All aspects of the new Illinois workers’ compensation statute went into effect on February 1, 2006 and we are beginning to feel the effects on all of our cases. New procedural rules apply to all cases regardless of the date of accident. This means more petitions for immediate hearings. Penalties are increased and it seems every time we receive a motion for trial – there is also a penalty petition alleging some generic error allegedly made during the handling of the claim.

We have to carefully watch each case to apply the correct PPD schedule based on the date of accident – we have to apply the new TTD and PPD minimums even in cases involving part-time workers.

I am not sure I like this new law – in fact – I am sure I don’t.

Several employer groups are pushing for legislative changes and I would love to help them – I wish some had voiced stronger opposition when the legislation passed last year.

There is no crying in baseball – nor in litigation. We will continue to battle the curve balls being thrown at us.
AROUND THE COMMISSION

At the Arbitration Level

A second Chicago arbitrator has resigned. At the beginning of the year, Arbitrator Joseph Reichart resigned, retiring after many years of service. Arbitrator Reichart was not replaced. Instead his cases were reassigned among the remaining Chicago arbitrators.

One month later, Arbitrator Valerie Peiler resigned. Again, she has not been replaced. Instead, her cases were reassigned among the remaining Chicago arbitrators.

Arbitrator Reichart’s resignation was not surprising. He was of retirement age. However, Arbitrator Peiler was not of retirement age. She resigned after many years of dedicated service to enter private practice in part because she was fed up with the Chairman. The Chairman is dedicated to make continual changes placing increased burdens on the arbitrators and making the system more unfair to employers.

Despite the loss of two arbitrators in Chicago, the arbitration process remains on track. Despite the Chairman’s demand that the arbitrators try more cases, there are still more than enough arbitrators in Chicago available to try cases. The current number of Chicago arbitrators is sufficient to handle the current caseload. However, with money in the budget, I expect eventually the Governor will appoint more arbitrators. Regrettably, we have now lost the fairness associated with Arbitrators Reichart and Peiler that we had come to expect over the years.

That is not to say that some of the new arbitrators are unfair. All of the new appointments in Chicago have proven to be excellent arbitrators. Arbitrators Black, O’Malley, Carlson, Jutila, and DeVriendt, four of whom are former petitioner attorneys, have all proven to be outstanding arbitrators who know the system well and try cases efficiently. Their decisions have generally been fair and reasonable.

At the Commission Level

Long delays. The appeal process from the arbitration level to the Commission level has become extraordinarily long. After a case is tried, an appeal can be filed within 30 days. After the appeal is filed, it takes generally 30-60 days to get the arbitration transcript. The case is then scheduled for a return date on review in 30-60 days. After that, the parties have 45 days to file briefs with the Commission. That whole process takes generally four to five months. Thereafter, the case needs to be scheduled for oral arguments before the Commission. However, oral arguments before the Commission have been delayed now for 10 months to over a year. This delay even includes cases involving petitions for immediate hearing. The delay is interminable
and unconscionable. There simply are not that many cases being appealed that it should take the Commission so long to schedule cases for oral argument. Even with the same number of cases three years ago, with the prior commissioners, the delay was not nearly this long.

Under the new Act, the number of commissioners was increased by three to add a third panel of commissioners to hear appeals. The effective date of that statute was July 20, 2005. The Governor could have appointed three new commissioners July 21, 2005, but as of now, nine months after the passage of the new Act, the Governor has still not appointed the third panel of commissioners. I thought it was unnecessary and frankly, I still think it’s unnecessary that a third panel of commissioners be appointed. However, based on the current delays at the Commission, a third panel is definitely needed to handle appeals from the arbitration level.

**The New Statute – Double Check the Date of Accident**

Our new statute is now fully in effect. It is important to remember the effective dates of the various statutory provisions. We have many new changes in the statute. The effective dates of the statutory changes are varied. Some of the changes went into effect July 20, 2005, some November 16, 2005, and some February 1, 2006. It is especially important to double check the date of accident because the changes vary based on the date of accident.

It is especially confusing with respect to the new PPD schedule. Please recall that the old PPD schedule is in effect for dates of accident before July 20, 2005 and again from November 16, 2005 to January 31, 2006. The new PPD schedule is in effect for dates of accident from July 20, 2005 to November 15, 2005 and again from February 1, 2006 and thereafter.

**Medical Fee Schedule Implementation**

The medical fee schedule is now fully in effect. The medical fee schedule applies to all cases which are not settled. **The medical fee schedule applies to all medical treatment rendered on or after February 1, 2006.** The medical fee schedule can be accessed through the Commission’s website. Any medical bill properly coded can be analyzed by going to the Commission’s website at [http://www.state.il.us/agency/iic](http://www.state.il.us/agency/iic). In order to analyze a bill using the medical fee schedule, you must have the correct American Medical Association CPT (current procedural terminology) code plus the zip code where the service was performed. If a fee cannot be determined through the medical fee schedule, the default percentage of payment is 76% of the original bill. I have been skeptical that the medical fee schedule would result in total overall savings for employers. I am interested to see if carriers may change their medical bill review process and use the medical fee schedule rather than hire third party vendors to review and reprice their bills.

The NCCI issued a memorandum on April 26, 2006 assessing the cost-effectiveness of the medical fee schedule. The analysis is not surprising to me at all, but it is disappointing. I had reviewed the medical fee schedule and felt that it would not significantly lower employer costs. The NCCI evaluated the medical fee schedule and determined that the total overall cost savings as a result of implementation of the medical fee schedule was a savings of 0.2%. The total cost savings to all employers is estimated at $6-million annually. The NCCI expects that the medical
fee schedule will result in a slight decrease in employer costs for medical professional services (the doctors). This is estimated at 0.5%. The NCCI doesn’t feel that the medical fee schedule will result in any overall cost savings with respect to outpatient care, ambulatory surgery, dental, or emergency room care. The NCCI doesn’t feel that the medical fee schedule will result in any decrease with respect to medical care, equipment and services. The NCCI wasn’t able to evaluate hospital inpatient or anesthesia charges, but they only represent a small percentage of total medical costs. The NCCI concludes that any temporary savings that employers might see right now will eventually be eliminated because the medical fee schedule does not have any specific caps. The caps are based on the percentage of a medical provider’s charges – so the cap will continue to constantly go up.

This means that employers should not rely on the medical fee schedule to save money – but should continue to seek contractual arrangements and PPD discounts to save medical costs.

BEFORE THE SUPREME COURT OF ILLINOIS

Employer Barred from Pursuing Modification of Wage Differential Award


Petitioner suffered an injury in 1988 and couldn’t return to his regular job. He suffered a wage loss and the Industrial Commission granted him a wage differential award under §8(d)(1) in 1993. The wage differential award was for $203.55 per week. Ten years later, the employer found out that petitioner’s wages had increased and were at or above the level petitioner was earning at the time of his accident in 1988. The employer filed a petition with the Commission to suspend the wage differential award. The Commission denied the petition, ruling that the §8(d)(1) phrase “for the duration of his disability” refers to the duration of the employee’s physical and medical disability, not the duration of his economic loss. Therefore, even though petitioner’s wages had increased, petitioner was still entitled to the wage differential award.

The employer appealed to the circuit court and the circuit court confirmed the Commission’s denial. The employer appealed to the appellate court, and the appellate court vacated the decision of the Commission and dismissed the employer’s motion to suspend benefits, finding that the Commission didn’t even have jurisdiction to entertain the petition.

The employer appealed to the Supreme Court, and the Supreme Court affirmed. The Supreme Court ruled that the Commission did not have jurisdiction to review a wage differential award under §8(d)(1) except as part of a petition for reopening under §19(h) of the Act. The court ruled that there was no provision in §8(d)(1) which allowed an employer to reopen a wage differential award. Further, the court ruled that there was no provision of §8(f), the permanent total disability section, which granted the employer the right to reopen a wage differential award under §8(d)(1). The court held:

“...The language of section 8(d)(1) does not authorize either party to petition for review of an award, as section 19(h) does. It does not authorize the Commission to recall an award, as section 19(f) does. Nor does it authorize an employer to
petition for review, as section 8(f) does. It would be inappropriate for us to read one of these procedures into section 8(d)(1) when the legislature has included none of them in that section. Reading the Act as a whole, we hold that section 8(d)(1) does not specifically authorize the Commission to reopen final installment awards for partial disability. Thus, the Commission does not have jurisdiction under section 8(d)(1) to reopen [petitioner’s] final award.”

The court ruled that the employer could have filed a §19(h) petition to keep this issue alive but did not. No other section of the Act allows the employer to reopen this award.

The court rejected the employer’s allegation that the refusal to allow reopening is unfair. The court ruled that the Commission has to consider all evidence when making a wage differential award and found that the employer must present all evidence to the Commission in making a wage differential award. The court found it appropriate for the Commission to make varying wage differential awards to a claimant. However, the court ruled that once such an award is entered, it cannot be reopened unless pursuant to a §19(h) petition.

Comment: The ruling of the Supreme Court is overly harsh to employers. The court ignores the fact that the Workers’ Compensation Act has been amended multiple times since initially enacted. The court reads the statute as a whole as if the original drafter crafted the whole. The court ignores the fact that the legislature’s modifications sometimes fail to address the consequences of one modification on another section of the Act. Taken as a whole, wage differential awards, which are for perpetuity, should be subject to modification at any point in time when the basis for the award is no longer viable. Therefore, in a circumstance where a claimant has suffered a wage loss and gets an award for wage loss, but then is able to earn as much or more as before his accident, the basis for the wage differential award is ended and the award itself should end. The employer should have the right to reopen at any point in time that the wage loss ends.

However, based on this decision, employers do not have that right. Therefore, it is imperative that all evidence as to an individual’s earning capacity be offered at the time of trial. Moreover, if a wage differential award is entered against an employer, that employer should file a §19(h) petition within 30 months to have that award reviewed. Even if the §19(h) petition is denied, the employer can in perpetuity keep that issue alive because the employer will have the opportunity to file a new §19(h) petition 30 months after the final award denying the last §19(h) petition. It is only by this procedure under our current Act that an employer can continue to pursue the right to modify a §8(d)(1) wage differential award.

BEFORE THE APPELLATE COURT OF ILLINOIS –
NON-WORKERS’ COMPENSATION COMMISSION DIVISION

Prior Award of Workers’ Compensation Benefits Barred Village from Relitigating Issue of Causality in a Case Demanding Public Employee Disability Benefits

Petitioner was employed by the Village of Schaumburg as a firefighter. He slipped and fell down some stairs on his way to a roll call on April 12, 1999. He filed a workers’ compensation claim and the Commission awarded him benefits. He appealed and while the case was pending in the appellate court, the case was settled for $32,500.00.

He then demanded that the employer pay him sick leave and vacation pay benefits pursuant to the Public Employee Disability Act (PEDA). Such benefits were available to petitioner if his accident occurred “in the line of duty.” The employer disputed liability and wanted to litigate the issue of petitioner’s entitlement to PEDA benefits. The trial court granted petitioner summary judgment. The court ruled that the employer was barred by the doctrine of collateral estoppel from relitigating whether or not petitioner’s accident arose out of “the line of duty.”

The Village appealed, but the appellate court affirmed. The appellate court found that the Commission’s finding of compensability was the equivalent of finding that the accident occurred in the line of duty. The court held:

“We see no meaningful difference between the ‘line of duty’ standard in PEDA and the causation test in workers’ compensation claims – that the injury ‘arose out of and in the course of employment.’ There is no reason to require a firefighter to provide different proof that he was injured in the line of duty under PEDA than he would in a ‘line-of-duty’ pension case. Accordingly, we find the defendant is collaterally estopped from relitigating the issue of causation, based on the finding in the workers’ compensation claim that plaintiff’s injury arose out of and in the course of his employment.”

The court ordered that the Village reinstate petitioner’s sick leave and vacation pay benefits.

Comment: Cases involving public employee claims for workers’ compensation, PEDA benefits, and pension benefits are intertwined but not equal. The operative language to justify benefits in each of the different statutes and codes is not identical. However, the courts appear to be moving closer to finding an identity of standards. Based on this decision, there is no difference in the type of case presented. If a claimant proves a workers’ compensation claim, according to this decision, the petitioner also proves a PEDA claim and a pension claim. Nevertheless, this appellate court decision is not likely to be the last litigated case on this issue. The different standards in the different statutes will likely require further litigation unless and until there is an identity of language in the different statutes and codes. Just because a case is compensable under the WC Act in my view does not mean it is “within the line of duty” nor does it necessarily mean that it is within an act “inherently involving special risk, not ordinarily assumed by a citizen in the ordinary walks of life.” There are many and varying benefits available to public employees under workers’ compensation, PEDA, and the pension code. The benefits are substantial. Each agency obligated to pay the benefits should have a right to dispute and defend each claim based on the specific statutory provisions associated with each type of claim.
Petitioner filed a claim against the employer for injuries and also filed a 19(b) petition. The arbitrator awarded petitioner approximately $40,000.00 in TTD and $85,000.00 in medical bills. The total award was approximately $125,000.00. The employer appealed to the Commission and the Commission affirmed on August 7, 2002. The employer appealed to the circuit court, and the circuit court affirmed on February 10, 2003. The employer appealed to the appellate court, and the appellate court affirmed on February 19, 2004.

On March 30, 2004, the employer filed a motion with the Commission seeking to adjudicate payment of the awarded medical bills. The employer claimed that it paid the TTD. The employer claimed that the medical bills had been paid by the employer’s group insurance carrier. The employer sought a ruling that it only needed to pay the claimant $3,500.00 to resolve the disputed medical bills submitted at the time of arbitration.

The claimant did not even appear and defend himself at this Commission proceeding. Instead, on May 26, 2004, the claimant filed a §19(g) petition in the circuit court seeking an order forcing the employer to pay the entire award. In addition, the claimant sought attorney’s fees for prosecuting the entire case at a rate of $300.00 per hour.

The circuit judge ruled in favor of the claimant and awarded $125,000.00 for the Commission’s award plus another $41,000.00 in attorney’s fees. The court refused to consider the payments made by the group medical carrier. The court would not even consider the payments made for TTD. The court awarded attorney fees for the entire work petitioner’s attorney performed on the case at a rate of $250.00 an hour.

The employer appealed. The employer claimed that the court did not have jurisdiction because the employer had filed a motion with the Commission. The appellate court rejected that argument. The appellate court ruled that the Commission didn’t have jurisdiction over the case anymore except to determine the permanent partial disability to be awarded petitioner. The court held that the Commission’s §19(b) award was final and the Commission had no authority or jurisdiction to assess additional benefits and/or amend the award it had already made. The court ruled that the §19(g) action in the trial court was the proper venue.

The court also ruled that the trial court was proper in awarding the full $127,000.00 judgment without giving the employer any credits for what was paid. The court stated that the employer was not entitled to any partial payment credits.

The court found that the award of attorney’s fees was not an abuse of discretion. The court found that since the Commission didn’t have any jurisdiction in the case, it was proper for the circuit court to have jurisdiction. The court found that the employer’s action of refusing to pay the award of medical bills directly to petitioner was unjustified even though the employer’s group medical carrier had satisfied virtually all of the medical bills. The court found that the
employer’s actions were not justified in refusing to pay the award. The court confirmed the entire judgment and the entire award of attorney’s fees.

**Comment:** This is truly a terrible decision from the appellate court affirming a very unfavorable trial court ruling. The employer took a gamble by processing petitioner’s medical bills through its group medical carrier. The employer apparently decided that it could not defend the workers’ compensation claim and it could save money by processing the medical bills through its group medical carrier. However, the medical bills were not processed prior to trial and a claim for a §8(j) credit was not made prior to trial. The trial court ignored the group carrier payments and ruled that the employer had to pay the entire award whether or not the employer had issued other payments to resolve the medical bills.

The Act provides that once an award is entered, it must be paid to the claimant. Employers who choose to pay medical bills directly to providers after an award is entered run a risk of having to pay more than once. However, this result of forcing the employer to pay and not even give credit for the compensation paid is outrageous.

The award of attorney’s fees of $41,000.00 is truly excessive. The court awarded the fees at $250.00 an hour. Moreover, the court awarded fees to the attorney at that rate for the entire time that he spent working on petitioner’s case, not just for prosecuting the §19(g) action. The appellate court ruled this was not an abuse of discretion. Clearly, employers must be careful in handling payment in disputed cases. A failure to pay the judgment as entered creates a possible excessive risk.

**BEFORE THE APPELLATE COURT OF ILLINOIS – WORKERS’ COMPENSATION COMMISSION DIVISION**

**Nurse Who Suffered Stroke While Giving a Speech for Retiring Doctor Awarded Permanent and Total Disability**

*Pinckneyville Community Hospital v. Industrial Commission and Mary Downen, No. 5-05-0204WC, filed March 30, 2006.*

Petitioner was employed by respondent for 25 years as a nurse at Pinckneyville Community Hospital. In 1986 she became the director of nursing. In 1997 the administrator changed and instituted changes designed to improve the hospital and obtain accreditation for the hospital. As a result of these changes, petitioner claimed that she worked even harder than before.

In 1998, Dr. Cawvey, a long-time member of the hospital staff, retired. Petitioner and two other nurses decided to have a retirement dinner. The hospital board agreed to pay some of the costs of the dinner. Several meetings were held planning the dinner. A discussion was held as to who would give a speech about the retiring doctor, and it was agreed that petitioner would give the speech. Petitioner testified that she was very nervous about giving the speech. Petitioner gave the speech and during the speech she suffered a stroke. As a result of the stroke, she became permanently and totally disabled.
She filed a claim for workers’ compensation benefits, and the claim was denied by the arbitrator. The arbitrator ruled this was a voluntary recreational event. The arbitrator ruled that petitioner was neither ordered nor assigned to participate. Moreover, the arbitrator found that petitioner’s stroke was the result of a personal condition neither caused nor accelerated by giving the speech.

On appeal, the Industrial Commission reversed. The Commission found that petitioner was ordered or assigned to participate in the event despite contradictory testimony. The employer’s administrator specifically testified that he did not create the agenda or order anyone to speak at the event and that he did not direct or require any employees to attend the event.

Evidence showed petitioner had a long history of hypertension. Several experts testified that her stroke was the result of her hypertension and had nothing to do with giving a speech. However, petitioner’s family doctor testified that she was nervous while giving the speech and that caused her stroke. Petitioner also retained an expert to testify that giving the speech put more pressure on the weak blood vessel in her brain.

The circuit court and the appellate court confirmed the Commission’s decision. The court completely ignored the testimony of the administrator and ruled that the dinner was not a voluntary event because petitioner was a member of the management committee, she helped plan the dinner, and she was worried she would lose her job if she did not attend this dinner. The court found that the Commission’s finding on causation was not contrary to the manifest weight of the evidence since the Commission had the ability to choose which of the medical experts to believe. Several medical experts were presented and had contrary opinions. The court therefore affirmed the Commission’s award of almost $300,000.00 in medical bills and total and permanent disability.

Comment: From the employer’s standpoint here, the old adage is again true “no good deed goes unpunished.” The claimant was the director of nursing and one of her long-time friends, a doctor, retired. Petitioner chose to join a group of other nurses to plan a retirement dinner. The employer wanted to be nice and decided to fund the event. The employer likely figured there was no potential workers’ compensation liability since this was a voluntary recreational activity. The employer didn’t require anyone to attend. Petitioner chose to attend and in fact chose to participate on the committee. Someone on the committee suggested she give a speech and petitioner didn’t refuse. She had a stroke during the speech that everyone agrees was likely the result of her hypertension. Perhaps she was nervous when she gave the speech. The employer now sustains a liability of probably half a million dollars or more because they agreed to pay in part for a retirement dinner for one of the doctors. The hospital will certainly think twice the next time a doctor retires.

Section 11 of the WC Act was specifically amended over 15 years ago to prohibit exactly this type of claim – the Act was changed so that employers could have voluntary picnics and parties, softball teams, etc. without having WC liability. Now employers have to be wary when they fund any type of voluntary event. The Court has really diminished the meaning of this section.
John Maciorowski has obtained several excellent decisions, both at the arbitration and Commission levels.

He obtained a unanimous reversal from the Commission of an unfavorable arbitration decision in the case of Richard Kletz v. City of Bloomington, 02 WC 13083, 02 WC 41404 (06 IWCC 113). Petitioner claimed accidents on March 3, 2002 and June 25, 2002. The arbitrator awarded 13 weeks of TTD, $87,000.00 in medical bills, and 20% loss of use of a man in the first case. In the second case, he awarded 17 weeks of TTD, $76,000.00 in medical bills, and continuing TTD and medical. We appealed to the Commission claiming that all of petitioner’s problems were the result of his pre-existing conditions. We proved multiple prior work comp claims. We discredited petitioner’s credibility. In a 13-page decision, the Commission reversed the arbitrator. The Commission found that petitioner was not credible. The Commission found that petitioner failed to prove that he sustained accidental injuries as alleged and failed to prove his condition of ill-being causally related to the accidents alleged. The Commission validated the testimony of our examining physician, Dr. Marshall Matz.

Mr. Maciorowski obtained an excellent decision from Arbitrator Kane for AIG Insurance in the case of James McCarthy v. Kewitt/Delgado Contractors, 02 WC 60771. In this case, petitioner claimed an injury of October 7, 2002. The carrier initially accepted the injury and paid benefits in the amount of $45,000.00. We disputed liability for the claim. We presented testimony from the foreman indicating that petitioner did not timely report any work injury. We presented medical evidence which showed contradictory histories. We presented testimony from Dr. Player who opined that petitioner’s condition of ill-being was not causally related to the accident alleged. The arbitrator ruled in our favor and found that petitioner failed to prove that he sustained accidental injuries and failed to prove causal connection. The claim was denied in its entirety.

Mr. Maciorowski received a great decision from Arbitrator O’Malley for AIG Insurance in the case of Mary McKimmy v. American Residential Services, 00 WC 66459. In that case, petitioner claimed an injury on October 31, 2000. The case was tried on several dates, the last one being January 23, 2006. Petitioner claimed that she was entitled to TTD for over five years. She claimed continuing medical and she demanded penalties and attorney’s fees. The demand prior to trial was for benefits over $500,000.00.

We admitted that petitioner sustained an accident, but we claimed that she simply had an ankle strain. Petitioner presented multiple witnesses and claimed that she was suffering from RSD. However, we disputed petitioner’s credibility. We presented several witnesses along with the testimony of Dr. Samuel Vinci, who concluded that petitioner did not have RSD. The arbitrator concluded that petitioner was not credible. He relied on our evidence. Instead of awarding the five and a half years of TTD claimed, the arbitrator awarded only 23 6/7 weeks of TTD cutting off petitioner’s claim for TTD on May 8, 2001, almost five years ago.

Finally, Mr. Maciorowski obtained another no accident decision for AIG Insurance from Arbitrator Pulia in the case of Simpson Nelson v. Arc Underground, 03 WC 40317. Petitioner
claimed an injury on July 10, 2003. Petitioner claimed that he was working with a hose and it threw him across a deck. Petitioner was working with a crew of co-workers pouring concrete. We presented witnesses who stated that petitioner didn’t report any accident and no accident was witnessed by any co-workers or managers. Petitioner did not seek any immediate medical care. Petitioner did visit a doctor five days later. The arbitrator evaluated petitioner’s testimony and the testimony of our witnesses. The arbitrator found petitioner’s testimony not credible. The arbitrator stated, “The arbitrator finds it inconceivable that the accident could have occurred as claimed by petitioner and not be witnessed by any other employees working the job.”

Mark Cosimini obtained an excellent decision from Arbitrator White for AIG Insurance in a case involving an interesting factual and legal scenario. In the case of Gary Troxel v. McLane Midwest, 02 WC 29418, petitioner claimed an injury on December 29, 2000. It was undisputed that petitioner suffered an accident, and he was diagnosed with a disc bulge. Thirteen months later he fell at home and had a disc herniation. He eventually had a lumbar fusion at L5-S1. A 19(b) hearing was held and petitioner claimed that we were responsible for his surgery. However, the arbitrator denied liability. Petitioner appealed and the decision was affirmed by the Commission.

The initial hearing was a 19(b) hearing. Petitioner went back before the arbitrator and claimed entitlement to permanent disability. We claimed that petitioner wasn’t entitled to any permanent disability because he had an intervening accident and intervening surgery. Petitioner claimed that he was entitled to some PPD because the initial injury was undisputed. Arbitrator White ruled in our favor and denied permanent partial disability in its entirety. The arbitrator ruled that the intervening accident broke the chain of causation and therefore petitioner was not entitled to PPD.

Ted Powers received an excellent decision from the Commission for AIG Insurance in the case of Linda Kallvy v. CC Food Mart/Wade Development, 04 WC 27704, 04 WC 27705 (06 IWCC 327). This case involved a claimant who alleged two accidents against the same employer. We represented the employer in the second accident. The first accident was July 1, 2001. The second accident was May 10, 2004. After the second alleged accident, petitioner had knee surgery. We contended that petitioner’s first accident necessitated the surgery. The first carrier claimed it was the second accident. The arbitrator ruled in our favor and found that petitioner’s knee surgery was causally related to the first accident and not the second accident. We supported our contention with the testimony of Dr. Marvin Mishkin, an orthopedic surgeon. The first employer appealed, but the Commission affirmed and adopted the decision of the arbitrator, finding our client had no responsibility for this condition of ill-being.

Randy Stark obtained a great decision for West Bend Insurance from Arbitrator Carlson in the cases of Pedro Rodriguez v. Triple A Services, 02 WC 3613 and 22507. Petitioner worked on a food truck that sold sandwiches and drinks primarily at construction sites. Petitioner was killed by an armed robber while working. His widow filed a claim against the owner of the truck and also our client, Triple A Services. Triple A sold food products to the truck owner, Roberto Gonzalez. The arbitrator found Roberto Gonzalez was an employer and awarded benefits and penalties. The arbitrator ruled that Triple A Services was not an employer.
Dan Arkin obtained an excellent decision from Arbitrator Giordano in Rock Island on behalf of Underwriters Safety & Claims. In the case of Wayne Viager v. Norcross Safety Products, 02 WC 65983, petitioner alleged that he sustained an accident on August 5, 2002. Petitioner claimed that he thought the accident was witnessed by one individual and that he told another individual about the accident shortly thereafter. We presented three witnesses and they all contradicted petitioner’s testimony. The arbitrator found the respondent’s witnesses credible and ruled that petitioner failed to prove that he sustained accidental injuries alleged. The claim for compensation was denied in its entirety.

Joe Marcinia obtained a denial from Arbitrator Carlson on behalf of AIG Insurance. In the case of Roger Angel v. Quality Craft, Inc., 05 WC 5012, petitioner claimed an accident on January 7, 2005. Petitioner claimed that he injured his back while moving boxes. However, he couldn’t testify to any specific event when his pain began.

We presented a witness who testified that petitioner had stated he was going to claim a work comp injury because he didn’t get a raise like he wanted. We presented another witness who testified that petitioner initially sought medical treatment forms for group insurance and denied any work injury. Petitioner’s family doctor’s records showed that petitioner complained of back pain, but initially there was no history of an accident. Our IME physician, Dr. Kevin Walsh, concluded there was no connection between petitioner’s alleged accident and his condition of ill-being. The arbitrator found that petitioner failed to prove he sustained an accident at work and compensation was denied in its entirety.

Dan Arkin obtained another excellent decision from Arbitrator Lee on behalf of IRMA. In the case of Lynn Sheet v. Park Forest Fire Department, 02 WC 32624; 02 WC 41555, petitioner had two injuries while working as a firefighter and could not return to work as a firefighter. His attorney demanded a settlement equal to 68% loss of use of the man as a whole.

After trial, petitioner’s attorney submitted a proposed decision asking for 70% loss of use of the man as a whole plus 25% loss of use of the leg. We proposed an award of 21% loss of use of the man as a whole. The arbitrator adopted our proposed decision and awarded petitioner only 25% loss of use of the man as a whole. That’s approximately one-third of what petitioner’s attorney was looking for and only 4% more than we proposed.

We also claimed an overpayment of TTD because petitioner stopped looking for work after an unrelated motor vehicle accident. Moreover, we proved that petitioner actually found employment, but continued to collect TTD without letting us know. The arbitrator cut back on the TTD award leaving us with an overpayment of almost $17,000.00.

CONCLUSION

We are certainly starting to feel the effects of the new statute. We are paying increased TTD and PPD rates because of the new minimums. We are paying increased PPD because of the higher number of weeks associated with the scheduled members. We know as time progresses and we start dealing with more and more accidents occurring on and after February 1, 2006 we will be paying more and more for TTD and PPD.
However, we were supposed to get cost savings as a result of the medical fee schedule. I had been skeptical that the medical fee schedule would actually result in any significant cost savings for employers. The NCCI analysis confirmed my expectations. The cost savings projected by the medical fee schedule are minimal and are expected to disappear. The NCCI concluded, “It is expected that any initial cost savings in service categories with maximum reimbursements based on discounts off the charged amounts will diminish and disappear over time as the schedule provides no specific upper bound on the charged amounts.”

The maximums set forth in the medical fee schedule currently are not that low. If employers are going to get any significant savings, there have to be realistic, maximum charges set on fees, especially surgery charges. Because the fee schedule is premised on what the doctor’s charge is rather than what a reasonable amount would be for the service, the schedule is always going to benefit the physicians. Moreover, as more physicians increase fees, any cost savings will continue to diminish.

We will need more experience with the new statute to see how much more it is going to cost us than what we paid under the old statute. I don’t expect the experience to be pleasant.

Medical cost savings can be achieved through the medical fee schedule and also through utilization review. The Chairman has scheduled a utilization review seminar. It is scheduled for May 5, 2006. I’m interested in seeing what the Chairman thinks of how utilization review will affect litigated cases. I view it as a shield for employers against abuse by doctors. His perspective is likely different.

The Commission offices continue to undergo extensive remodeling to accommodate the new commissioners. However, the new commissioners have yet to be appointed even though the Governor could have appointed them as long ago as July 20, 2005. The Commission review process has been extraordinarily and frustratingly slow. The time delay between the return date on review and oral arguments is now in the range of ten months to a year or longer. That includes cases involving petitions for immediate hearing. Employers have to consider this time delay in appealing cases, especially those involving accruing TTD benefits. In cases that are appealed with TTD as an issue, the employer should consider taking whatever action is needed to control accruing TTD benefits while the case is pending on appeal. Secondary defenses to accruing TTD must be established in order to control the TTD and medical exposure in the event the employer does not receive a favorable ruling while the case is on appeal.

Employers must consider this issue even if they received a favorable decision from the arbitrator. Even if you win and petitioner appeals, the employer must consider what may happen on appeal and consider establishing secondary defenses.

Although the new medical fee schedule has taken effect, it is still too new for any significant decisions to have been issued concerning its applicability and operation. More meetings of the Medical Fee Advisory Board have been scheduled. Permanent rules have not yet been established by the Commission.
Court decisions and Commission decisions continue to frustrate and aggravate employers. We had some really good decisions this quarter and we expect them to continue – but we need good evidence. Our best successes have come in cases where the employer and carrier have performed an early and thorough investigation. We then have the ammunition to establish successful defenses.

In addition to work, I spent the winter of 2006 training to race in the 110th running of the Boston Marathon. The winter weather cooperated and I was able to complete all of my scheduled training runs with the exception of one blustery Saturday with wind chills at 25 below zero. I made many new friends in my training group as we trudged through several 18 – 20 miles runs up and down hills in northwest Barrington. We did speed work along the lakefront in snow, sleet and sometimes hail. I didn’t realize how scary Lake Michigan can be in wintery weather.

The training was well worth it. I successfully ran several warm-up races including the Cary Half Marathon (13.1 miles) in 1 hour 36 minutes (11th in my age group). I ran the Shamrock Shuffle 8K in 34 minutes (750 overall of 20,500 runners). I qualified for a competitive start next year and will actually be able to go shoulder to shoulder with a Kenyan. Finally, I ran the Miles for Smiles 10K in 42 minutes 35 seconds. I won my age group in the 10K and took home a gold medal (currently valued at $1.99).

I raced the Boston Marathon on April 17, 2006, Patriots’ Day. The race was a phenomenal and rewarding experience. I ran it in 3 hours 34 minutes, which was a spectacular result for me. I not only completed the race well, but ran fast enough to qualify for the 2007 Boston Marathon. Being in Boston for the first time in many years was a great deal of fun. We walked the Freedom Trail the day after the race. (Quite slowly) We visited the Old North Church, Paul Revere’s home, and the Bunker Hill monument. We saw where the two lanterns were hung in the Old North Church to warn of the British invasion.

The Marathon itself was extraordinarily hard for a midwesterner used to the flat lands of Illinois and not the hills of New England. From Mile 16 through Mile 21 the course is virtually all uphill. For Mile 20 to Mile 21, runners encounter the infamous “Heartbreak Hill.” The hill is properly named. Many runners including me struggle to make it to the top. I was elated when I reached the crest of the hill, but then I realized I still had over five miles to run in the race. It was truly a unique experience and I can’t wait to start training to return next year.

My summer race schedule will be full. I am looking forward to running in the Indianapolis Mini Marathon (a 13.1-mile half marathon) on May 6, 2006. Part of the course is on the Indianapolis Speedway. I’ll learn what it feels like to be a race car on the track. However, I doubt I’ll be approaching 200 miles per hour. After multiple shorter races this summer, I will start training in mid-summer for a fall marathon, likely the Detroit Free Press Marathon on October 29, 2006.

Some of my friends (accomplices) are encouraging me to take up adventure racing this summer. Adventure races frequently include a variety of skills including running, swimming, biking, paddling, climbing and orienteering. I am fine with all of the endurance aspects. However, the orienteering worries me a bit because I haven’t used a compass since I was a Boy Scout. I will have to learn to “be prepared” and not get lost in some forest in the middle of nowhere.
Here are two photos taken at Mile 22 – I am not sure if I was smiling or grimacing.