found that the petitioner’s testimony regarding ongoing symptoms was corroborated by her medical records.

Ultimately, the arbitrator awarded the petitioner 17.5 percent loss of use of her left leg. The final paragraph of the arbitrator’s decision noted that, “In making a permanent partial disability evaluation, consideration is not given to any single factor as the sole determinate.”
J. **Manion v. Old National Bank**

In *Manion v. Old National Bank*, 12 WC 28686 (2012), the petitioner injured his right knee on March 27, 2012, while squatting down to pick up some materials. Imaging studies taken shortly after the accident revealed a partial tear of the right medial meniscus, which required arthroscopic repair. The petitioner underwent an arthroscopic partial medial meniscectomy on June 14, 2012. The petitioner was released from treatment at maximum medical improvement on July 15, 2012.

This was a *pro se* settlement, and the petitioner had an opportunity to discuss his ongoing complaints with the arbitrator. The petitioner stated that he felt fine, but later acknowledged that he had some difficulty performing a full squat with his right leg. After being released, the petitioner returned to his regular job, without restrictions.

Pursuant to section 8.1b, the arbitrator noted the following:

1. **AMA impairment rating:** Two percent of the right leg per Dr. Thomas L. Sutter. The respondent requested and presented the AMA rating. The petitioner did not have a separate rating report.
2. **Occupation:** The petitioner returned to his regular position as a building superintendent for the bank.
3. **Age:** At the time of the accident, the petitioner was 61 years old. The arbitrator noted that, at age 61, the petitioner may take longer to fully recover than a younger worker.
4. **Future earning capacity:** The petitioner did not present any evidence of diminished future earning capacity.
5. **Evidence of disability corroborated by medical records:** The petitioner repeatedly told the arbitrator that he felt fine. The arbitrator asked multiple times if there was anything the petitioner could tell her to assist in her evaluation of this case. Ultimately, the petitioner explained that he had some difficulty performing a full squat with his right leg. At the time he was released, the petitioner had told his treating physician that he felt fine. As such, the claim regarding an inability to perform a squat was unsupported by the medical records.

Ultimately, the arbitrator awarded the petitioner ten percent loss of use of a right leg.

K. **Sprague v. Dickey John Corp.**

In *Sprague v. Dickey John Corp.*, 12 WC 30146 (2013), the petitioner developed bilateral carpal tunnel syndrome after working on the respondent’s assembly line. The petitioner underwent a right carpal tunnel release on January 5, 2012. Postoperatively, Dr. Michael Watson found that the petitioner’s neurological symptoms had resolved, her strength was near normal, and her
pain was minimal. She was released without restriction. The petitioner did not undertake surgery with regard to her left hand.

The petitioner underwent an AMA impairment evaluation by Dr. Robert Gordon. He concluded that her impairment was one percent loss of use of the left upper extremity, and four percent impairment of the right upper extremity.

Pursuant to Section 8.1b, the arbitrator noted the following:

1. **AMA impairment rating:** One percent left upper extremity; four percent right upper extremity.
2. **Occupation:** The petitioner returned to work unrestricted to regular job.
3. **Age:** The petitioner was 58 years of age at the time of the accident. Sixty years of age at the time of arbitration.
4. **Future earning capacity:** The arbitrator found that there was a limitation to her future earnings capacity. The petitioner returned to her regular job for 14 months, and then proceeded to retire. The petitioner testified that her decision to retire was based on both her new hand symptoms and spinal stenosis.
5. **Evidence of disability corroborated by medical records:** The arbitrator noted that the petitioner had severe right carpal tunnel syndrome which resulted in atrophy. Her functional abilities were diminished. Her left hand was not her dominant hand, and was not damaged to the same extent as the right. As to her left hand, the arbitrator found that her nerve conduction studies were borderline for carpal tunnel syndrome; however, her symptoms were consistent with nerve entrapment.

The arbitrator awarded 15 percent loss of use of the right hand, noting that the petitioner demonstrated the “maximum level of disability.” The arbitrator awarded 7.5 percent loss of use of the left hand.

**L. Rummans v. City of Peoria**

In *Rummans v. City of Peoria*, 12 WC 663 (2013), the petitioner served as a policeman and was injured while involved with an altercation with a suspect. The petitioner initially undertook conservative treatment for his right foot. He was then diagnosed with navicular syndrome and underwent surgery for removal of the left accessory of the navicular bone and transposition of the posterior tibialis tendon. The petitioner was ultimately released to return to work full duty. Petitioner testified that he had pain when running, and therefore had to limit his running to 2-2.5 miles. He also complained of pain after prolonged standing.

Dr. Nord performed an AMA impairment rating. He concluded that the petitioner had an impairment of one percent disability of the person as a whole. Dr. Nord also testified that the
petitioner performed heavy work and his occupation could potentially aggravate his condition in the future.

Pursuant to 8.1b, the arbitrator noted the following:

1. **AMA impairment rating:** One percent person as a whole.
2. **Occupation:** The petitioner returned to work as a police officer. Due to the period of temporary total disability, the petitioner was unable to continue working as a part-time security guard for Hy-Vee.
3. **Age:** The petitioner was 27 years of age; however, the arbitrator did not note how this may impact his permanency award.
4. **Future earning capacity:** No evidence that injury will affect future earnings potential.
5. **Evidence of disability corroborated by medical records:** The arbitrator simply concluded that the petitioner’s award was corroborated by the treating medical records and evidence.

The decision by Arbitrator Fratianni specifically noted that Dr. Nord did not perform his evaluation in accordance with the AMA impairment guidelines as set forth in the Sixth Edition. She noted that Dr. Nord did not use a lower limb questionnaire as set forth in Appendix 16A to the Sixth Edition, but rather used his own intake questionnaire. She further noted that Dr. Nord found that the petitioner’s impairment was one percent loss of use of the person; however, the injury to the foot under the Illinois Workers’ Compensation Act requires that the disability be based upon the foot and not person as a whole.

**M. Buxton v. Caterpillar**

In *Buxton v. Caterpillar*, 11 WC 41682 (2013), the petitioner suffered a left thumb fracture in the course of his employment as a welder. On October 20, 2011, the petitioner underwent surgery consisting of screw fixation at the proximal phalanx. The petitioner underwent a second thumb surgery in November of 2011 for failed hardware and revision fixation was performed. The hardware was removed during a third surgery on May 4, 2012. The petitioner was released from treatment May 17, 2012. The petitioner testified as to stiffness and loss of range of motion to the thumb, as well as achiness and sensitivity to cold.

Dr. Ethiraj performed an AMA impairment rating. He provided the petitioner with an impairment rating of 6 percent of the digit (2 percent of a hand or 2 percent of upper extremity).

Pursuant to section 8.1b, the arbitrator noted the following:

1. **AMA impairment rating:** 6 percent of left thumb (2 percent hand or 2 percent upper extremity)
2. **Occupation:** Welder. The arbitrator noted this is a labor intensive job and therefore his partial disability will be greater.
3. **Age:** 45 years of age and since he is younger, PPD will be more extensive as he will have to live and work with the permanent partial disability longer.

4. **Future earning capacity:** Petitioner returned to same position before accident, but no evidence presented as to loss of future earning capacity.

5. **Evidence of disability corroborated by medical records:** Petitioner had objective measured loss of range of motion, lacking 40-50 percent of flexion at the IP joint of the thumb. Petitioner credibly testified as to stiffness and loss of range of motion, as well as sensitivity to cold temperatures.

The arbitrator awarded 25 percent loss of use of the left thumb.

**N. Saner v. Caterpillar**

In *Saner v. Caterpillar*, 12 WC 4413 (2013), the petitioner suffered a left shoulder injury while pushing a drawer into a seal press. The petitioner was diagnosed with a possible rotator cuff tear, as well as labral injury and impingement syndrome. He underwent surgery for left shoulder impingement and to repair the long head biceps and superior labral tear. An arthroscopic subacromial decompression and AC resection were also performed. Dr. Kefalas released the petitioner prn approximately three months after surgery.

Dr. Ethiraj performed an AMA impairment rating and concluded that the impairment was 5 percent loss of use of the upper extremity.

Pursuant to section 8.1b, the arbitrator noted the following:

1. **AMA impairment rating:** 5 percent of the left upper extremity
2. **Occupation:** Petitioner is a brake assembler, which is a labor intensive job and therefore PPD will be larger compared to persons performing lighter duty work.
3. **Age:** 35 and therefore PPD will be more extensive because petitioner will have to live and work with permanent partial disability longer.
4. **Future earning capacity:** No evidence that petitioner’s future earning capacity is diminished.
5. **Evidence of disability corroborated by medical records:** Arbitrator Zanotti noted that the petitioner undertook surgery of his left shoulder and received a good outcome from his surgery. Petitioner testified credibly as to pain he continues to experience as a result of the accident. Arbitrator Zanotti indicated that he would place great weight on this factor in determining the permanency award.

Arbitrator Zanotti awarded 10 percent loss of use of the person as a whole.
O. Terry v. Caterpillar

In Terry v. Caterpillar, 12 WC 16355 (2013), the petitioner suffered a right shoulder injury while lifting a barrel above her head. The petitioner was diagnosed with a biceps tendon tear and a severe tear was identified during surgery, resulting in a release and resection of the tendon stump back to its origin. Subacromial inspection revealed bursitis, resulting in a bursectomy. No rotator cuff tear was identified. Postoperatively, she was released full duty with no restrictions, however, the petitioner bid on a new job with reduced physical requirements.

Pursuant to section 8.1b, the arbitrator noted the following:

1. **AMA impairment rating:** 5 percent loss of use of the upper extremity.
2. **Occupation:** Petitioner changed positions to a lighter duty position as an inventory clerk. Arbitrator Zanotti also noted that the petitioner chose to change positions and was not restricted.
3. **Age:** 55. Petitioner is a somewhat older individual with fewer working years than a younger worker and will not have to live with the permanency of her condition as long as a younger worker.
4. **Future earning capacity:** No evidence that the petitioner’s future earning capacity is diminished.
5. **Evidence of disability corroborated by medical records:** Petitioner underwent an arthroscopic debridement of the biceps tendon with a release/tenotomy with bursectomy. She later underwent a closed manipulation for frozen right shoulder. Dr. Huss noted that she made an excellent recovery. The petitioner testified credibly regarding her pain and tingling in her right arm and difficulty lifting.

Arbitrator Zanotti awarded 10 percent loss of use of the person as a whole.

P. Harrison v. Village of Forest Park

In Harrison v. Village of Forest Park, 11 WC 48412 (2013), the petitioner was employed as a police officer. On October 22, 2011, the petitioner began running towards a fight to assist another police officer when he felt a pop in his right ankle. He was diagnosed with an Achilles tendon rupture. The petitioner underwent surgery to repair the Achilles tendon and an avulsed bone fragment from the calcaneus. The petitioner was released from treatment six months later. Dr. Simon Lee prepared an AMA impairment rating, find the impairment at 1 percent loss of the right lower extremity. Upon arbitration, Arbitrator Kain awarded 12.5 percent loss of use of the right foot.

Pursuant to section 8.1b, the arbitrator noted the following:

1. **AMA impairment rating:** 1 percent loss of use of the right lower extremity
2. **Occupation:** Petitioner is a police officer requiring him to perform strenuous activities on a daily basis.

3. **Age:** 41. Permanent partial disability will be greater than an older individual.

4. **Future earning capacity:** Petitioner, prior to his injury, worked 12-22 hours of overtime each pay period. He was paid $57.00 per hour for each hour of overtime. Since the occurrence, he works approximately six hours of overtime each pay period and does not volunteer for additional overtime. Based on his hourly rate, the petitioner suffered lost earnings in the range of $600-$1800 per month and will continue to experience this diminution of earning capacity into the future.

5. **Evidence of disability corroborated by medical records:** The petitioner’s medical records as to his initial injury, surgery and follow-up treatment confirm the severity of the petitioner’s injury and post occurrence symptoms, which continued, including throbbing, swelling and stiffness.

Arbitrator Kain awarded 12.5 percent loss of use of the right foot.

**Q. Griffin v. Caterpillar**

In *Griffin v. Caterpillar*, 11 WC 40321 (2014), the petitioner suffered an injury to his left knee, resulting in medial meniscectomy. The petitioner was employed as a machinist and experienced a pop to his left knee while carrying a ladder weighing approximately 50 pounds. Dr. Ethiraj prepared an AMA impairment rating, finding that petitioner’s impairment was 2 percent loss of use of the left lower extremity or 1 percent loss of use of the person. Arbitrator Mathis awarded 15 percent loss of use of the leg.

Pursuant to section 8.1b, the arbitrator noted the following:

1. **AMA impairment rating:** 1 percent loss of use of the left lower extremity
2. **Occupation:** Petitioner was employed as a machinist.factory worker and therefore, permanent partial disability is greater as his occupation requires physically strenuous labor.
3. **Age:** 62. Arbitrator Mathis simply “acknowledges” the petitioner’s age and limitations associated with the injury.
4. **Future earning capacity:** Future earning capacity was limited. He chose not to bid for more physically demanding or higher paying positions because of his knee injury and did not volunteer for overtime.
5. **Evidence of disability corroborated by medical records:** Petitioner credibly testified regarding pain, stiffness and swelling, as well as a locking of his left knee. The complaints were corroborated by the treating medical records.
Arbitrator Mathis awarded 15 percent permanent partial loss of use of the left leg.

R. **Gutzler v. Continental Tire of North America**

In *Gutzler v. Continental Tire of North America*, 11 WC 46999 (2013), the petitioner suffered a low back injury while working as a tire builder when he attempted to remove a cassette from a machine. Dr. Rerri prepared an AMA impairment rating, finding that the petitioner suffered a 12 percent loss of use of the person pursuant to the AMA guidelines. The petitioner had been diagnosed with an extruded disc at L4-L5, requiring hemilaminectomy and discectomy.

Pursuant to section 8.1b, the arbitrator noted the following:

1. **AMA impairment rating:** 12 percent loss of use of the person.
2. **Occupation:** Petitioner’s position as a tire builder required a significant amount of heavy manual labor.
3. **Age:** 31. He will have to live with the affects of his disability for a substantial amount of time.
4. **Future earning capacity:** Petitioner will experience a diminished earning capacity as prior to the accident he worked 4-12 hours of overtime per week, but now only takes overtime when scheduled or required to do so.
5. **Evidence of disability corroborated by medical records:** Arbitrator Gallagher simply noted that the disability testimony of the petitioner was corroborated by the medical records and that ongoing complaints and symptoms were consistent with the injury sustained.

Ultimately, Arbitrator Gallagher awarded 20 percent loss of use of the person.

VI. **COMMISSION DECISIONS**

A. **Thomas v. People’s Gas, Light & Coke**

In *Thomas v. People’s Gas, Light & Coke*, 12 W.C. 18268, 13 I.W.C.C. 1001 (Nov. 22, 2013), Stephen Thomas worked as a crew leader for People’s Gas, Light & Coke as a member of the emergency crew that would handle broken gas mains, poor gas supply and non-emergencies. On October 26, 2011, he pulled plastic piping and experienced a pop in his right shoulder. He underwent subacromial decompression and biceps tenodesis and open rotator cuff repair. Petitioner was released to full duty, but experienced continuing symptoms. Dr. Mash performed an AMA impairment rating finding that the petitioner experienced 5 percent loss of use of the upper extremity and 3 percent loss of use of the person.

At arbitration, Arbitrator Flores awarded 7.5 percent loss of use of the person as a whole.
On review, the commission noted that it viewed the evidence slightly different than the arbitrator and modified the award to 12.56 percent loss of use of the person as a whole. The commission did not make specific comment as to the weight it may have placed on the factors for determining permanent partial disability.

B. **Liazuk v. Bolingbrook Police Dept.**

In *Liazuk v. Bolingbrook Police Dept.*, 12 W.C. 11804, 13 I.W.C.C. 934 (Nov. 4, 2013), the petitioner was a 40 year old police officer assigned to a K9 unit. On September 6, 2011, the petitioner was wearing a “bite suit” during the course of K9 training when a dog tackled him to the ground and he felt low back spasms. The evidence indicated that the petitioner had prior low back complaints and an MRI two years previous. Post occurrence, the petitioner undertook epidural steroid injections at L3-L4. Dr. Klaud Miller performed an AMA rating evaluation on the petitioner. He concluded that the petitioner’s impairment rating was zero. Upon arbitration, Arbitrator Falcioni noted that Dr. Miller did not address the L3-L4 disc space in his AMA rating, and he appeared to confuse the pre-occurrence MRI of 2009 with the post-occurrence MRI of 2011.

Arbitrator Falcioni awarded 5 percent loss of use of the person at arbitration.

On review, the commission affirmed and adopted the decision of Arbitrator Falcioni without making a specific factual finding.

C. **Fassero v. UPS**

In *Fassero v. UPS*, 12 W.C. 17291, 13 I.W.C.C. 858 (Oct. 7, 2013), the petitioner, Rick Fassero, was employed by UPS as a delivery person. While making a delivery on March 12, 2013, he was on a steep stairway when he felt a pop in his right knee. He ultimately underwent a medial meniscectomy with debridement of the patella femoral joint. Dr. Li performed an AMA impairment rating, finding that the petitioner suffered 1 percent loss of use of the lower extremity. At arbitration, Arbitrator Zanotti made the following findings pursuant to section 8.1b of the Act:

1. **AMA impairment rating:** 1 percent loss of use of the lower extremity
2. **Occupation:** UPS delivery driver. Petitioner did not provide evidence of the petitioner’s specific job activities or whether he worked in a light, medium or heavy physical demand level. Therefore, Arbitrator Zanotti only gave some weight to this factor.
3. **Age:** 44. Based on the petitioner’s age, Arbitrator Zanotti found that the PPD would be moderately greater than that of an older individual.
4. **Future earning capacity:** No evidence presented and therefore, no weight given to this factor.
5. **Evidence of disability corroborated by medical records:** The petitioner’s medical records documented his right knee arthroscopy and
postoperative diagnosis. Arbitrator Zanotti noted that there were very little treating medical records admitted besides the petitioner’s surgical report. He further noted that the petitioner testified that he had no problems performing his current job duties. Arbitrator Zanotti placed great weight on this factor.

Upon arbitration, Arbitrator Zanotti awarded 15 percent loss of use of the right knee.

Upon review, the commission affirmed the decision of Arbitrator Zanotti without making any specific factual or legal findings.
Toney is a partner who concentrates his practice in the areas of workers’ compensation, third-party defense of employers, workers’ compensation appeals, and protecting workers’ compensation liens.

Toney works out of the Urbana and Edwardsville offices covering a vast majority of the state of Illinois for workers’ compensation docket and trial coverage purposes. Based upon the current makeup and system put in place by the Illinois Workers’ Compensation Commission, Toney has become familiar with most, if not all, of the Arbitrators and Commissioners who have been appointed by the IWCC.

Toney takes great pride in working directly with employers and their insurance carriers in order to build an important relationship and foster a team mentality and approach to defending workers’ compensation claims. This includes consistent and constant communication and on-site meetings to enable and form the trust within the team which has proven to be an important formula in protecting the client’s most important asset -- the client’s business itself.

**Significant Cases**
- *Land v. Montgomery*, Eight week medical malpractice class action lawsuit.
- *Jerry Grant v. Clennon Electric, et al.* 02-WC-10537/09 MR 503

**Public Speaking**
- "Recent Impact of AMA Ratings in Workers’ Compensation” Heyl Royster (2013)
- "Use of Utilization Review Under the New Act” Heyl Royster (2012)

**Professional Associations**
- Champaign County Bar Association
- Illinois State Bar Association
- Will County Bar Association
- Illinois Trial Lawyers Association
- Illinois Association of Defense Trial Counsel

**Court Admissions**
- State Courts of Illinois
- United States District Court, Central District of Illinois

**Education**
- Juris Doctor, Louisiana State University, 1995
- Bachelor of Arts (Golden Key Honor Society), University of Illinois, 1992