AMA Impairment Ratings Two Years Later: Has Section 8.1b "Shaved" Any Permanency Off Settlements or Awards?

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I. The Barber

a. AMA Guides to Evaluation of Permanent Impairment, 6th Edition

The Guides to the Evaluation of Permanent Impairment is in its 6th edition. An impairment guide was first published by the American Medical Association as an article, "A Guide to the Evaluation of Permanent Impairment of the Extremities and Back," in 1958. A formalized first edition of the Guides was published in 1971. The Guides seek to provide a medically acceptable measure of impairment utilizing the most up to date scientific research and data. The goal is to utilize "evidence based medicine" to establish standards upon which impairment can be established. The 6th edition was published by the American Medical Association in 2008.

Over the course of the first five editions, modifications were made to offer greater standardization and ease of use. The 6th edition has adopted terms used by the International Classification of Functioning, Disability and Health (ICF). The 6th edition also seeks to become more reliant on diagnostic testing, to become easier to use, and to base impairment on the concept of "function."

The ICF is a model of disablement developed by the World Health Organization to describe and measure health and disability on individual and population levels. It has been described as a:

> classification of health and health-related domains that describe body functions and structures, activities, and participation. The domains are classified from body, individual and societal perspectives. The ICF systematically groups different domains for a person in a given health condition (e.g. what a person with a disease or disorder does do or can do). 'Functioning' is an umbrella term encompassing all body functions, activities and participations; similarly, 'disability' serves as an umbrella term for impairments, activity limitations or participation restrictions. Since an individual's functioning and disability occurs in a context, the ICF also includes a list of environmental factors.
>
> As described in *The Guides Newsletter, AMA, January/February, 2008.*

With inclusion of Section 8.1b "AMA Guides" to the Act effective September 1, 2011, the "most current edition of the American Medical Association 'Guides to the Evaluation of Impairment' shall be used." Thus, Illinois is currently using the 6th edition.

b. Disability v. Impairment

The concepts of "disability" and "impairment" are different. As provided in the Guides:

> The relationship between impairment and disability remains both complex and difficult, if not impossible, to predict. In some conditions there is a strong association between level of injury and degree of functional loss expected in one's personal sphere of activity (mobility and ADL's*). The same level of injury is in no way predictive of an affected individual's ability to participate in major life functions (including work) when appropriate motivation, technology, and sufficient accommodations are available. Disability may be influenced by physical, psychological, and psychosocial factors that can change over time.
>
> *AMA Guides, 6th edition, p. 5 – 6.*
> (*activities of daily living)

In its most general terms, an impairment is the "injury" and its measureable results, the disability the "effect" it has upon the individual. The Guides cites the example of Christopher Reeve, whose cervical spine injury resulted in significant "impairment" but which offered a lesser "disability" to him as, due to his own and external resources, he was able to be highly functional and productive.

AMA Guides, 6th edition, p. 6.

i. Disability defined

Merriam Webster's dictionary defines disability as "a condition (such as an illness or an injury) that damages or limits a person's physical or mental abilities," or "the condition of being unable to do things in the normal way." Additionally, it can be the "limitation in the ability to pursue an occupation because of a physical or mental impairment."

"disability." Merriam-Webster.com. Merriam-Webster, 2014. Web. 9 January, 2014.

The 6th edition of the Guides defines disability as "activity limitations and/or participation restrictions in an individual with a health condition, disorder or disease."

AMA Guides, 6th edition, p. 5.

Prior to the most recent amendment to the Illinois Workers' Compensation Act, the Act did not formally define "disability." The "duration of disability" was used as the measure of wage differential entitlement in Section 8(d)(1). The portion "partial disability" bears to "total disability" was the basis for a person as a whole award in Section 8(d)(2). The phrase "partial

permanent disability," a term of art in the practice, compensated for "a further period for the specific loss" under Section 8(e). Disability, in general, was the permanent residual which resulted from the work related injury.

With the amendments to the Act in 2011, a new definition of permanent partial disability can be construed by what Section 8.1b says is required to establish permanent partial disability: an AMA impairment rating as set forth in subsection (a), along with Commission consideration of the five factors set forth in subsection (b).

ii. Impairment defined

Merriam Webster's dictionary defines impairment as to be in a "damaged or weakened" state, or "diminished in some material respect."

"impairment." Merriam-Webster.com. Merriam-Webster, 2014. Web. 9 January, 2014.

The 6th edition of the Guides defines impairment as "a significant deviation, loss, or loss of use of any body structure or body function in an individual with a health condition, disorder or disease."

AMA Guides, 6th edition, p. 5.

Section 8.1b of the Act does not define impairment but does set forth how it is to be established, with a report conforming to the requirements of subsection (a) to include "measurements of impairment" such as loss of range of motion and strength, atrophy, and "any other measurements that establish the nature and extent of the impairment."

iii. Impairment ratings - method

An impairment rating is to be performed after an individual has reached maximum medical improvement. The rating is to be based on four basic factors, 1) the clinical history, 2) the physical examination and the results of any objective testing performed, 3) an analysis of the clinical data, and 4) an application of the data to the criteria set forth in the Guides.

In general, impairments cannot exceed 100% of a whole person or the maximum assigned to any body part. Impairments are rated based on the body part where the injury primarily arose.

The Guides specifically sets forth that a licensed physician must perform an impairment rating. A chiropractic physician can perform an impairment rating limited to ratings of the spine.

A valid impairment rating report must contain the clinical evaluation, analysis of findings and discussion of how the impairment was calculated. Medical knowledge, generally accepted in the medical community, shall be used. Findings that conflict with established medical principles cannot be used to justify an impairment rating.

Motion and strength measurements should be analyzed carefully for any self limitation. Rating of future impairment shall not be provided.

If more than one method can be used to define an impairment, the method yielding the higher rating shall be used. Subjective complaints alone cannot be used to set an impairment rating. Finally, impairment ratings are to be rounded to the nearest whole number.

Pain related impairment can be assessed using the Guides, however, where it is possible to utilize an objective finding of illness or injury elsewhere in the Guides, that is the measure of impairment. Any pain not accompanied by objective ratable findings may be ratable to a maximum of 3% of a whole person. The impairment rating can be lowered if the examiner questions the credibility of the patient.

iv. Impairment ratings – modifiers

Modifiers are the variables that increase or decrease the grade, and thus the amount, of impairment. The Guides provides a series of adjustment grids based on reported impairment, functional history, physical examination, and clinical studies. Each of these is placed on a Grade Modifier between 0 and 4.

For example, a "diagnosis based" impairment adjustment grid will rate between Grade Modifier 0 to 4, depending on the degree of the problem: none, mild, moderate, severe or very severe.

Functional history, in turn, can be modified depending on whether the patient is: asymptomatic, has pain or symptoms only with strenuous activity, has pain or symptoms with normal activity, has pain or symptoms with less than normal activity, or has pain or symptoms even at rest. These grades, themselves, may be further modified depending on ability to perform self care activities, from fully to none at all. Further modifications exist for observed and palpatory findings, stability, and range of motion on exam, and for the imagining studies, from none available to showing very severe pathology.

The goal is to assess, as fully as possible, the level of impairment by considering as many objective factors as are necessary to determine the impact of the injury.

c. Section 8.1b of the Act

This section provides that permanent partial disability shall be established using the criteria it sets forth.

i. Who can prepare the AMA impairment rating

Section 8.1b provides that it shall be a physician licensed to practice medicine in all of its branches. The section does not specifically state that a chiropractic physician cannot perform an

impairment rating. However, in reviewing the Medical Practice Act which governs the practice of medicine in Illinois, distinctions are made between those who practice "medicine in all of its branches" and those who are "licensed to treat human ailments without the use of drugs or operative surgeries."

A physician is one who "is licensed under the Medical Practice Act to practice medicine in all of its branches." A chiropractor is defined as one who is "licensed to treat human ailments without the use of drugs or operative surgeries." There are minimum education requirements for each, separate and distinct from each other.

Illinois Medical Practice Act of 1987, 225ILCS60

As noted above, the AMA Guides requires the impairment rating be performed by a licensed physician. Unlike the Act, the Guides specifically provides that a chiropractic impairment rating shall be limited to the spine.

ii. What is required to conduct

The AMA Guides provides that an impairment rating shall be prepared with review of:

1. Review of the medical records for past medical history;
2. Review of the medical records for current history;
3. Note and reconcile any consistencies;
4. Review all diagnostic testing performed;
5. Review any laboratory testing performed.

The examination shall:

1. Create a line of communication between examiner and claimant;
2. Encourage full effort;
3. Document findings in the injured as well as non injured extremity, as appropriate;
4. Provide results of specific measurements taken;
5. Provide diagnoses, maximum medical improvement, and bases for conclusions.

The written report shall provide:

1. Clinical evaluation;
2. Analysis of the findings;
3. Impairment rating and how achieved.

iii. The five factors to be considered in determining permanent partial disability

The section delineates the five factors to be considered by the Commission in determining permanent partial disability: the reported level of impairment as set forth in the written report prepared per subsection (a), the occupation of the injured employee, the age of the injured employee at the time of the injury, the employee's future earning capacity, and the evidence of disability corroborated by the treating records.

The section goes on to provide that no single factor shall be the sole determining factor in setting disability. Finally, a permanency award is to set forth the relevance and weight of any of the factors used in addition to the level of impairment set.

Effective date of implementation. The section specifically provides that it shall be in effect for accidental injuries that occur on or after September 1, 2011.

II. Are the correct razors being used?

a. Evidentiary Issues

Section 8.1(b) of the Workers' Compensation Act does not refer to "evidence" or "proof" of permanent partial disability. Rather, it refers to "the following criteria", and then specifically refers to the five "factors". Even in the closing sentence of that section, the Legislature appears to have scrupulously avoided reference to "evidence" or "proof":

> "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. (Emphasis added)"

Under the amendment, therefore, the practitioner still has to plan and prepare for the introduction of relevant and admissible evidence.

A review of the four factors to be considered in addition to the AMA rating tells how permanency must be determined. Section (ii) requires consideration of the occupation of the injured employee. However, the Statute does not instruct on how to introduce evidence of occupation and presumptively, therefore, does not change the ordinary Rules of Evidence. It requires the consideration of age but again, does not change the requirements as to proof of age. The fourth factor (iv) requires a consideration of future earning capacity, but does not turn an otherwise inadmissible report from a vocational specialist into admissible evidence.

The fifth factor contains the only reference in the section at issue to "evidence". The Statute requires determination based on "evidence of disability corroborated by the treating medical records". Note that treating medical records and their admissibility into evidence are addressed

in a separate section of the Act, and thus Section 8.1(b), again, does not change the applicable Rules of Evidence (See 16 820 ILCS 305/16):

> The records, reports, and bills kept by a treating hospital, treating physician, or other treating healthcare provider that renders treatment to the employee as a result of accidental injuries in question, certified to as true and correct by the hospital, physician, or other healthcare provider or by designated agents of the hospital, physician, or other healthcare provider, showing the medical and surgical treatment given an injured employee...shall be admissible without any further proof as evidence of the medical and surgical matters stated therein.

i. Hearsay

As to evidence of AMA Impairment Ratings, Section 8.1(b) refers only to a report: "A physician...shall report the level of impairment in writing." Requiring a report in writing, however, does not make such a report admissible into evidence as an exception to the hearsay rule. An examination of Section 12 of the Act illustrates this point.

Section 12 allows an employer to obtain a medical examination of the Petitioner for, among other things, "the purpose of determining the nature, extent, and probable duration of the injury," and furthermore requires in most cases the generation of a written report:

> "In all cases where the examination is made by a surgeon engaged by the employer, and the injured employee has no surgeon present at such examination, it shall be the duty of the surgeon making the examination at the instance of the employer to deliver to the injured employee, or else his representative, a statement in writing of the condition and extent of the injury to the same extent that said surgeon reports to the employer and the same shall be an exact copy of that furnished to the employer."

Even though Section 12 requires the production of an IME report, it does not change the Rules of Evidence. An IME report is hearsay, and is not admissible into evidence:

> "The Rules of Evidence apply to all proceedings before the Commission or an Arbitrator except to the extent that they conflict with the Act. 50 Ill. Admin. Code, Section 7030.70(a)(2002); Paganelis v. Industrial Commission, 132 Ill.2d 468, 479, 139 Ill.Dec. 477, 548 N.E.2d 1033 (1989).

* * *

In Taylor (v. Kohli), 162 Ill.2d 91, 96, 204 Ill.Dec. 766, 642 N.E.2d 467 (1994), our Supreme Court held that, as a matter of law, an expert witness is not per se an agent of the party who hired him or her and therefore the expert's statement and opinions are not admissible as admissions against that party's interest...We have since applied the holding

in Taylor to the reports of examining physicians in workers' compensation actions. Kraft General Foods v. Industrial Commission, 287 Ill.App.3d 526, 531-32, 223 Ill.Dec. 119, 678 N.E.2d 1250 (1997). ... Because (the Section 12 doctor) was hired by (Respondent) to perform an independent medical examination of the claimant, rather than to assist in the treatment of his injury, his report is not admissible under the exception to the hearsay rule we announced in Fencl-Tufo Chevrolet, Inc. v. Industrial Commission, 169 Ill.App.3d 510, 514-15, 120 Ill. Dec. 15, 523 N.E.2d 926 (1988). (Greaney v. Industrial Commission, 158 Ill.App.3d 1002, 1010-11, 832 N.E.2d 331, 340-1 (1st. D. 2005). See also Weston Hotel v. Industrial Commission, 372 Ill.App.3d 527, 536-7, 865 N.E.2d 342 (1st. D. 2007)).

It is apparent that in crafting the 2011 amendments to the Workers' Compensation Act, the General Assembly was cognizant of, and considered, issues of admission of evidence and proof of facts. In revising Section 8.7 of the Act, for example the General Assembly added language stating "An admissible utilization review shall be considered by the Commission, along with all other evidence and in the same manner as all other evidence, and must be addressed along with all other evidence in determination of the reasonableness and necessity of the medical bills or treatment." In Subsection 5 of Section 7(i) of the Act, the General Assembly also provided requirements and procedures for obtaining the deposition of a physician who offers a utilization review report. It can fairly be concluded that having addressed evidence of the results of a utilization review, the General Assembly knew about problems of admitting reports and obtaining depositions when it wrote the amendment. Its failure to address those issues with respect to a Section 8.1(b) report, therefore, appears to have significance. Inclusio unius est exclusio alterius. (See Williams, Marq. L. Rev. 1930.)

There are presently no reported decisions from either the Commission or reviewing Courts addressing the admissibility of a Section 8.1(b) report over a hearsay objection. As a practical matter, therefore, until that issue is settled the practitioner should approach admission of 8.1(b) reports exactly as one would approach admission of a Section 12 report.

ii. Depositions

As practitioners before the Commission will be well aware, questions of admissibility of evidence and hearsay objections are confronted in virtually every workers' compensation trial and so consideration of 8.1(b) reports present no new or additional challenges. Start by asking the opposing party if they will stipulate to the admission of a report. As a practical matter, this saves time, effort, energy, and resources. As with IME reports, practical experience suggests that one who wishes to proffer the contents of a written report will ultimately be able to secure the admission of the information or opinions contained therein with direct testimony of the expert, and so there is little to be gained by the opponent by objecting to the report just in an effort to keep the information out of the record. A prepared attorney who wants to introduce the

opinions from a Section 12 report will either secure an agreement to its admissibility or will obtain the doctor's deposition.

iii. Weight

The real question for the practitioner is not whether they want to keep the information out, but rather if they wish to cross-examine the doctor. A deposition of the AMA rating physician gives both parties an opportunity to explore the testimony and opinions, and the bases thereof. The attorney proffering the report can obtain detailed testimony about the documents reviewed and the result of the examination. The doctor can be interrogated about the injury, treatment, and current clinical presentation. The doctor also can be asked to review the procedure whereby an impairment rating is obtained, including description of information obtained from the Petitioner, results of a Quick Dash survey, and clinical appearance and performance.

The physician can be asked to define and describe grade modifiers required by an impairment evaluation, explain his classification of the Petitioner and his injury, and explain or justify his findings and conclusions. He can also specifically justify the results of his opinion by referencing the impairment tables included in the Sixth Edition of the Illinois Guidelines. Unless the opposing party wishes to cross-examine the ratings physician, however, the report itself generally will contain the necessary information to support the conclusions contained therein. The real question is what can be obtained by cross-examination.

Cross examination allows the party opposing the opinions contained in the report an opportunity to challenge the structural incompatibility between the AMA rating system and the Workers' Compensation Act. For example, the cross examiner can point out circumstances where injury to a portion of a body part, like the base of the thumb, is converted by a chart to a larger body part, like the hand. The cross examining party can point out that AMA system may not allow the rating physician to incorporate into his assessment the fact that the patient had more than one operation.

On cross-examination, an honest rating physician will also acknowledge that AMA guidelines do not allow consideration of likely future deterioration. For example, the fact that a fracture went through an articular surface and will likely cause problems in the future is not by itself a factor in determining impairment. According to one preeminent impairment rating physician, consideration of the future effect of a work injury on future work life or future activities is not allowed by AMA Guidelines 6th Edition:

Q: Did you consider the future effect this injury is going to have on his work life…

A: It's not allowed by the AMA Guides, 6th Edition.

Q: So, an AMA guide impairment rating really isn't very effective in determining how this kind of injury is going to affect his future work life, is it?

A: No. It's (only) present (life).

Cross examination of the AMA ratings physician can help emphasize the most important consideration all parties must make in addressing an impairment report. The physicians themselves will help you explain how "impairment" is fundamentally different from "disability". The physician will also help explain why the impairment rating does not reflect the other four factors included in Section 8.1(d).

Regarding the weight to be given an impairment rating, the Statute itself states "In determining the level of disability, the relevance and weight of any factor used in addition to the level of impairment as reported by the physician must be explained in a written order."

iv. Who submits

Neither the Statute nor any precedent addresses the issue of who can submit an AMA Guideline report. Cases decided by the Commission, as included in the materials below, demonstrate however that in practice AMA Impairment Reports have been submitted into evidence by both parties. The cases below do not address circumstances in which a party objects to an AMA report based on hearsay. In such a case, as noted above, a deposition of the evaluating physician would be necessary. There appears to be no statutes or decisions limiting the authority of either party to either admit the report by stipulation or offer into evidence a deposition of the rating physician in accordance with stipulation or the applicable Rules of Evidence.

b. Other uses

i. Establish work restrictions

An AMA impairment report must be distinguished from an independent medical evaluation. Section 12 of the Act provides for an examination by a physician selected by the opposing party "for the purpose of determining the nature, extent, and probable duration of the injury received by the employee."

Section 8.1(b), on the other hand, requires a physician licensed to practice medicine to present a report including "an evaluation of "medically defined and professionally appropriate measurement of impairment."

ii. Settlement negotiation and pro se offers

The Statute is silent on the use of AMA Guideline ratings in settlement negotiations or pro se contract approval. One would expect as much. From a Respondent's standpoint, one would assume that an AMA Impairment Rating Report would be an integral part of evaluation of the case and the proffering of a settlement offer just like an IME report. From a Petitioner's standpoint, the simple truth is that an AMA rating is a factor that the Workers' Compensation Commission will ultimately consider when determining permanent partial disability and, therefore, a circumspect Petitioner's attorney should do the same. Similarly, one would presume that an AMA impairment rating could be submitted to the Workers' Compensation Commission in support of a settlement contract for purposes of pro se contract approval.

c. Required to meet burden of proof?

The question remains open as to whether a Petitioner has met his burden of proof by presenting a case without introducing an AMA Guidelines report. The materials that follow show that the Industrial Commission has rendered decisions and awarded permanent partial disability in cases in which no guideline report was introduced. This issue has yet to be decided by an Appellate Court. For that reason, the question of whether a burden of proof can be met is an open one. In deciding whether to obtain a report, read the statute carefully, evaluate your case, and even consider discussing the matter with the opposing side.

i. 8(e) and 8(d)(2)

ii. Section 8(d)(1)

By its terms, Section 8.1(b) applies only to specific losses. The Section itself describes how "permanent partial disability shall be established." Nothing in the Act suggests that AMA Guidelines are applicable to wage differential awards or permanent total disability awards. This, of course, is logical. Wage differential awards under Section 8(d)(1) provide awards to workers who become "partially incapacitated from pursuing (their) usual and customary line of employment."

iii. 8(e)(18) and 8(f)

Similarly, permanent total disability under Section 18(e)(18) requires the award of permanent total disability benefits as a result of two statutory losses and technically do not include a consideration of the worker's actual work capacity. Similarly, permanent total disability under Section 8(f) is incompatible with an impairment rating as it provides benefits to workers incapable of any employment. These awards relate to work capacity rather than permanent partial disability as that term is used in the Act.

Neither the Statute nor the case law as it has developed through the present address issues of admissibility, reliance, and use of AMA impairment reports. Until Courts decide otherwise,

however, one should anticipate that evidentiary issues will be resolved much as they were under Section 12. In the meantime, the impact of impairment ratings can be determined by a review of Commission decisions that have been handed down since the rating system became effective.

III. The Shave-Decisions Using/Not Using Section 8.1(b)

a. AMA Impairment Rating Tendered

In Thomas v. Peoples Gas, Light and Coke, 12 IL.W.C. 18268, the Commission modified the Arbitrator's award and increased it from 7.5% man as a whole to 12.65% man as a whole. Claimant was a 43 year old foreman and crew leader who injured his right shoulder when he attempted to pull a 300 foot roll of plastic piping. Claimant underwent a right shoulder arthroscopy which included a subacromial decompression, bicep tenodesis and open rotator cuff repair. The post operative diagnosis was right subscapularis tear and subluxated biceps tendon. Claimant was released to full duty but testified his shoulder continued to give him trouble with certain work activities necessitating assistance from co-workers. Claimant testified he had difficulty playing baseball with his nephew and performing chores such as gardening and lawn maintenance. Claimant also stopped playing golf after his release from care. Claimant testified to use of over the counter medication three to four times weekly and applied cold/heat to alleviate pain and swelling to his right shoulder.

Dr. Mash performed an AMA impairment rating at the request of Respondent and found Petitioner had a 5% upper extremity impairment which equaled a 3% impairment of the whole person. Petitioner did not offer an impairment rating. The Arbitrator noted only one impairment rating was provided and thus the evidence was uncontroverted. The Arbitrator then stated the AMA rating, Claimant's occupation as a foreman/crew leader performing construction laborer duties and supervising other employees, his age of 42 years, and Petitioner's treatment consisting of surgery and testimony were all assigned significant weight. The Arbitrator noted Petitioner returned to his prior position and was released to full duty. Thus no weight was assigned to future earning capacity.

Based on a "measured evaluation of all five factors" the Arbitrator determined Petitioner was entitled to 7.5% loss of use of the person as a whole. The Arbitrator's Decision was appealed to the Commission and the Commission modified the Arbitration Decision and stated "the Commission views the evidence in a slightly different light than does the Arbitrator, and thus modifies the Arbitrator's ruling regarding nature and extent. The Commission awards Petitioner 12.65% loss of use of his person as a whole." There was no indication by the Commission as to what factor or factors they viewed differently in awarding a higher permanency award.

In Liazuk v. Bolingbrook Police Department, 12 IL.W.C. 11804, the Commission affirmed the Arbitration Decision finding Claimant entitled to 5% man as a whole. Claimant was a 40 year old police officer who injured his low back while shoveling stone. Claimant underwent physical therapy and two epidural steroid injections at L3-4. Claimant had two MRI's. The first, done on September 29, 2009, showed a mild defused disc bulge at L3-4 and a small central disc protrusion as well as a disc herniation at L4-5. The second, performed on September 30, 2011, showed a central disc protrusion at L3-4 which now extended to the right of midline associated with deformity of the anterior surface of the thecal sac and spinal stenosis. At L4-5 there was a minimal central protrusion which abutted but did not deform the thecal sac. Claimant was examined at Respondent's request with Dr. Klaud Miller. Physical examination of the low back revealed no abnormal findings. Dr. Miller reviewed the MRI film of September 30, 2011 and agreed with the radiologist that Claimant had a "mild bulging disc at L3-4 and minimal disc bulge at L4-5." Dr. Miller stated there was no evidence at herniated disc at L4-5 seen on the earlier MRI of September 29, 2009. Dr. Miller diagnosed a lumbar sprain. Dr. Miller opined Claimant had an AMA impairment rating of 0%. Claimant's last visit with his treating physician documented Claimant had complaints of 0-3/10 pain, morning stiffness, and demonstrated a full range of motion without significant pain.

At trial, Claimant testified he had morning stiffness and low back pain which occasionally radiated into his right buttock. Claimant continued to work as a canine officer. Claimant testified he played less frequently in a "no contact" hockey league and has cut down on his weightlifting. Claimant also testified that he has not worn the "bite suit" at work for fear of re-injury and was unable to complete a recent department defensive training course due to the onset of low back pain.

In rendering an award of 5% man as a whole, the Arbitrator stated Dr. Miller's AMA rating was not helpful as he did not address the disc at L3-4. It was the Arbitrator's impression that Dr. Miller confused the two MRI reports and the findings at L3-4 and L4-5. The Arbitrator found persuasive the right-sided disc protrusion which was consistent with Claimant's complaints of right-sided low back pain that radiated into his right buttock, Claimant's medical treatment of physical therapy and two epidural steroid injections at L3-4, his ability to work without losing time, his inability to wear a "bite suit" since the accident, inability to complete his defensive skills training and curtailment of his person recreational activities. The Arbitrator's Decision did not specifically enumerate the five factors or the weight assigned to them under Section 8.1(b).

In Fassero v. UPS, 12 IL.W.C. 17291, the Commission affirmed the Arbitration Decision finding Claimant was entitled to 15% loss of use of a leg. Claimant was a 44 year old delivery man when he injured his right knee while walking on stairs. Claimant underwent surgery consisting of a right knee arthroscopy with posterior horn medial meniscectomy and arthroscopic debridement of the patella femoral joint. The post-operative diagnosis was internal derangement of the right knee with a posterior horn medial meniscus tear with chondromalacia of the medial facet of the patella femoral joint. Claimant was allowed to return to work regular duty approximately a month and a half after surgery. Claimant testified he had no problems performing his job duties after his release.

Claimant was examined at Respondent's request by Dr. Lawrence Li. Dr. Li diagnosed Claimant with a right knee medial meniscus tear with an excellent result. Dr. Li performed an impairment rating and found Petitioner had a lower extremity impairment of 1% which translated to a whole person impairment of 1%. Dr. Li noted Claimant walked without a limp and that his right knee range of motion was 0-120 degrees.

At trial, Claimant testified he felt there was "bone-on-bone" with every day activities and he currently wore a knee brace that was not prescribed by a physician.

In applying Section 8.1(b) to the permanency analysis, the Arbitrator noted Dr. Li's impairment rating was unrebutted by Claimant. The Arbitrator then described that there was very little evidence presented regarding the description of Claimant's occupation other than he had made deliveries for Respondent and specifically noted there was no evidence as to whether Claimant's job was "light", "medium" or "heavy" physical demand level position. He therefore gave only some weight to this factor. Concerning Claimant's age of 44 years, the Arbitrator concluded Claimant's disability would be moderately greater of that of an older individual because Claimant would have to live with the consequences of the injury for a longer period of time and therefore place some weight on this factor. No weight was given to future earning capacity as no evidence was submitted. The Arbitrator then discussed Claimant's treatment as well as his testimony in determining the evidence of disability was corroborated by the treating medical records. The Arbitrator placed great weight on the corroborating evidence of the records and Claimant's testimony in awarding 15% loss of use of a right leg. The Arbitrator specifically stated that in evaluating permanent partial disability, consideration is not given to any single numerated factor as the sole determinant and was not simply a calculation but an evaluation of all factors as stated in Section 8.1(b) of the Act.

In Reilly v. Con-Way Freight, Inc., 12 IL.W.C. 11083, the Commission affirmed the Arbitration Decision in awarding Claimant 27.5% loss of use of the right leg. Claimant was a 46 year old freight truck driver sales representative who slipped off a form lift and injured his right knee. Dr. McIntosh reviewed Claimant's MRI and diagnosed Claimant with a proximal fibular fracture and an ACL tear and recommended ACL reconstruction. Claimant underwent an arthroscopic ACL repair. Claimant underwent a period of work hardening and released to full duty. At the last visit, Dr. McIntosh noted Claimant had full range of motion and recommended home exercise for strengthening purposes.

At Claimant's attorney's request, Dr. McIntosh prepared an AMA rating and opined Claimant had 7% impairment of the extremity which translated to 3% impairment of the whole person. Claimant testified he returned to his usual and customary employment. He still used a hinged knee brace while working but did not use it at home or while performing leisure activities. Claimant testified his knee continued to improve but it ached from time to time but did not require medication. The Arbitrator applied the facts to Section 8.1(b) but did not state the amount of weight given to any of the five factors in arriving to an award of 27.5% loss of use of a leg.

In Oltmann v. Continental Tire The Americas, LLC, 12 IL.W.C. 11777, the Commission affirmed the Arbitration Decision in awarding Claimant 5% loss of use of a left hand. Claimant was a 49 year old right hand dominant labor trainer who injured his left wrist when he tripped and fell over a guardrail landing on his left hand. Claimant was diagnosed with a non-displaced fracture and provided a splint. The Decision did not describe which bone was fractured. Approximately one month later, it was noted Claimant was doing "a lot better" with good range of motion and Dr. Brown noted Claimant's residual symptoms would likely resolve and discharged Claimant to full duty and MMI. Dr. Brown prepared an AMA rating report in which he opined Claimant had a 0% impairment at the level of the left wrist. Claimant testified that he continued to work in his pre-injury position, had some occasional discomfort in the left wrist but continued to engage in recreational activities which included his four handicap golf game and acknowledged that he won his recreational golf league after he achieved maximum medical improvement.

In assessing the five factors pursuant to Section 8.1(b), the Arbitrator noted Claimant's AMA rating of 0% of the wrist, Claimant's employment, Claimant's age of 49 years, Claimant's release to his regular job and Claimant's testimony of some minor residual symptoms in the wrist. In considering the totality of the evidence, the Arbitrator awarded 5% loss of use of a left hand.

In Williams v. Flexible Staffing, Inc., 11 IL.W.C. 46390, the Commission modified and decreased the Arbitration Decision from 30% loss of use of a right arm to 25% loss of use of the right arm. Claimant was a 45 year old right hand dominant welder/fabricator who injured his right arm when he grabbed for a piece of falling rail. Claimant was diagnosed with a biceps tendon rupture that was surgically repaired. Claimant was released at maximum medical improvement but was noted to lack 5 to 10 degrees of full supination.

At the employer's request, Claimant was examined by Dr. Mark Levin. Claimant reported continued pain complaints for which he took narcotic pain medication and Dr. Levin noted Petitioner lacked full extension with his right arm. Dr. Levin opined Claimant had an AMA rating of 4% of a whole person or 6% loss of use of the right arm.

In applying Section 8.1(b) to the permanency analysis, the Arbitrator noted Dr. Levins AMA rating was defective as he referenced to "an AMA disability rating" even though he was rating impairment only and not permanent partial disability; did not specifically include loss of range of motion or any other measurements that establish the nature and extent of impairment; used a physical examination grade modifier of two indicating a moderate problem; Dr. Levin did not consider a grade modifier for clinical studies in his impairment report; and that Dr. Levin scored the QDASH report for functional history grade modifier as 23 but did not include a copy of the QDASH in his report so that the Arbitrator could review his findings.

The Arbitrator noted Claimant's occupation as a welder/fabricator and took judicial notice that his position would be "medium to heavy work" where a conclusion could be made Claimant's permanent partial disability would be greater than for an individual who performs lighter work. The Arbitrator considered Claimant's age of 45 years which would put him in a category of a somewhat younger individual and therefore his permanent partial disability would be more extensive of that of an older individual as he would have to live with permanent partial disability longer. The Arbitrator found Claimant's future earning capacity would be undiminished as he was able to return to full duty work but also noted Claimant no longer had a job which might negatively impact Claimant's future earning capacity. The Arbitrator further found Claimant demonstrated evidence of disability which was corroborated by his treating medical records.

In awarding 30% loss of use of right arm, the Arbitrator stated that the determination of permanent partial disability was not simply a calculation but an evaluation of all five factors and

consideration was not given to any single numerated factor as the sole determinant. In modifying the Arbitrator's Decision, the Commission did not specifically state as to what factor or factors led them to the conclusion Claimant was entitled to a lower award of 25% loss of use of a right arm.

b. AMA Impairment Rating Not Tendered

In Harper v. Southwestern Illinois College, 12 IL.W.C. 39942, the Commission affirmed the Arbitration Decision in awarding Claimant 3% loss of use of the body as a whole. The Arbitrator noted that neither party tendered into evidence an AMA impairment rating report. While not referencing to Section 8.1(b), the Arbitrator did discuss the five factors and noted Claimant was 32 years of age, worked as a bus driver, had low back pain complaints especially when sitting in one position for any length of time and when assisting wheelchair bound passengers. There was no evidence of any effect from Claimant's injury to her future earnings capacity. Claimant treated from October, 2012 to January, 2013 for soft tissue injuries to the left wrist, neck and low back, at which time all injuries were resolved.

In Brown v. Dot Foods, Inc., 12 IL.W.C. 08555, the Commission affirmed the Arbitration Decision in awarding Claimant 10% loss of use of the right foot. Claimant was a 22 year old order selector and worked on a forklift getting product to ship out and was involved in an accident with another forklift which crushed Claimant's right foot between two forklifts. Claimant underwent conservative treatment consisting of an immobilizer boot and crutches and was placed at maximum medical improvement approximately five months after the accident. Claimant did follow up with Dr. Mulshine approximately four months after the maximum medical improvement finding with continued complaints of pain in the right foot. Dr. Mulshine questioned whether there were any secondary gain issues at work and recommended Claimant give it some time to calm down.

In applying the Section 8.1(b) permanency analysis, the Arbitrator noted no impairment rating was submitted into evidence. Claimant was currently employed as a machine operator for a paper cup manufacturer. Claimant was 22 years of age. There was no evidence introduced concerning Claimant's future earning capacity. Claimant had minimally displaced fractures of the lateral cuneiform and proximal medial cuboid bones of the right foot, with intermittent swelling, pain and discoloration. At the last medical visit Dr. Mulshine stated he would not be surprised if Claimant had some vague ongoing pain across the dorsum of the foot.

The Arbitrator stated that all of the factors were taken into account in rendering the disability award. There was no indication whether the Arbitrator took into account Dr. Mulshine's final medical record which questioned Petitioner's subjective complaints.

In Lape v. State of Illinois Department of Vandalia Correctional Center, 12 IL.W.C. 13416, the Commission adopted the Arbitration Decision in finding Claimant was entitled to 15% loss of use of the left leg. Claimant was a 29 year old correctional officer who suffered a left knee injury from a slip and fall on wet floor. Claimant underwent surgery which consisted of an excision of an inflamed plica. There was no tear found in the medial meniscus. Claimant was released from care without restrictions. Claimant testified he was able to return to work full duty although he still had some ongoing discomfort in his knee.

In applying Section 8.1(b), the Arbitrator noted neither party tendered an AMA impairment rating into evidence. Claimant was a correctional officer. Claimant was 29 years of age. No evidence was submitted that Claimant's injury would have any effect on his future earning capacity. The testimony of Claimant's treating physician corroborated the need for surgery and it was noted Petitioner continued to experience discomfort in his left knee.

In Wadkins v. Pinckneyville Correctional Center, 12 IL.W.C. 2866, the Commission affirmed the Arbitration award of 2% loss the person as a whole. Claimant was a 54 year old correctional officer who suffered a right shoulder injury from falling at work. Claimant underwent conservative treatment consisting of over the counter pain medication, one injection and a home exercise program. Claimant was released from care full duty approximately three and a half months after his accident. In applying Section 8.1(b) of the Act, the Arbitrator noted neither party tendered an AMA report. Claimant was a correctional officer with the rank of lieutenant. Claimant was 54 years of age. Claimant had recently retired from his position. Claimant's disability was corroborated by the treating medical records with conservative treatment of over the counter pain medication, one injection and a home exercise program.

In looking at the factors, the Arbitrator believed the positive findings reported by Claimant's treating physician including the MRI finding showing tendinopathy and mild to moderate osteoarthritis provided a basis for an award. The Arbitrator also found Claimant's age and retirement along with the fact there were no work restrictions mitigated his degree of disability.