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FLIGHT ATTENDANT'S REIMBURSEMENT OF EXPENSES IS NOT INCLUDED IN THE AVERAGE WEEKLY WAGE

Mary Ritter in 1998, employed by United Airlines as a flight attendant, suffered two work-related accidents. The first occurred on August 27, 1998 when she sustained an injury to her back and the second on September 9, 2000 when she re-injured the back and never returned to work as a flight attendant. She retired from United on August 2, 2002 and, at the time of the arbitration hearing, she was working twenty hours per week as an assistant chaplain providing religious and social services to inmates at the Sarasota Florida County jail.

The claimant introduced into evidence the Collective Bargaining Agreement governing the wages for United flight attendants. In addition to an hourly rate of pay and premiums for certain positions, flight attendants receive per diem payments which were included in the claimant's regular paychecks, 1) when the claimant was not required to stay overnight, her per diem payments were subject to income taxes; and 2) no taxes were withheld for the per diem payments made during trips that lasted more than one day. At the time of her second injury, the claimant was flying primarily to Japan and no taxes were withheld.

The claimant testified that her per diem

payments approximated \$230 for each trip but that she would only spend around \$50 when she went to Japan with her expenses varying on the trips. The claimant argued that the difference between her average meal expense of \$50 and the \$230 per diem payment constituted a “real economic gain” and should be included when calculating her average weekly wage. She admitted, however, that she did not keep “any expense vouchers or track of any costs while (she was) traveling.” United argued that the claimant’s own trial testimony established that any claim of “real economic gain” was at best, speculative. The Commission found that all of the per diem payments constituted economic gain, and therefore, should have been included in computing the claimant’s average weekly wage and that, therefore, the claimant was entitled to a wage differential of \$327.04 per week.

The circuit court affirmed the Commission decision but the appellate court reversed. The court stated:

In arguing for affirmance, the claimant maintains that the reimbursements for her travel expenses should not be excluded from her average weekly wage, absent evidence of the actual expenses she incurred. Such a rule, however, would improperly shift the burden of proof to United to prove that the per diem payments did not represent real economic gain. The claimant, and not United, had the burden of proving her average weekly wage. As noted above, the record reflects that the claimant presented some evidence from which it could be inferred that the per diem payments she received exceeded her actual expenses. Consequently, this cause

must be remanded to the Commission for a determination as to whether, and to what extent, the claimant’s per diem payments exceeded her actual expenses.

EDITOR’S NOTE: Clearly, the fact that the circumstances of the per diem payment had been described in the Collective Bargaining Agreement limited the claimant’s ability to establish “real economic gain.” The very nature of the claimant’s testimony exhibited “uncertainty” as to the allocation of the per diem payments. She used terms such as “usually”, “it would vary” and “it’s hard to remember” which testimony would make a calculation impossible.

The appellate court opinion reverses the IWCC’s expansive treatment of “travel expenses” as earnings includeable in average weekly wage unless there is proof of “real economic gain.”

PETITIONER DENIED SPECIFIC LOSS AWARD IN ADDITION TO TWO-MEMBER PERMANENT TOTAL DISABILITY BENEFITS

On April 19, 1995, Jack Carson, a truck driver employed by Beelman Trucking, was involved in a serious motor vehicle accident resulting in severe and permanent injuries. He suffered a burst fracture at C5-6 resulting in a complete loss of use of both legs and the near complete paralysis of the left arm. He also sustained an injury to the right arm which ultimately resulted in an above-elbow amputation of the arm. The spinal injury resulted in a complete loss of sensation below the level of his mid chest and paralysis of his left arm below the shoulder level. The right arm amputation did not permit him to utilize a prosthesis of that arm.

The arbitrator's award included the following:

1. Total disability of both legs resulting in a two-member disability award;
2. Total loss of use of the right arm for the right arm amputation resulting in an award of 250 weeks;
3. Total loss of use of the left arm because of the left arm paralysis resulting in an award of 235 weeks;
4. Medical benefits of \$12,674 for the acquisition of a voice-activated computer environmental control unit which resulted in additional safety and security and permitted him to operate his telephone, television set and lamp; and
5. \$708 for a handicapped modification endorsement of his automobile insurance premium.

Upon review, the Commission affirmed and adopted the arbitrator's decision with one modification. The Commission increased the award of the right arm from 250 to 300 weeks because of his inability to utilize a prosthetic device. The circuit court confirmed the decision of the Commission and the employer appealed.

The first issue is whether the Commission erred in awarding specific loss benefits under Section 8(e)(10) in conjunction with the statutory permanent disability award under Section 8(e)(18) where the injuries were incurred in a single accident. Section 8(e)(18) provides as follows:

The specific case of loss of both hands, both arms, or both feet, or both legs, or both eyes, or of any two hereof, or the permanent and complete loss of the use thereof, constitutes total and permanent disability, to be compensated according to the compensation fixed by paragraph (f) of this Section. These specific cases of total and permanent disability do not exclude other cases.

Any employee who has previously suffered the loss of permanent and complete loss of the use of any of such members, and in a subsequent independent accident loses another or suffers the permanent and complete loss of the use of any one of such members[,] the employer for whom the injured employee is working at the time of the last independent accident is liable to pay compensation only for the loss of permanent and complete loss of the use of the member occasioned by the last independent accident.

In finding that the claimant could not receive specific loss awards in addition to the two-member permanent disability, the court, citing prior decisions, stated:

[I]t would be specious reasoning to conclude that the loss of more than two members would not constitute permanent and total disability, but revert to a condition of specific loss. The loss of the additional members over and above the two specified in the act cannot convert such statutory permanent and total disability into a case of specific losses. That the employee disabled by the loss of more than two

members may sustain greater hardship than an employee who has lost only two members should be recognized by the legislature and provision made for him in the act. However, this circumstance does not modify his condition into one of specific losses under the present law, or give him the right to elect whether he will itemize his disabilities or claim permanent total disability. There is no provision in the act giving any employee previously handicapped or otherwise, the right to elect whether he will claim compensation for the cumulative loss of members sustained in one accident or claim statutory permanent and total disability. Any such interpretation of the act would render meaningless both the provision relating to the sum payable to permanent and total disability and the provision defining the loss, or loss of use of two members, or the sight of both eyes as permanent total disability. An employee so disabled could either add up the compensation due for loss or loss of use of members sustained in an accident and compare that sum with the amount payable to him for permanent total disability, and then label his condition so as to procure the greatest amount of compensation. It is evident that such a procedure is not within the purport of the act.

The next issue involved the Commission's decision to award the voice-activated computer under Section 8(a) of the Act which required the employer to pay reasonable medical and rehabilitative services. After noting that Illinois had

interpreted Section 8(a) to include nursing care, home care, and services for home modification, the court stated:

In this case, Dr. Lieb, the occupational therapists, and the rehabilitative consultant strongly recommended the computer system and the environmental control unit as reasonable and necessary appliances to improve the claimant's physical and psychological health and well-being. There is overwhelming competent evidence in the record to support the Commission's conclusion that the appliances were reasonable and necessary to relieve the effects of the injury. The commission's award is in keeping with the purpose of section 8(a) and the overall purpose of the Act to fully compensate an employee for work-related injuries. In this case, the computer and environmental control system are appliances that have restored some independent function to Carson. These devices have benefitted his physical and psychological health and well-being. The award is clearly warranted under the unique circumstances in this case.

The final question concerned the award for that portion of the automobile insurance premium covering the handicapped modification endorsement. The court noted that the employer had provided Carson with a van and agreed that it would make no sense to exclude from the employer's 8(a) obligation the duty to cover that portion of the insurance premium which referred to modifications necessary to accommodate Carson's disability.

In a dissenting opinion, Justice Donovan concluded that the Commission award for the specific loss for the two arms was supported by the facts and the law. He pointed out that the claimant's award under Section 8(e)(18) did not require that the employee be wholly and permanently incapable of work. His dissent emphasized:

In the case at bar, the claimant sustained numerous injuries in a single accident. It is beyond debate that the injury to the cervical spinal and the degloving injury to the right arm are concurrent and distinct injuries. The degloving injury to the right arm required multiple surgeries, including an above-elbow amputation. It resulted in a specific loss of the type contemplated under section 8(e)(10). The C5-6 burst fracture resulted in the complete loss of use of the claimant's legs and the near-complete paralysis of his left arm. A statutory permanent total disability award under section 8(e)(18) of the Act is appropriate because there is no evidence that the disability resulting from the C5-6 burst fracture would have left the claimant wholly incapable of work. The degloving injury to the right arm resulted in an additional impairment to the claimant's earning power and warranted additional compensation. This is not a case where the maxim "a workman can only be 100% disabled" applies. There is no evidence that either injury, by itself, would have left the claimant without a market for his skills, and thus completely unemployable. To declare, as the majority has, that a statutory permanent and total

disability award under section 8(e)(10) precludes an additional permanency benefit where a distinct injury results in additional impairment of earning power is to create an exception to the employer's liability that violates the letter and spirit of the Act.

EDITOR'S NOTE: The claimant has apparently not filed a leave to appeal to the supreme court. While the majority opinion suggested that the payment of specific loss in addition to the two-member total disability would allow the claimant to elect whether he would claim compensation for the loss of all members sustained in one accident or claim total disability, the majority felt that such a procedure was not available under the Act.

LIMITATION OF TWO-PHYSICIAN RULE NOT APPLICABLE WHEN SECOND PHYSICIAN HAD NOT REQUESTED PAYMENT

As we all know, Section 8(a) of the Act describes the so-called two-physician rule. Subsections 8(a)(2) and (a)(3) provides as follows:

*[T]he employer's liability to pay for *** medical services selected by the employee shall be limited to:*

(2) all medical, surgical and hospital services provided by the physician, surgeon or hospital initially chosen by the employee or by any other physician, consultant, expert, institution or other provider of services recommended by said initial service provider or any subsequent provider of medical services in the chain of referrals

*from said initial service provider;
plus*

(3) all medical, surgical and hospital services provided by any second physician, surgeon or hospital subsequently chosen by the employee or by any other physician, consultant, expert, institution or other provider of services recommended by said second service provider or any subsequent provider of medical services in the chain of referrals from said second service provider. Thereafter the employer shall select and pay for all necessary medical, surgical and hospital treatment and the employee may not select a provider of medical services at the employer's expense unless the employer agrees to such selection. At any time the employee may obtain any medical treatment he desires at his own expense.

Included in the provisions, selection of the first physician would include all medical services in the chain of referrals from said initial physician. A similar interpretation applies to the nature and value of the services provided.

Onasis Youanis, the claimant, an employee of Comfort Masters, sustained a back injury as a result of a fall. The claimant obtained medical treatment from Dr. Cirrincione and several other providers in a chain of referrals from Dr. Cirrincione. The claimant later moved to New Mexico and commenced treatment with Dr. Jack Vick. The arbitrator awarded medical expenses amounting to \$61,776.69, but denied the claim for \$44,659.83 in medical expense for treatment the claimant received in New Mexico, finding that he had exhausted his two-physician choices. The

opinion notes:

In an office note dated June 27, 1998, Doctor Cirrincione wrote that Youanis "apparently received some chiropractic treatments to his lower back, which have helped." Based on this notation, Comfort Masters asked Youanis on cross-examination if he had seen any additional chiropractors, doctors or acupuncturists. Youanis answers no, and the arbitration hearing was then continued. When the hearing resumed, he testified that while in Chicago (during the period of Doctor Cirrincione's care) he received treatment from his wife's best friend, Dina Chris-Rogers: "She is like a Chinese acupuncture, you know, not a chiropractor. She's an acupuncture." Contrary to the suggestion in Doctor Cirrincione's office note, Chris-Rogers is not a licensed chiropractor. Youanis testified that he went to her house on two occasions for back massages and never sought treatment in her office. Chris-Rogers performed the massages free of charge because she was best friends with Youanis' wife.

The Commission reversed the arbitrator and found that the claimant had not exhausted his two physician choices. The trial court and the appellate court agreed that the treatment from the wife's best friend did not preclude the employer's obligation to pay for the treatment rendered in New Mexico for the reason that the employer did not incur any liability for Ms. Chris-Rogers' services as petitioner was not charged for any services that Ms. Chris-Rogers may have rendered and when there were no medical bills, there would be no employer

liability.

The court stated:

Nothing in this opinion prevents a claimant from obtaining treatment by a provider like Chris-Rogers outside the two chains of referrals mentioned above. The question is simply one of the employer's liability for payment. Subsection 8(a)(3) allows a claimant "[a]t any time" to "obtain any medical treatment he desires at his own expense."

EDITOR'S NOTE: Several interesting questions are raised by the opinion. If Ms. Chris-Rogers, an alleged acupuncturist, had submitted a bill which the employer had not paid, would this have amounted as the employee's second selection? If Ms. Chris-Rogers had been a licensed medical physician and had waived her charges because of the personal relationship, would that have constituted a second selection? Finally, if Ms. Chris-Rogers had not submitted a bill until after the claimant had received treatment in New Mexico, would that have eliminated the employer's liability to pay for the New Mexico treatment?

The opinion notes that "the question is simply one of the employer's liability for payment." It would seem that the employer might be liable for the treatment by Ms. Chris-Rogers even if the bill was not submitted until after the New Mexico treatment was completed. In other words, one might question whether the failure to render a bill would be sufficient to eliminate the fact that there may have indeed been a second selection.

**WHEN A "SALE" OF A LIEN
AMOUNTS TO A RECOVERY OF
THE COMPENSATION LIEN**

On April 25, 2008, the First District Appellate Court, Fifth Division, decided the case of Michael Evans vs. Doherty Construction, et al. which has ramifications for any employer who attempts to assign a workers' compensation lien to avoid potential third party liability and still recover a portion of the lien, without incurring the 25% attorney's fee prescribed by statute.

In Evans, the plaintiff was injured in a construction accident. He subsequently brought suit against a general contractor and several sub-contractors who, in turn, filed Third Party contribution actions against the plaintiff's employer. The employer paid the plaintiff \$152,000.00 in workers' compensation benefits and claimed a lien pursuant to Section 5(b) of the Workers' Compensation Act. 820 ILCS 305(b) (2006).

Prior to trial, all the direct defendants entered into an agreement with the employer to "purchase" its workers' compensation lien for \$90,000.00. The defendants and employer informed the trial Judge that the lien had been "sold" to the defendants for \$90,000.00. As part of the assignment, the defendants agreed to dismiss the Third Party Complaints brought against the employer.

The following day, the defendants informed the Court they had reached a settlement with the plaintiff for \$650,000.00 from which the \$90,000.00 paid for the lien would be subtracted. The trial court related that it understood the employer no longer had a lien to enforce but under Section 5(b) of the Compensation Act, the employer was liable to pay the plaintiff's counsel a 25% attorney's fee and its pro rata share of the recovery costs on the amount recovered by the employer. The employer argued that it was paid for the transfer of its lien rights, and not for its lien, so the plaintiff's attorney

was not entitled to a fee and pro rata costs. In ruling that the employer had to pay the plaintiff's attorney a 25% fee and pro rata costs, the Court rejected the employer's position that it received \$90,000.00 not in satisfaction of the lien, but as an assignment of its lien rights. The Court found this characterization to be a "distinction without a difference." The Court emphasized that the language in Section 5(b) requires that: "Out of any reimbursement received by the employer," the employer has a duty to pay a 25% attorneys fee and its pro rata share of the costs arising out of the recovery. It is the fact that the employer is reimbursed, and not the timing or characterization of the reimbursement that obligates the employer to pay attorneys fees and pro rata costs. In its Order, the Trial Court required the employer to pay the statutory 25% attorney fee (\$22,500.00) and its pro rata share of the costs. The Appellate Court affirmed the trial court's opinion.

EDITOR'S NOTES: The Court "would not buy" the employer's primary position that the money it received from the sale of the lien rights was not "reimbursement" under the Act. The plain and ordinary meaning of "reimbursement" means repayment or compensation for money spent.

By: Thomas W. Weber

W & M ANNOUNCES OPENING OF ST. LOUIS OFFICE

Because of requests from clients to provide workers' compensation defense in the southern part of Illinois, W & M has opened an office in Clayton, Missouri, a suburb of St. Louis. Investigation and inquiry have confirmed the fact that this portion of Illinois is best served by using St. Louis as the base.

The office is presently staffed by Shaun M. Falvey and Yvette M. Boutaugh, two experienced workers' compensation attorneys, who are licensed in both Illinois and Missouri for hearing in either state. The office will be supervised by Mark Wiedner of the Chicago office.

The new address is 8000 Maryland Avenue, Suite 610, Clayton, MO 63105. For further information, you should contact Shaun Falvey at (314) 721-3400 or Mark Wiedner of the Chicago office.

We would also like to announce that our offices will service the following additional hearing locations:

Belleville	Carlinville
Carlyle	Clinton
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Decatur	Galesburg
Jacksonville	Lawrenceville
Mattoon	Mt. Vernon
Peoria	Quincy
Springfield	Taylorville
Urbana	Whittington/Herrin

FRANK J. WIEDNER
Editor

