NO. 4-09-0677WC Order Filed 3/24/11

IN THE APPELLATE COURT OF ILLINOIS

FOURTH DISTRICT

Workers' Compensation Commission Division

KAREN LYNN HAWKINS, Plaintiff-Appellant, v. WORKERS' COMPENSATION COMMISSION *et al.* (Apostolic Christian Home, Defendant-Appellee).	)))))))	Appeal from Circuit Court of Woodford County No. 08MR29 Honorable John B. Huschen, Judge Presiding.

PRESIDING JUSTICE McCULLOUGH delivered the judgment of the court.

Justices Hoffman, Hudson, and Donovan concurred in the judgment.

Justice Holdridge dissented.

ORDER

Held: The circuit court of Woodford County correctly confirmed the decision of the Workers' Compensation Commission (Commission), finding claimant, Karen Lynn Hawkins, was not entitled to receive payment of certain medical expenses under the Workers' Compensation Act (Act) (820 ILCS 305/1 *et seq.* (West 2002)).

Claimant filed an application for adjustment of claim pursuant to the Act, seeking benefits from employer, Apostolic Christian Home, for back injuries she sustained on April 3, 2003. On May 30, 2007, an arbitration hearing was conducted where the only contested issues were the nature and extent of clamant's permanent disability and the amount of medical expenses to be paid by employer. The arbitrator found claimant was permanently partially disabled to the extent of 35% of the person-as-a-whole

and denied her request for payment of medical bills. Claimant appealed to the Commission, which unanimously affirmed and adopted the arbitrator's decision. She then sought judicial review with the Woodford County circuit court, which confirmed the Commission's decision. In the instant appeal, claimant maintains that the Commission erred in denying her medical expenses.

Claimant worked for employer for 17 years as a Certified Nurse Assistant (CNA). Her job duties included assisting nursing home patients with functions such as walking, bathing, and getting in and out of bed. On April 3, 2004, Claimant injured her back while attempting to make a patient’s bed. She sought medical treatment and was referred by her family physician to Dr. Keith Kattner, a neurosurgeon. Initially, Dr. Kattner recommended conservative treatment. However, when conservative treatment failed, he recommended claimant undergo artificial disc replacement surgery. On February 5, 2005, claimant was evaluated by Dr. Brett Taylor, an orthopedist, at employer's request. Dr. Taylor concluded that claimant’s condition of ill-being was causally related to her work injury and agreed with Dr. Kattner’s recommendation for artificial disc replacement surgery.

Claimant testified a dispute arose between her and employer over whether Dr. Kattner or Dr. Taylor would perform the

recommended surgery. Dr. Kattner proposed to charge significantly more for the procedure than Dr. Taylor. Also, Dr. Kattner had never before performed an artificial disc replacement procedure, while Dr. Taylor had performed several such procedures. Claimant chose Dr. Kattner because she felt more comfortable with him and because he would perform the operation in Bloomington, Illinois, which was approximately 35 miles from claimant's home. Dr. Taylor would have performed the procedure at Barnes Hospital in St. Louis.

On April 27, 2005, Dr. Kattner performed the surgical procedure at BroMenn Hospital (BroMenn) in Bloomington, Illinois. The record includes a bill from BroMenn for $78,637.71, and shows claimant submitted it to her husband's group medical insurer, Blue Cross/Blue Shield of Illinois (Blue Cross). After requesting and receiving a letter from employer's workers' compensation insurance carrier, indicating it would deny coverage for the procedure, Blue Cross paid $77,420.71, leaving a deductible in the amount of $1,217 to be paid by claimant. Employer's workers' compensation carrier then paid claimant $1,217 which she sent to BroMenn. BroMenn provided a letter to claimant's attorney, showing its bill had been paid in full. At arbitration, claimant testified that, to her knowledge, BroMenn's bill had been paid in full and she owed no balance due to BroMenn.

On April 4, 2007, Blue Cross notified employer's workers' compensation insurance carrier that it had a lien on any workers' compensation medical benefits which might be payable to claimant. Employer introduced evidence that it had paid Blue Cross $50,000 to settle its lien. The record contains a letter from Blue Cross to employer's attorney, dated May 29, 2007, showing Blue Cross would accept $50,000 "to fulfill the lien obligation ***."

The arbitrator ruled that claimant was not entitled to any medical expenses charged by BroMenn. The Commission affirmed and adopted the arbitrator's decision, and the circuit court of Woodford County confirmed the decision of the Commission.

This appeal followed.

The sole issue on appeal is whether the Commission erred in not awarding medical benefits to the claimant for expenses incurred at BroMenn. We find the Commission committed no error.

The Act entitles a claimant to all reasonable and necessary medical expenses incurred to cure or relieve the effects of his or her accidental injury. 820 ILCS 305/8(a) (West 2002). "The claimant bears the burden of proving, by a preponderance of the evidence, his entitlement to an award of medical expenses under section 8(a)." *Westin Hotel v. Industrial Comm'n*, 372 Ill. App. 3d 527, 546, 865 N.E.2d 342, 359 (2007).

The Commission (DeMunno, Masurto, Gore) unanimously affirmed Arbitrator Neal, finding:

> "Respondent has introduced evidence that it has reached an agreement with BlueCross BlueShield for reimbursement for payments made by BlueCross BlueShield to Bromenn Healthcare (Respondent's Exhibit 2). This exhibit indicates Respondent has compromised the claim with BlueCross BlueShield for less than the amount claimed by Petitioner in his [sic] Exhibit.
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> Petitioner has further testified that she owes no money to Bromenn Healthcare, and, in fact, received a check from Respondent's carrier for her out-of-pocket deductible (Petitioner's Exhibit 13). Despite this, Petitioner still seeks an Award of $78,637.71 from Respondent.
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> In this case, the evidence reflects that with respect to the Bromenn Healthcare bill, that bill has been paid in full. The question is the amount owed by Respondent. Respondent has introduced evidence that the

bill has been compromised with the healthcare Insurer. Petitioner has been reimbursed for her out-of-pocket expenses, and readily admitted to such. Evidence reflects that Petitioner is not liable for any out-of-pocket for any expenses to Bromenn Healthcare. Therefore, awarding any sum to Petitioner as a result of that bill is moot and unnecessary.

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The evidence also establishes that Bromenn has been paid in full, and that BlueCross BlueShield has reached an accommodation with Respondent's carrier. *** Under Section 8.2e [of the Act (820 ILCS 305/8.2(e) (West 2006))], 'if the employee participates in a group health plan, the provider may submit a claim for services to the group health plan. If the claim for service is covered by the group health plan, the employees' responsibility shall be limited to applicable deductibles, co-payments and co-insurance. *** A provider shall not bill or otherwise attempt to

recover from the employee the difference between the providers charge and the amount paid by the employer or the insurer on a compensable injury.'

Therefore, the Petitioner is not at risk for any additional charges in this case *** the bill from Bromenn Healthcare has been paid and Petitioner is not entitled to any further payment directly from Respondent on the Bromenn Healthcare bills."

The claimant wants to be given the (face values) full amount of the medical bills even though there are no outstanding claims by any provider. The record shows BroMenn's bill was paid in full; employer reimbursed claimant for her out-of-pocket expenses; and claimant, by her own admission, is not responsible for any further charges. The Commission committed no error.

For the reasons stated, we affirm the circuit court's judgment, confirming the Commission's decision.

Affirmed.

JUSTICE HOLDRIDGE, dissenting:

The sole issue on appeal is whether the Commission erred in not awarding medical benefits to the claimant for expenses incurred at BroMenn Hospital. I would find that the Commission erred as a matter of law in failing to award her

medical expenses for the BroMenn bill.

Under section 8(a) of the Act, an employer is required to provide or pay "the negotiated rate, if applicable, or the lesser of the health care provider's actual charges or according to a fee schedule, subject to section 8.2, in effect at the time the service was rendered for all the necessary first aid, medical and surgical services" (820 ILCS 305/8(a) (West 2006)) which are reasonably required to treat the claimant's accidental injuries. As is the case with any element of a workers' compensation claim, the claimant bears the burden of proving, by a preponderance of the evidence, his or her entitlement to an award of medical expenses under section 8(a). *Max Shepard, Inc. v. Industrial Comm'n*, 348 Ill. App. 3d at 903.

As to the amount of medical expenses to be paid by the employer, section 8(a) requires the employer to pay either: (a) the negotiated rate, if applicable; or (b) the lesser of the health care provider's actual charges; or (c) according to a statutory fee schedule in effect at the time the services were rendered. 820 ILCS 305/8(a) (West 2006). Here, a statutory fee schedule is not at issue. Moreover, there is no evidence that any negotiated rate was applicable to BroMenn's services, since the record contains no indication that BroMenn reduced the cost of its services. In fact, the record only established that, between Blue Cross and the employer's workers' compensation

carrier, those two had settled Blue Cross's lien between themselves. There is nothing in the record to indicate that BroMenn returned any of the $77,420.71 it received for treating the claimant.

Apostolic maintains that no evidence was introduced that the amount sought by Hawkins for the services rendered by BroMenn in the amount of $77,420.71 was reasonable. It maintains that the amount accepted by Blue Cross ($50,000) established conclusively that the reasonable value of BroMenn's services was only $50,000. It further maintains that the record established that BroMenn, in fact, accepted $50,000 as payment in full for its services. There is no such proof in the record. The record indicates only that BroMenn billed $78,637.71 for its services and received that amount ($77,420.71 from Blue Cross and $1,217 from Hawkins) as payment for its services. There is nothing in the record to indicate that BroMenn billed and was paid $50,000.

The only evidence in the record concerning the amount of medical expenses incurred by Hawkins's treatment at BroMenn was the health care provider's actual charges, as evidenced by BroMenn's invoice. Moreover, the record shows that BroMenn received the full amount of its invoice in payment for its services. It is well settled that when evidence is admitted, through testimony or otherwise, that a medical bill was for treatment rendered and the bill has been paid, the bill is *prima*

facie reasonable. *Land & Lakes Co. v. Industrial Comm'n*, 359 Ill. App. 3d 582, 590-91 (2005).

I would find that the Commission's decision not to award Hawkins any medical expenses was erroneous as a matter of law since it failed to award medical expenses in accordance with section 8(a) of the Act. I would also find that the Commission erred in relying upon section 8.2(e) of the Act, which applies to medical expenses incurred after February 1, 2006. 820 ILCS 305/8.2(e) (West 2006). The medical expenses at issue herein were incurred in April 2005. I would agree that, had the medical expenses at issue been incurred after February 1, 2006, the Commission's decision would have been correct as a matter of law.[1]

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[1] Effective February 1, 2006, the Act was amended to provide that medical expenses paid by group health care providers would be paid without recourse to the employee: "If the employee participates in a group health plan, the provider may submit a claim for services to the group health plan. If the claim for service is covered by the group health plan, the employee's responsibility shall be limited to applicable deductibles, co-payments, or co-insurance." 820 ILCS 305/8.2 (West 2005) as amended by P.A. 94-227 (eff. February 1, 2006). Had this stautory provision been in effect in the instant matter, only the co-payment of $1217 would have been recoverable under the Act.

The claimant acknowledges that, while the Commission erred in not awarding her the entire $77,420.71 in medical expenses paid on her behalf to BroMenn, she seeks from the employer only $27,420.71, reflecting a credit to the employer for the $50,000 paid to Blue Cross. She maintains that, at a minimum, she and her attorney would have sought their share of the "common fund" created by her attorney's actions on her behalf. Under the common-fund doctrine, "an attorney who performs services in creating a fund should in equity and good conscience be allowed compensation out of the whole fund from all those who seek to benefit from it. *Baier v. State Farm Insurance Co.*, 66 Ill. 2d 119, 124 (1977). A claim for attorney fees under the common fund doctrine is an equitable remedy wherein the attorney maintains a cause of action on his or her own behalf against all those who have a claim to the fund allegedly created by the efforts of that attorney. *Tenney v. American Family Mutual Insurance Co.*, 128 Ill. App. 3d 121, 124 (1984). As such, a claim under the common fund doctrine must be brought in a separate cause of action by the claimant's attorney in the circuit court, a court of equity. See *Taylor v. State Universities Retirement Systems*, 203 Ill. App. 3d 513, 520 (1990) (Attorney who represented occupational diseases claimant before the Industrial Commission made common fund doctrine claim in the circuit court on the Commission's permanent partial disability

benefit award where the Retirement System claimed reimbursement for disability retirement benefits it paid during pendency of the claim before the Commission). Thus, whatever claim the claimant's attorney may have over the medical expenses paid on behalf of the claimant must be pursued in a separate cause of action, and the common fund doctrine has no relevance in the instant proceedings.

The record shows that BroMenn's bill for $78,637.71 was paid in full. Given that the bill for $78,637.71 was actually paid to BroMenn, under section 8(a) of the Act, the employer was responsible for the health care provider's actual charges. I would find the Commission erred as a matter of law in not awarding BroMenn's actual charges. I would reverse the decision of the Commission and remand the matter to the Commission with instruction that it award the claimant medical expenses of $78,637.71. Upon remand, in view of the fact that the claimant did not seek the $50,000 already paid by the employer, the employer would be able to claim a credit for amounts previously paid by it on behalf of the claimant for these expenses.

I acknowledge that if the matter was to be remanded to the Commission, there is a possibility that a windfall of $27,420.71 might benefit the claimant. However, I would point out that the employer has created this unique problem by trying to circumvent the purposes of the Act in the first instance. At

the time the employer negotiated the settlement with Blue Cross, there was no mechanism under the Act for the employer to pay reasonable medical expenses outside the application for adjustment of claim under the Act. Moreover, the record supports the conclusion that BroMenn received $78,637.71 as reasonable and necessary medical expenses. These expenses should have been paid in a manner consistent with the Act. While it may not be equitable to award a possible windfall to the claimant by following the letter of the Act, the Commission has no equitable powers. *Daniels v. Industrial Comm'n*, 201 Ill. 2d 160, 165 (2002). The only powers the Commission possesses are those granted to it by the legislature, and any action it takes must be specifically authorized by the legislature. *JMH Properties, Inc. v. Industrial Comm'n*, 332 Ill. App. 3d 831, 833 (2002). The Act in effect at the time this matter was before the Commission required the Commission to award reasonable and necessary medical expenses to the claimant. I would have reversed the Commission on that basis.