DISABILITY EVALUATIONS

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The cases and materials presented here are in summary and outline form. To be certain of their applicability and use for specific claims, we recommend the entire opinions and statutes be read and counsel consulted.
DISABILITY EVALUATIONS

I. INTRODUCTION

Disability evaluations under the Illinois Workers' Compensation Act are much more art than science. Unlike some states which have specific schedules defining how certain injuries will be compensated, Illinois awards permanent disability based upon a more subjective analysis of all evidence available on the issue of permanency. In deciding permanent disability on cases which are tried, arbitrators are free to consider the evidence and make a judgment as to the percentage loss awarded as a result of the petitioner's level of disability. Despite this level of subjectivity, experience, practice, and prior decisions have produced some degree of certainty in the level of permanent disability assessed to most injuries.

Disability, under the Act, covers a wide range of topics and can include temporary total disability, temporary partial disability, permanent total disability, and wage differential. For purposes of this section, we will analyze the Industrial Commission's approach to man as a whole cases, as well as specific loss cases. We will also analyze proposals which have been discussed as potential statutory changes to the Workers' Compensation Act in the area of disability evaluations.

II. MAN AS A WHOLE – SECTION 8(d)(2)

Compensation under section 8(d)(2) of the Illinois Workers' Compensation Act is “that percentage of 500 weeks that the partial disability bears to total disability.” When the petitioner sustains an injury that involves neither a disfigurement (section 8(c)) nor a scheduled loss (8(e)), it will be compensated under the man as a whole provisions of section 8(d)(2). Section 8(d)(2) addresses certain minimum PPD awards based on man as a whole as follows:

- Six-week minimum compensation for fractured skull or each fractured vertebrae;
- Two-week minimum compensation for facial fractures, including nasal, lachrymal, vomer, zygoma, maxilla, palatine, or mandible;
- Minimum three weeks compensation for each fractured transverse process; and
- Not less than 10 weeks compensation for loss of kidney, spleen, or lung.

It is important to note that all of the specific weeks mentioned above in 8(d)(2) are minimums. In most situations, the Industrial Commission will award more than the weeks outlined, taking into account additional evidence supporting higher levels of disability.

By far, back injuries represent the most common injury falling under 8(d)(2). Any injury to any level of the spine will be compensated based upon a man as a whole loss. Most workers' compensation practitioners become experienced at learning the Industrial Commission's approaches to certain types of back injuries. While permanency levels can range dramatically
from case-to-case based upon a review of the totality of the evidence, generally back injuries are compensated at a level of 5% man as a whole for minor back sprains, up to 50% man as a whole for more serious back injuries involving multiple surgeries. MRI findings documenting the presence of bulging or herniated discs also impact permanency evaluations for back injuries. As with all injuries, the ultimate level of recovery and presence of permanent restrictions bears on the permanency amount. Sometimes 8(d)(2) permanency awards involving back injuries are increased if there are disputed perm total or wage differential issues present in the case.

Section 8(d)(2) further provides that a petitioner also can recover under sections 8(b), 8(c), and 8(e), in addition to a man as a whole award under section 8(d)(2). For example, the petitioner was struck by a 4 x 6 piece of lumber resulting in cervical fusion for a herniated disc, as well as diminished use of one arm. The Appellate Court upheld an award for both a man as a whole (for the cervical fusion), as well as an award under section 8(e) for loss of use of the arm. *Mitchell v. Industrial Comm’n*, 148 Ill. App. 3d 690, 499 N.E.2d 999, 102 Ill. Dec. 209 (3d Dist. 1986).

An employee who injured a foot and two years later developed back pain and psychological disorders was awarded 100% loss of use of the foot under section 8(e) and 40% loss of use of a man under section 8(d)(2). *Minner v. Cook County Sheriff’s Office*, 83 WC 12778, 86 Ill. L.C. 136 (Feb. 5, 1986). In addition, where a bone graft is performed, a separate award for harvesting the bone graft from the donor site has been allowed. *Jewel Food Companies, Inc. v. Industrial Comm’n*, 256 Ill. App. 3d 525, 630 N.E.2d 865, 196 Ill. Dec. 700 (1st Dist. 1993).

While back injuries are the most common injury addressed under section 8(d)(2), man as a whole awards are also entered for virtually any type of disability which is not covered under section 8(e) involving scheduled losses. Any injury to the head is likely to be compensated based upon man as a whole. Abdominal injuries including hernias are also compensated based upon man as a whole. In the event the petitioner can prove a psychological injury, an award under section 8(d)(2) is also possible.

It is interesting to note that section 8(d)(2) clearly states that compensation will be awarded when “the employee sustains serious and permanent injuries.” In fact, a body of practice and case law has developed over the years which clearly results in man as a whole awards being entered when there is, in reality, little or no permanent disability. As an example, often following a back surgery to repair a herniated disc, the petitioner is fully recovered, and sometimes even better off physically than prior to the injury and surgery. Despite this, a generally accepted permanency award will almost always be entered. While it is important to analyze all evidence addressing the presence of permanent disability in evaluating permanency, it is rare for the Commission to find no permanency, even when there is strong evidence to support that conclusion.
III. **SECTION 8(e)**

A. **Scheduled Losses**

Section 8(e) of the Illinois Workers’ Compensation Act sets forth the number of weeks of compensation for permanent and total loss of specific body parts or percentage loss thereto. In addition, section 8(e) defines the parameters of statutory permanent total disability and the survival of actions when an employee is deceased prior to receipt of a permanent disability award. Section 8(e) further addresses the burden of proof in hearing loss claims and the calculation of compensable hearing loss. Although section 8(e) provides that once recovery is had under section 8(e), the employee “shall not receive any compensation under any other provisions of this Act” that has been interpreted to allow for an additional award for loss of use of a man as a whole (See, section 8(d)(2)).

Where a single accident occurs resulting in multiple injuries to a single extremity, the Industrial Commission may make more than one award, such as percentage loss of use of a hand and percentage loss of use to an arm, **providing** there are multiple injuries. Customarily, petitioner’s counsel will attempt to increase the value of a petitioner’s claim by arguing that the claim is compensable under the more significant body part (arm versus a hand).

The maximum weeks available for compensation for certain body parts is as follows:

<table>
<thead>
<tr>
<th>SCHEDULED LOSSES (100%)</th>
<th>Pre 2/1/06 (Except 7/20/05 to 11/15/05)</th>
<th>Effective 2/1/06 (and 7/20/05 to 11/15/05)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person as a whole</td>
<td>500 wks</td>
<td>500 wks</td>
</tr>
<tr>
<td>Arm</td>
<td>235 wks</td>
<td>253 wks</td>
</tr>
<tr>
<td>Amp at shoulder joint</td>
<td>300 wks</td>
<td>323 wks</td>
</tr>
<tr>
<td>Amp above elbow</td>
<td>250 wks</td>
<td>270 wks</td>
</tr>
<tr>
<td>Hand</td>
<td>190 wks</td>
<td>205 wks</td>
</tr>
<tr>
<td>Thumb</td>
<td>70 wks</td>
<td>76 wks</td>
</tr>
<tr>
<td>Index</td>
<td>40 wks</td>
<td>43 wks</td>
</tr>
<tr>
<td>Middle</td>
<td>35 wks</td>
<td>38 wks</td>
</tr>
<tr>
<td>Ring</td>
<td>25 wks</td>
<td>27 wks</td>
</tr>
<tr>
<td>Little</td>
<td>20 wks</td>
<td>22 wks</td>
</tr>
<tr>
<td>Leg</td>
<td>200 wks</td>
<td>215 wks</td>
</tr>
<tr>
<td>Amp at hip joint</td>
<td>275 wks</td>
<td>296 wks</td>
</tr>
<tr>
<td>Amp above knee</td>
<td>225 wks</td>
<td>242 wks</td>
</tr>
<tr>
<td>Foot</td>
<td>155 wks</td>
<td>167 wks</td>
</tr>
<tr>
<td>Great toe</td>
<td>35 wks</td>
<td>38 wks</td>
</tr>
<tr>
<td>Other toes</td>
<td>12 wks</td>
<td>13 wks</td>
</tr>
<tr>
<td>Hearing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both ears</td>
<td>200 wks</td>
<td>215 wks</td>
</tr>
<tr>
<td>One ear</td>
<td>50 wks</td>
<td>54 wks</td>
</tr>
<tr>
<td>Eye</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enucleated</td>
<td>160 wks</td>
<td>173 wks</td>
</tr>
<tr>
<td>One eye</td>
<td>150 wks</td>
<td>162 wks</td>
</tr>
</tbody>
</table>
1. **Amputations**

Bear in mind that while this chart refers to the weeks representing the scheduled loss, the rate to which these weeks are multiplied has been increased by the recent amendments to a minimum of 50% of the state average weekly wage in effect at the time of the injury. The current minimum rate applied to amputations is $466.13.

(a) Amputation of the first or distal phalanx of any thumb, finger or toe compensated at 50% of the value of the extremity. Amputation of more than one phalanx (mid-phalanx) considered loss of the entire thumb, finger or toe. Amount received for loss of more than one finger cannot exceed value for loss of a hand.

(b) Any loss of bone to a finger that is more than a *de minimus* loss will be compensated at a minimum of 50% loss of use of the digit. See, *Macon County Coal Co. v. Industrial Comm’n*, 367 Ill. 458, 11 N.E.2d 924 (1937). However, where the loss of bone is *de minimus* (1/16 of an inch) it did not constitute 50% loss under section 8(e)(8). *Edward E. McMorran & Co. v. Industrial Comm’n*, 290 Ill. 569, 125 N.E. 284 (1919).

2. **Hand Injuries**

Customarily, injuries to the wrist are resolved based on the loss of use of a hand. The loss of two or more digits or one or more phalanges of two or more digits of a hand may be compensated on the basis of loss of use of a hand; however, the amputation or loss of use of four digits in the same hand shall constitute complete loss of use of the hand.

3. **Arm Injuries**

Customarily, injuries that occur to the elbow and shoulder, as well as fractures to other bones in the arm, are resolved on the basis of loss of use of an arm. Amputation of the arm below the elbow shall be compensated as loss of use of an arm. Where amputation is above the elbow, an additional 15 weeks shall be paid. For amputations at the shoulder joint or so close that an artificial arm cannot be used, an additional 65 weeks shall be paid.

4. **Foot Injuries**

Customarily, ankle injuries, sprains, and fractures are resolved on the basis of a loss of use of a foot.

5. **Leg Injuries**

Amputation below the knee shall constitute loss of the entire leg. Amputation above the knee results in an additional 25 weeks compensation. Where amputation at the hip joint or so close to the hip joint that an artificial leg cannot be used or results in disarticulation of the leg at the hip joint, then an additional 75 weeks shall be paid. Keep in mind the special minimum rate which applies to all amputations.
6. **Eyesight**

Section 8(e)(16) provides for compensation for permanent *partial* loss of eyesight and hearing. The amount of PPD for vision loss is a question of fact for the arbitrator and Commission. *Walker v. Industrial Comm’n*, 72 Ill. 2d 408, 381 N.E.2d 238, 21 Ill. Dec. 160 (1978). There is not a standardized formula or table for measuring vision loss. In *Walker, supra*, the Supreme Court acknowledged use of the Wisconsin Vision Chart as a factor to be considered for measuring loss of vision although other factors were considered. The Wisconsin Vision Table sets forth the following percentages of disability:

<table>
<thead>
<tr>
<th>Uncorrected Vision</th>
<th>Disability Percentage</th>
<th>Uncorrected Vision</th>
<th>Disability Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>20/20</td>
<td>0%</td>
<td>20/60</td>
<td>35%</td>
</tr>
<tr>
<td>20/25</td>
<td>5%</td>
<td>20/70</td>
<td>40%</td>
</tr>
<tr>
<td>20/30</td>
<td>10%</td>
<td>20/80</td>
<td>50%</td>
</tr>
<tr>
<td>20/40</td>
<td>20%</td>
<td>20/100</td>
<td>75%</td>
</tr>
<tr>
<td>20/50</td>
<td>25%</td>
<td>20/150</td>
<td>85%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20/200</td>
<td>100%</td>
</tr>
</tbody>
</table>

Generally, permanent partial disability associated with partial loss of eyesight is to be determined by the actual injury to the victim’s eyes as he “used” them at the time of injury. If he used no corrective lenses, then the difference between uncorrected vision at the time of injury and thereafter is the measure of damage; if he used corrective lenses, then the difference between corrected vision at the time of injury and thereafter is the measure of damage. *Motor Wheel Corp. v. Industrial Comm’n*, 75 Ill. 2d 230, 388 N.E.2d 380, 26 Ill. Dec. 665 (1979). As a practical matter, an arbitrator will make an award for permanent partial loss of eyesight even where the petitioner wore glasses prior to the occurrence and his corrected vision after the occurrence is the same but has required a more powerful lens prescription.

7. **Hearing Loss – Section 8(e)(16)(a)-(f)**

Section 8(e)(16)(a)-(f) sets forth standards and calculations for both compensability of hearing loss and calculating the amount to be paid for permanent partial loss of use of hearing.

Audiology reports will graph the amount of hearing loss at several frequency levels. For purposes of the Workers’ Compensation Act, only hearing loss at 1,000, 2,000 and 3,000 cycles is considered. The use of a hearing aid to restore functional hearing is not considered.
In calculating hearing loss, the hearing loss at 1,000, 2,000 and 3,000 cycles is averaged. The petitioner must experience an average loss of 30 decibels in order for the loss of hearing to be compensable. Where the loss of hearing does not average 30 decibels, the claim is non-compensable. For that amount of hearing loss in excess of 30 decibels, a statutory factor of 1.82 is multiplied to the hearing loss and that becomes the percentage of hearing loss.

**Hearing Loss Example**

**Graph**

![Audiogram Graph]

O = Left ear  
X = Right ear

**Decibel Loss**

Left  
Date .5 1K 2K 3K 4K 6K 8K  
03/28/96 5 35 50 40 50 35 NT

The audiogram graph reveals hearing loss at .500 to 8,000 cycles. The relevant hearing loss at 1,000, 2,000 and 3,000 cycles for the left ear is 35, 50, 40, respectively. The average decibel hearing loss is, therefore, 41.6 which is a compensable hearing loss exceeding the 30 decibel minimum. Subtracting the 30 decibel minimum from 41.6 leaves a net of 11.6 multiplied by 1.82 for the statutory allowance, leads to a figure of 21.11. This constitutes 21.11% loss of use of hearing in the left ear, multiplied by 54 weeks, results in compensable hearing loss of 10.5 weeks, which will be multiplied to the PPD rate.
Total loss of hearing in one ear under the new amendments is 54 weeks; whereas total hearing loss in both ears is 215 weeks. The Occupational Diseases Act, however, provides for 100 weeks compensation for complete loss of use of hearing in one ear. As a practical matter, compensable hearing loss due to occupational noise levels will be pursued and awarded under the Occupational Diseases Act, whereas traumatic hearing loss secondary to a single accident or explosion will be compensated under the Workers’ Compensation Act.

An average hearing loss of 85 decibels shall constitute 100% loss of use of hearing.

Where occupational exposure is the purported cause of loss of hearing, the petitioner bears the burden of proving exposure for a sufficient period of time to cause permanent impairment under the following schedule:

<table>
<thead>
<tr>
<th>Sound Level DBA</th>
<th>Slow Response</th>
<th>Hours Per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>90</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>92</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>97</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>100</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>102</td>
<td>1½</td>
<td></td>
</tr>
<tr>
<td>105</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>110</td>
<td>½</td>
<td></td>
</tr>
<tr>
<td>115</td>
<td>¼</td>
<td></td>
</tr>
</tbody>
</table>

Note the schedule on the previous page only applies to occupational noise exposure and does not apply to traumatic or exposure to explosion.
B. Credits – Section 8(e)(17)

The Act allows the employer to obtain a credit for prior injuries stating:

In computing the compensation to be paid to any employee who, before the accident for which he claims compensation, had before that time sustained an injury resulting in the loss by amputation or partial loss by amputation of any member, including hand, arm, thumb or fingers, leg, foot or any toes, such loss or partial loss of any such member shall be deducted from any award made for the subsequent injury. For the permanent loss of use or the permanent partial loss of use of any such member or the partial loss of sight of an eye, for which compensation has been paid, then such loss shall be taken into consideration and deducted from any award for the subsequent injury.

820 ILCS 305/8(e)(17).

Where the employee has a prior injury resulting in partial amputation, the employer receives a credit for the partial amputation to the hand, thumb, fingers, leg, foot or toes regardless of whether there was a prior workers’ compensation claim or award. Where there was not an amputation, but rather a partial loss of use to any such member or partial loss of eyesight, then the disability to which the employer is entitled to a credit will be based on prior workers’ compensation payments for permanent partial disability.

There is no provision for a credit to prior awards or payments for loss of use under a man as a whole. Isaacs v. Industrial Comm’n, 138 Ill. App. 3d 392, 485 N.E.2d 1093, 92 Ill. Dec. 850 (5th Dist. 1985).

Note: The statute refers to “such loss” with regard to the credit to be obtained; and, therefore, the credit is based on the prior percentage loss of use award and not the dollar amount previously received by the petitioner. For example, if the petitioner previously received an award of 5% loss of use of an arm, equating to the sum of $2,000, the employer in the subsequent loss of use of an arm case will receive a credit for the 5% of an arm, as opposed to a credit for the dollar amount previously awarded.

IV. PRACTICE POINTERS

- Always remember a permanency evaluation is a subjective determination made by the arbitrator. There will be cases where there is little or no evidence of disability, and a permanency award at a certain level is likely. Arbitrators are given this discretion, and will likely follow traditionally accepted guidelines for values on certain injuries. While evidence of no disability should always be used in an effort to reduce exposure, certain injuries have certain values irrespective of that evidence.
Permanency values of certain injuries will vary depending upon the venue. It is necessary to have knowledge of the arbitrator who will be deciding the case before evaluating permanency exposure. Also, certain arbitrators vary in terms of what they will approve on a pro se settlement as opposed to what they will award at trial. Consultation with counsel is important on this point.

A surgery will always increase the permanency value of an injury. Even when the surgery completely cures the effect of the injury resulting in no permanency, the mere fact of the surgery moves the permanency value to a different level.

Objective tests such as MRIs, EMG/NCVs, x-rays, and CT scans are often considered to be important by the Commission in evaluating permanency. A back strain without surgery which includes an MRI identifying a herniated disc will result in an increased permanency amount. A non-operated carpal tunnel will be worth more if the condition is objectively identified on an EMG/NCV. Conversely, results from these tests identifying no objective abnormality can reduce permanency values.

Even when the petitioner returns to his normal job, permanent restrictions can also elevate permanency values. Developing opinions clearly stating that the petitioner is released without restriction and is at MMI from a treatment standpoint will help to reduce permanency exposure.

The final permanency amount is based upon the petitioner’s average weekly wage and PPD rate, which means that similar injuries can be worth dramatically different amounts depending upon the average weekly wage. Technically, this should not, and often does not enter into permanency evaluations made by arbitrators and commissioners. In practice, arbitrators often take into account the amount of the wage, and the ultimate dollar amount of a potential permanency award. This can sometimes be used to the employer’s advantage. When there is a low wage rate involved, a higher permanency percentage may still result in a dollar amount which represents a reasonable settlement.

In recent years, the Commission has been more likely to enter permanent total wage differential awards. Petitioner’s attorneys will constantly try to develop evidence to establish wage differential exposure, in an effort to increase permanency. It is important to pay attention to countering this evidence early in the case. The sooner it becomes clear the petitioner can return to work at a level comparable to pre-injury levels, the sooner a reasonable permanency amount can be negotiated.

V. POSSIBLE LEGISLATIVE CHANGE

Much discussion has taken place recently regarding potential legislative changes which would bring greater objectivity and certainty to the determination of disability evaluations. Employer interest groups have made numerous proposals regarding the need for permanency evaluations
to track the objective medical evidence, which arguably in some cases would reduce permanency values.

Most proposals being discussed include use of the *AMA Guides to the Evaluation of Permanent Impairment*. This is the most widely used guide for determining impairment and disability in workers’ compensation systems around the country, although the manner in which the AMA Guides are used varies dramatically. Some states make use of the sixth edition published in 2007, while other states still use the fifth edition published in 2000 and the fourth edition published in 1990. Illinois is one of the few states in the nation that uses no officially published guideline for determining disability or impairment.

Debate rages as to the effectiveness of the AMA Guides in determining disability. Critics of the AMA Guides point out they are published for the purpose of quantifying impairment, not disability. They also are argued to be less objective than advertised, due to the level of judgment employed by the physician when applying the guides. Proponents of the AMA Guides argue they outline at least some objective standard. The current debate in Illinois is centered on the hope that a disability evaluation under the AMA Guides will often result in a lower percentage of loss than is typically seen under the current system.

In fact, when analyzing the manner in which the guides are applied, it is not certain they will always be helpful in reducing permanency amounts. An example of this can be seen by looking at a simple application of the AMA Guides to a cervical spine injury. The guidelines require evaluation in several different categories as follows:

1. **(0% impairment)**
   - No significant clinical findings
   - No muscle spasm or guarding
   - No documentable neurological impairment
   - No alteration in structural integrity
   - No fractures

2. **(5-8% impairment)**
   - History and exam include:
     - Muscle spasm
     - Asymmetrical loss of range of motion
     - Complaints of radiculopathy without objective findings
     - No alteration – structural integrity

   **OR**

   - Significant radiculopathy
   - Disc herniation at expected site verified by imaging study
- Patient improvement after non-operative treatment

*OR one of the following fractures:*

- Less than 25% compression of one vertebral body
- Healed posterior element fracture without loss of structural integrity or radiculopathy
- Spinous or transverse process fracture with displacement

3. (15-18% impairment)

- Significant signs of radiculopathy
- Dermatomal pain and/or sensory loss
- Loss of reflexes
- Loss of strength
- Muscle atrophy
- Neurological impairment verified by electro diagnosis

*OR*

- Significant radiculopathy with disc herniation verified by imaging study
- Improvement of radiculopathy following surgery

*OR one of the following factors*

- 25-50% compression of one vertebral body (healed without loss of structural integrity)
- Posterior element fracture with displacement under the spinal canal (healed without loss of structural integrity)

4. (25-28% impairment)

- Bilateral or multi level radiculopathy
- Alteration in motion segment integrity determined from flexion extension radiographs as 3.5 millimeters or greater of translation or angular motion 11 degrees greater than each adjacent level (radiculopathy need not be present)

*OR*

- More than 50% compression of one vertebral body without residual neurological compromise

5. (35-38% impairment)

- Significant impairment of the upper extremity requiring adaptive functional devices
- Single level total neurologic loss
- Multi level neurological dysfunction

The above is actually an over simplification of the criteria the examining physician would look to in making an impairment evaluation. The physician is required to make conclusions that fall within a prescribed range. When compared to the percentage of loss under the current system for certain cervical spine injuries, it is easy to isolate situations where a rating under the AMA guides would be lower. Conversely, it is easy to imagine situations where a physician could arrive at a higher rating than would typically be assessed under the current system.

The manner in which the AMA guidelines would be used under various legislative proposals in Illinois to determine disability evaluations is also not clear. While a number of proposals have been circulated, the most recent proposal offered in the form of a bill as of the time of production of these materials is as follows:

(k) For accidental injuries that occur on or after the effective date of this amendatory Act of the 97th General Assembly, permanent partial or total disability shall be certified by a physician and demonstrated by use of medically defined objective measurements that include, but are not limited to: loss of range of motion; loss of strength; and measured atrophy of tissue mass consistent with the injury. In determining the impairment, subjective complaints shall not be considered unless supported by and clearly related to objective measurements. The then-current edition of the American Medical Association’s “Guides to the Evaluation of Permanent Impairment” shall be applied in determining the level of disability under this Act.


Clearly, this language would leave a large degree of flexibility with the physician in determining a disability rating. Although the AMA Guides are referenced, and the language indicates those guides shall be applied, the language clearly contemplates that the AMA impairment rating will not be determinative. Additional criteria including but not limited to loss of range of motion, loss of strength, and measured atrophy of tissue mass can also be considered.

In short, the legislative proposals which have been discussed, and the general nature in which the AMA Guides are used and applied, would appear to maintain a large degree of subjectivity and flexibility in the determination of disability evaluations. Both the physician who will be giving a rating under the AMA Guides, and the arbitrator who will be making a final determination of disability will maintain flexibility in arriving at the final rating. An additional concern in this process is that the petitioner’s attorney will always have direct access to the treating doctor who will be making the impairment rating under the AMA Guides.

Presumably, any legislative change which is enacted will maintain the ability of the employer to retain an expert to perform an independent disability evaluation under the AMA Guides.
Obviously, the arbitrator would then have to evaluate the opinions of all ratings offered into evidence at trial. It remains to be seen whether or not any legislative change on this issue can have meaningful impact on the level of disability ratings currently seen under the existing system.
Craig practices and has a leadership role in the firm’s workers’ compensation and employment law practice groups. Craig began his career at Heyl Royster as a summer clerk while in law school and became an associate in the firm’s Peoria office in 1985. He has spent his entire career with Heyl Royster and became a partner in 1993. He is recognized as a leading workers’ compensation defense lawyer in the state of Illinois and has handled all aspects of Illinois workers’ compensation litigation including arbitrations, reviews, and appeals. He has developed expertise in the application of workers’ compensation to certain industries including hospitals, trucking companies, municipalities, large manufacturers, school districts, and universities.

In addition to his expertise in litigated cases, Craig has developed a reputation for counseling employers regarding overall management of the workers’ compensation risk. Through seminars and presentations to local and national industry groups, in-house meetings, regular claims review analysis, and day-to-day legal counsel, Craig assists his clients in looking beyond each individual case in an effort to reduce overall workers’ compensation expense. His comprehensive approach to workers’ compensation issues also includes third-party liability and lien recovery issues.

Currently, Craig serves as Vice Chair of the workers’ compensation committee of the Defense Research Institute. He has also chaired DRI’s Program Committee and in that role assisted in nationally acclaimed teleconferences on specific issues relating to workers’ compensation defense. He has been designated as one of the “Leading Lawyers” in Illinois as a result of a survey of Illinois attorneys conducted by the Chicago Daily Law Bulletin. Craig is actively involved in supporting many local charitable organization and civic causes. He was the 2008 recipient of the Peoria County Bar Association’s Distinguished Community Service Award.

Public Speaking
- “Elements of a Winning Workers’ Compensation Program”
- “Family Medical Leave Act (FMLA); Americans with Disabilities Act (ADA); and Workers’ Compensation”
  Risk Control Workshop (2010)
- “Medical Science, Industrial Commission Science - Understanding the Industrial Commission’s Approach to Medical Issues”
  Lorman Education Services (2008)
- “The Employee Who Can’t Return to Work: Wage Differentials, Vocational Rehabilitation & Job Placement”
  Lorman Education Services (2008)

Professional Recognition
- Martindale-Hubbell AV Rated
- Selected as a Leading Lawyer in Illinois. Only five percent of lawyers in the state are named as Leading Lawyers.
- Peoria County Bar Association 2008 Distinguished Community Service Award

Professional Associations
- American Bar Association
- Illinois State Bar Association
- Peoria County Bar Association - Board Member and Chair of By-laws Committee
- Defense Research Institute - Workers’ Compensation Committee - Vice Chair

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

Education
- Juris Doctor, University of Illinois, 1985
- Bachelor of Arts-History (Summa Cum Laude), Bradley University, 1982