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Appellate Court Confronts Medical Bill Payment Conundrum in Workers' Compensation Claims

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INTRODUCTION


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The Governor's Office and the General Assembly are currently considering many controversial changes to the Illinois Workers' Compensation Act. It is unclear what legislative changes, if any, will be enacted during this legislative term. Current legislative proposals address restrictions upon an injured worker's choice of medical care; these proposals would also lower the current amount of payment that a physician may receive for medical services that are provided to the injured worker. If enacted, the legislation would have a significant impact upon the ability of injured workers to receive quality medical care from the best medical practitioners. However, these proposals do not address the vexing problems relating to the payment of medical bills in disputed or denied claims.

In Illinois, physicians and other medical providers receive payment for medical services pursuant to the Medical Fee Schedule, as set forth in the Illinois Workers' Compensation Act. Often, in a disputed claim, medical bills may be submitted for payment to a group medical provider. The amount paid under the group plan is usually at a different rate than under the Medical Fee Schedule. In other instances, medical bills might be paid by Medicare or Medicaid/Public Aid. In these instances, questions have arisen in the practice before the Illinois Workers' Compensation Commission as to whether the injured worker may claim the full amount of the medical bill, the amount of the medical bill due under the fee schedule, or whether the obligation of the employer is limited to the amount paid by the group plan, Medicare or Medicaid/Public Aid. The purpose of this article is to focus on a recent case from the appellate court, *Tower Automotive v. Illinois Workers' Compensation Commission*, 347 Ill.Dec.863, 943 N.E.2d 153(Ill. App.1st Dist. Jan.31, 2011), rehearing denied (March 2, 2011), that attempts to resolve these vexing issues. The result of the decision may be interpreted as limiting the liability of the employer for payment for medical services in workers' compensation claims.

In a case of first impression, the Illinois Appellate Court, in Tower Automotive, restricted the amount of recovery that an injured worker can claim for medical bills when those bills were paid by a source other than the employer or employer's workers' compensation insurance carrier. In Tower Automotive, the wife of the injured worker had group insurance, which was used to pay the disputed medical bills. The court resolved the issue as to whether recovery is limited to the amount paid by the wife's group insurance, or whether the injured worker may recover the full amount of the medical bills.

The appellate court has determined that the collateral source rule is not applicable to the payment of medical bills under the Workers' Compensation Act ("Act"). Future litigation will involve interpreting the holding of the Tower Automotive decision to determine whether it is applicable to the key provisions of the 2005 amendments to Section 8(a). In essence, future litigation will determine whether the payment of medical bills by a source other than the workers' compensation carrier will qualify as the "negotiated rate," thereby limiting recovery of medical benefits for those claims for payment of medical bills after February 1, 2006. P.A. 94-0277 (eff. July 20, 2005) (amending 820 ILCS 305/8(a)).

BACKGROUND

Collateral Source Rule and its Application to Payment of Medical Bills in Workers' Compensation Claims

In *Arthur v. Catour*, 216 Ill.2d 72, 833 N.E.2d 847 (2005), a personal injury case, the Illinois Supreme Court addressed the issue of whether a plaintiff at common law could recover the full amount billed by a medical provider or the amount paid by a group insurance carrier. In Arthur, the plaintiff incurred $19,314.07 in medical expenses, but due to a contractual agreement between the plaintiff's healthcare provider and insurance company, the group insurance carrier paid $13,577.97. Id. The court held that the plaintiff could recover the amount billed by the medical provider. Id. The court based its decision on the collateral source rule, which states that "benefits received by the injured party from a source wholly independent of, and collateral to, the tortfeasor will not diminish the damages otherwise recoverable from the tortfeasor." Id. The court in Arthur set forth that the justification for the collateral source rule is that a tortfeasor should not take advantage of the contracts that exist for the benefit of the injured party where the tortfeasor does not contribute to the cost of the contract. 216 Ill.2d 72.

The Arthur decision was applied in workers' compensation cases presented to the Commission. The Commission was spilt on the issue of whether the employer should pay the full amount billed by the medical provider or the amount paid by group insurance. In Crosby v. Anderson Hospital, 05 IWCC 0264, 2005 WL 1325066 (IWCC April 6, 2005), the injured worker's husband's group insurance paid a portion of the disputed medical bills. The Commission ordered the employer to pay the full amount of the medical bills and not the amount paid by group insurance. Id. The Commission cited Arthur as a basis for its decision. Id. However, in *Colborn v. Wal-Mart*, 94 IWCC 17928, 2001 WL 1692569 (Ill. Indus. Com'n Nov. 5, 2001), the Commission held that the negotiated adjustment or discounts by the group insurance plan of the injured worker's subsequent employer must be taken into consideration when determining the amount of medical expenses owed to the injured worker. Additionally, in *Teich v. Quick International and Subcontracting Concepts*, 07 IWCC 0832, 2007 WL 2152862 (IWCC June 29, 2007), the

Commission found that the injured worker was entitled to the amount of medical expenses approved by Medicare and BlueCross/Blue Shield and not the full amount charged by the medical provider.

The case of Tower Automotive resolves the split in the Commission regarding whether the award for medical bills should reflect the actual charges from the medical provider (the usual and customary charges) or the amount paid by another source, such as group insurance, Medicare or Public Aid, for accidents that occurred prior to February 1, 2006.

2005 Amendments Relating to Medical Bills

Prior to the amendment of the Act in 2005, the standard for payment of a medical bill was "that which is usual and customary for similar services in the community where the services were rendered." *Nabisco Brands, Inc. v. Indus. Com'n*, 266 Ill.App.3d 1103, 641 N.E.2d 578 (1st Dist. 1994). To admit a medical bill into evidence, it was necessary to satisfy the foundational requirements. *Land and Lakes Co. v. Indus. Com'n*, 359 Ill.App.3d 582, 834 N.E.2d 583 (2d Dist. 2005). The party also had to prove that the medical bill was reasonable. Id. A bill was presumed to be reasonable if it had been paid. Id. (citing *Baker v. Hutson*, 333 Ill.App.3d 486, 775 Ne.E.2d 631 (Ill. 2002)). The reasonableness of a medical bill could be established through the "testimony of a person having knowledge of the services rendered and the usual and customary charges for such services." Id. The witness would need to testify that the bill was fair and reasonable. Id.

Section 8(a) was amended in July of 2005 (effective date February 1, 2006) to provide that the amount of compensation which shall be paid to the employee for an accidental injury not resulting in death is: the employer shall provide and 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, and all necessary medical, surgical and hospital services thereafter incurred.

820 ILCS 305/8 (a). The amendments changed the standard by which medical bills were paid from the usual and customary charges to the negotiated rate or the lesser of the actual charges or fee schedule amount. Prior to the 2005 amendments, the Workers' Compensation Act did not include the term "negotiated rate." The Act did not define the term "negotiated rate." Thus, in the practice before the Worker's Compensation Commission, the issue has arisen as to whether payments made by group insurance, or some other source, such as Medicare or Medicaid/Public Aid, are considered a negotiated rate under Section 8(a).

Facts of Tower Automotive

In Tower Automotive, the injured worker worked for the employer as a material handler. In May of 2005, he began experiencing tingling in his hands and elbows as a result of a cervical spine injury. He sought medical treatment, which included various diagnostic tests, physical therapy and two (2) surgeries, a C3-C5 cervical fusion and a revision to the original fusion. At the arbitration hearing, the injured worker testified that the medical expenses were paid for by the group insurance provided by his wife's employer. The total amount that the medical providers charged was $165,167.54: the injured worker paid $1,183.27 out of pocket; the group insurance carrier paid $52,671.82; and the health care providers "wrote off" $111,298.35 of their charges.

The Arbitrator awarded Petitioner $165,289.16 in medical expenses, which represented the actual amount charged by the medical providers for medical services rendered. The Commission affirmed and adopted the Arbitrator's decision. The circuit court confirmed the Commission's decision.

Appellate Court Decision

The employer argued that the maximum that it was required to pay the injured worker for the medical bills was the amount actually paid to the medical providers, or $52,671.82. The appellate court agreed with the employer and reversed the holding of the circuit court with regard to the payment of the medical bills. The court specifically held that the Commission should award the injured worker the "amount actually paid to the providers of medical services rendered to him as a result of his injuries of June 30, 2005, and to require Tower to pay and hold claimant harmless from the payment of any reasonable future medical expenses necessary to cure or relieve him from the effect of his accident injury of June 30, 2005." (emphasis not in original).

The injured worker relied on the "collateral source rule" to argue that the employer was required to pay $165,167.54, the full amount charged by the medical providers, and not $52,671.82, the reduced amount that was paid by group insurance. The injured worker relied on the Arthur case to support its argument. The court rejected the injured workers' argument.

In explaining its rationale, the court set forth that the Workers' Compensation Act is a remedial statute and, as a result, must be distinguishable from an action in tort. There is no "wrongdoer" in a workers' compensation claim. With regard to payment of the medical bills, the court noted that the purpose of the Act is to relieve the employee of the costs and burdens on his care. Section 8(a) requires the employer to "provide and pay" for all necessary medical care related to the work-related accident. By limiting the amount the employer is required to pay under the Act to the amount actually paid, the purpose of the Act is satisfied. Thus, the court found that the collateral source rule did not apply to the right to recover under the Act. The collateral source rule is confined to common law cases.

The court noted in dicta that the holding "is of limited significance, as the legislature has seen fit to amend section 8(a) of the Act to provide that employers are obligated to provide and 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.'" 820 ILCS 305/8(a).

Justice Stewart dissented in part and concurred in part. The dissent would have held that the collateral source rule did apply to workers' compensation claims. Thus, the employer would have been obligated to pay the full amount charged by a medical provider. The dissent noted that when the Act was amended, "no provision was made for a reduction of the amount billed to the amount paid to the medical provider through a third party health insurance contract." The dissent would have held that the employer is obligated to pay the reasonable value of the medical services rendered to the employee. In support of his decision, Justice Stewart relied upon Hill Freight Lines, Inc. v. Industrial Commission, 36 Ill.2d 419, 223 N.E.2d 140 (1967).

Analyzing the "Dicta"

The court noted in dicta that the amendatory changes to Section 8(a), which were enacted in July 2005, apply to "accidental injuries that occur on or after February 1, 2006." This is the first time that the court has set forth that the amendments are applicable to accidental injuries that occurred after February 1, 2006. Therefore, a question exists as to whether the Medical Fee Schedule applies to treatment rendered after February 1, 2006 for injuries that occurred before February 1, 2006.

Tower Automotive resolved the issue of whether an employer's obligation for payment of medical bills is limited to the actual charges for medical services or the amount paid by group insurance for medical services provided before February 1, 2006. However, Tower Automotive did not specifically address how payments made by group insurance carriers should be treated for post amendment cases.

The dicta in the majority opinion creates significant questions as to whether group insurance payments should be considered a "negotiated rate" under Section 8(a). The meaning of the dicta in Tower Automotive is unclear. There are two (2) interpretations for the dicta: 1) that group insurance payments constitute a negotiated rate under Section 8(a); or 2) that group insurance payments do not constitute a negotiated rate under Section 8(a). The court does not specifically state whether group insurance payments would be considered a negotiated rate. Future litigation is required to resolve the issue of whether payments made by group insurance constitute a negotiated rate under Section 8(a).

The dissenting opinion supports the interpretation that group insurance payments constitute a negotiated rate. However, the dissent does not agree that group insurance payments should constitute a negotiated rate. The dissent expressly noted that in the amended Act "no provision was made for a reduction of the amount billed to the amount paid to the medical provider through a third party health insurance contact." The dissent also expressed concern over the majority's holding based on public policy. It explained that employers may deny claims so that group insurance would pay the medical bill. The employer would receive the benefit of the bargain that the group insurance carrier has with the medical provider. Thus, the concern expressed by the dissent, in light of its comment that the amended Section 8(a) does not specifically include group insurance payments, may imply that the majority would consider payments made by a group insurance carrier a negotiated rate under the amended Act.

Arnold G. Rubin concentrates his practice in the area of workers' compensation petitioner's law. He has represented clients at all levels of proceedings in the workers' compensation process including arbitration, review, circuit court, appellate court and supreme court. He has been listed in The Best Lawyers in America since 1995, SuperLawyers since 2006, and Leading Lawyers since 2004 including for the past two years being recommended by his peers as the number one workers' comp petitioner lawyer in the state, based upon the Leading Lawyers surveys. He received his B.A. from Northwestern University in 1975 and his J.D. from Chicago-Kent College of Law—Illinois Institute of Technology in 1978.

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