

Review of Illinois Workers' Compensation

JUNE 2011

SPECIAL EDITION

WORKERS' COMPENSATION REFORM – HOUSE BILL 1698 – A NEW REALITY

INTRODUCTION AND HISTORY

PROVISIONS IN THE NEW ACT – SUMMARY AND ANALYSIS

1. Burden of Proof Defined
2. Standards of Conduct for Hearing Officers
3. Employee Leasing Company Filing Requirements
4. Sanction Powers Given to Commission Insurance Compliance Division
5. Alternative Dispute Resolution Pilot Program
6. Medical Payment Changes – 1st section
7. TPD Formula Changed
8. Wage Differential Limitations Placed
9. Carpal Tunnel Cases – New limitations – Reduction in the Value of a Hand
10. Preferred Provider Program
11. Determination of Permanent Partial Disability
12. Medical Fee Schedule – Amendments and Reductions
13. Additional Medical Fee Changes
14. Electronic Claims Processing
15. Utilization Review – Amendments and Enforcement
16. Intoxication and Drug Use – Rebuttable Presumption Defense
17. Arbitrators and Commissioners – Rules, regulations and terminations
18. Attorney Gift Ban
19. Claims by Commission Employees sent to be heard by Independent Arbitrator
20. Fraud penalties – Defined

CONCLUSION



Significant Workers' Compensation statutory changes have been approved by the legislature and are awaiting Governor Quinn's signature. Attached is a Special Edition Newsletter summarizing the statutory changes and their effect on costs and claims handling. Please feel free to contact me if you have any questions concerning the statutory changes and how best to use the new statute to benefit your workers' compensation program. If your company would like a presentation on the statutory changes, please contact me and I will arrange a seminar date for your company.

CONTACT INFORMATION

Michael E. Rusin
312.454.5119
merusin@rusinlaw.com

10 S. Riverside Plaza
Suite 1530
Chicago, IL 60606

www.rusinlaw.com



REVIEW OF ILLINOIS WORKERS' COMPENSATION SPECIAL EDITION – WORKERS COMPENSATION REFORM LEGISLATION

June 2011
By Michael E. Rusin

WORKERS' COMPENSATION REFORM – HOUSE BILL 1698 – A NEW REALITY

INTRODUCTION AND HISTORY

It appears significant workers' compensation reform in Illinois may finally occur on **September 1, 2011.**

Illinois workers' compensation benefits first skyrocketed in 1975 when Democrats controlled both houses of the legislature and the governor's office. The 1975 Act drastically increased rates. It included automatic escalators in benefits and free choice of medical. As a result, benefits over the past 35 years have continued to rise exponentially. In the past 35 years, there have been attempts to reign in workers' compensation costs. However, there was never any serious legislation enacted to decrease exorbitant employer costs.

In 2005, the Democrats again controlled the legislature and Democratic Governor Rod Blagojevich (a convicted criminal) was in charge. He enacted "reform" legislation which imposed a ridiculously generous medical fee schedule and even further increased benefits to claimants. The new Act effective February 1, 2006 vaulted Illinois workers' compensation costs to one of the highest in the country. An Oregon study last year stated that Illinois workers' compensation costs were the third most expensive in the nation.

Workers' compensation reform became an election issue in the fall of 2010. Republican candidate, Senator Bill Brady stated he would reform a workers' compensation if he were elected. However, he lost the election and Governor Pat Quinn had no intention of reforming workers compensation.

However, multiple news articles from the Belleville News Democrat identified some significant issues with respect to Illinois workers' compensation. The most significant issue was the identification of almost \$10 million paid out to guards (and the warden) at the Menard State Prison for repetitive trauma claims. In addition, some unethical activities by two Arbitrators were brought to light. Business leaders began to demand workers' compensation reform. Caterpillar threatened to leave the state.

Democratic leaders finally were embarrassed by entire Illinois Workers' Compensation system and began to support the move for workers' compensation reform. One Democratic state representative (John Bradley from Marion, IL) even filed a bill to abolish workers' compensation in its entirety if the parties could not agree on reform.

Workers' compensation reform is more than a labor/business issue. Many parties are involved including the State and all municipalities. The costs are real and expensive. In great part, some of the biggest players in the workers' compensation system are the doctors and hospitals. Doctors and hospitals have received greater reimbursement from workers' compensation carriers in Illinois than any other insurance carriers and certainly a lot more than government reimbursement through Medicare or Medicaid. Medical providers have been most opposed to workers' compensation reform legislation.

For the last several months, legislators and lobbyists for the various business, labor and medical providers groups have been engaged in negotiating a reform bill. Trial lawyers have been given very little input.

A compromise bill emerged at the very end of the legislative session and was passed by the Senate. However, it failed in the House. Workers Compensation reform appeared dead this year. Surprisingly, on the last day of the legislative session and just before the midnight deadline, the bill was recalled for a vote and passed by a slim margin. The House needed 60 votes to pass the measure and the vote was 62-43 in favor. Democrats voted for the bill and virtually all Republicans opposed it.

None of the parties appear to be happy with the results. Business groups are complaining that the reforms are insufficient. Medical providers are complaining the most because the medical fee schedule reimbursement rate was cut by 30%. The bill represents a compromise of all the various positions. To a certain extent, the bill breaks new ground not anticipated by many of the parties involved.

The bill now sits on Governor Quinn's desk and is very likely to be signed into law. If signed the effective date of the statute is September 1, 2011. Most provisions in the Act will go into effect on that date and apply to accidents which occur on and after September 1, 2011. Some provisions in the Act go into effect January 1, 2012.

Please allow me to summarize and comment on the changes in the statute and how it will affect case handling and case costs.

PROVISIONS IN THE NEW ACT - SUMMARY AND ANALYSIS

1. Burden of Proof Defined.

Section 1 of the Act is amended to add a new section, Section 1(d). The new paragraph provides "To obtain compensation under this Act, an employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of employment."

Comment: The addition of this paragraph in the Act is of questionable significance. The Act never specifically stated that an employee had the burden of proof by a preponderance of the evidence to

prove that he sustained accidental injuries arising out of and in the course of employment. However, the Act had been interpreted by the courts over the years to require an employee to bear the burden of proof and to prove his case by a preponderance of the evidence. Employees have always been required to prove that their accidental injuries both arise out of and in the course of their employment.

Consequently, this additional paragraph appears to be meaningless with respect to changing the compensability of current claims. At most, it appears the legislature has simply codified existing case law. This prohibits courts from reducing the current burden of proof but the addition of the section does not appear to change existing case law on a claimant's burden of proof.

2. Standards of Conduct for Hearing Officers

The legislation adds a new section of the Act, 1.1, setting forth standards of conduct for Commissioners and Arbitrators. The new Act provides that "Commissioners and Arbitrators shall dispose of all workers' compensation matters promptly, efficiently, and fairly, without bias or prejudice. Commissioners and Arbitrators shall be faithful to the law and maintain professional competence. Commissioners and Arbitrators are to be faithful to the canons of the code of judicial conduct adopted by the Supreme Court of Illinois."

Further, the legislation provides "Decisions of an Arbitrator or a Commissioner shall be based exclusively on evidence in the record of a proceeding and material that has been officially noticed. Any findings of fact made by the Arbitrator based on inquiries, investigations, examinations, or inspections undertaken by the Arbitrator shall be entered into the record of the proceeding."

Comment: This new section imposing standards of conduct on Arbitrators and Commissioners is not surprising. The legislature was embarrassed by the actions of several Arbitrators and wanted to take action to impose new rules and regulations on the Arbitrators. However, this section of the statute does not require that the Arbitrators do anything differently than what they should have already been doing. Commissioners and Arbitrators should have already been disposing of workers' compensation matters promptly, efficiently and fairly, without bias or prejudice. They should have already been basing their decisions exclusively on the evidence in the record. Therefore, I do not see that this legislation will affect decision making. Now, it is really more a function of enforcing this requirement and eliminating any hearing officers who fail to follow proper procedures. The problem is how to discern which Arbitrators are acting fairly and without bias and which Arbitrators are not. We are certainly aware of several Arbitrators who rule consistently in favor of claimants on disputed cases. I do not see how the new legislation is going to affect our ability to change the way those individuals render decisions.

3. Employee Leasing Company Filing Requirements

Section 4 of the Act was amended to add Section 4(a-2). The additional language relates to employee leasing companies. The paragraph requires all employee leasing companies to provide to the Commission information about each workers' compensation policy it obtains. The employee leasing company is required to provide to the Commission information about any client company

named as an additional insured, an informational schedule which is attached to the master policy identifying the client companies and all certificates of insurance issued to client companies.

Comment: The Commission has had a number of cases where valid claims have been brought against companies who had been insured through an employee leasing company but, unfortunately, some employee leasing companies have not properly obtained insurance for their member companies. The actions of some employee leasing companies have created some cases for which there is no insurance available and other cases where there are significant disputes over who is responsible for the insurance. This additional language should give the Commission the power to require employee leasing companies to be more reputable. However, this section does not affect the average employer at all.

4. Sanction Powers Given to Commission Insurance Compliance Division

Section 4(d) of the Act is amended to give some additional sanctioning power to the Illinois Workers' Compensation Commission Insurance Compliance Division. This amendment grants the power to an investigator from the Insurance Compliance Division to issue a citation to any employer not in compliance with the workers' compensation insurance requirements under the Act. Fines can be imposed against noncompliant employers of not less than \$500.00 and not more than \$2,500.00.

Comment: The legislature has been focused on uninsured employers for a while now. They continue to impose more and more penalties on noncompliant employers. Fines that are paid fund the Injured Workers Benefit Fund. However, for the average employer, this has no bearing on their workers' compensation costs or premiums.

5. Alternative Dispute Resolution Pilot Program

A new Section 4(b) is added to the Act. This is entitled Collective Bargaining Pilot Program. This section of the Act allows the director of the Department of Labor to select two labor organizations to participate in alternative dispute resolution rather than have their members file workers' compensation claims with the Illinois Workers' Compensation Commission. This pilot program is limited to two labor unions and will apply to only "construction employers." The unions are entitled to come up with a program as part of a collective bargaining agreement that would include:

1. Alternate dispute resolution to resolve claims;
2. An agreed list of medical treatment providers;
3. A list of impartial physicians to conduct IMEs;
4. The creation of a light duty program;
5. A list of vocational rehabilitation consultants;
6. The establishment of joint labor management safety committees and safety procedures.

Any agreement reached between the labor unions and the construction employers has to last for two years. They have to get approval from the workers' compensation carrier. They have to have procedures with respect to the administration claims. They have to have forms for the filing of claims and they have to have a procedure in mind for treatment and adjudication of claims.

Significantly, the benefits that employees are entitled to under this procedure cannot be any less than the benefits provided for under the Act.

Comment: Construction employers and unions have been pushing for the last several years to have their claims decided outside the workers' compensation system. This section of the Act provides them an alternative on a pilot program so that they can do it. Some Unions and Employers have decided they are in a better position to resolve claims than having the cases be heard by the Commission. The unions don't trust the attorneys and the employers don't trust the Commission. Unions strive to have greater importance to their members and have promised quicker results for their members without paying attorney fees. Employers seek to avoid Commission decisions and save on attorney fees and other transactional costs. Obviously, right now, this will affect only a small group of individuals, especially as it is a pilot program. However, if the labor unions and construction employers demonstrate success with this program, we can expect that other employers will attempt to seek similar programs.

6. Medical Payment Changes – 1st section

Section 8(a) of the statute was amended. This is the medical provision section of the statute which obligates the employer to pay for reasonable and necessary medical treatment limited to the Fee Schedule set forth in Section 8.2. The amendment limits the medical provider fees “even if a health care provider sells, transfers or otherwise assigns an account receivable for procedures, treatments or services covered under this Act.”

Comment: This section of the Act is intended to prohibit excessive charges involving health care providers who contract with outside companies to provide services. It appears to be directly related to Med Finance type organizations. These organizations agree to fund disputed medical treatment. They then contract with physicians to provide the treatment at reduced rates but then charge the employer rates equal to or greater than the Fee Schedule. Because the Illinois Fee Schedule is so generous, companies like Med Finance were able to make significant profits. The amendment to the statute should end these unreasonable profits.

7. TPD Formula Changed

Section 8(a) is also amended as to the calculation of temporary partial disability. The statute was amended to create temporary partial disability as of February 1, 2006. Oddly, the temporary partial disability calculation is contained in the medical provision of the Act, Section 8(a). The new temporary partial disability calculation “is equal to two-thirds of the difference between the average amount that the employee would be able to earn in the full performance of his or her duties in the occupation which he or she was engaged at the time of the accident and the **gross** amount which he or she is earning in the modified job.”

Comment: This change in the statute makes great sense. The prior TPD calculation was eminently unfair and difficult to calculate. The prior calculation set the TPD rate at two-thirds of the difference between what petitioner's gross earnings would have been before the accident compared to his net earnings while on light duty. Now, with the change, employers can calculate TPD based on what a

claimant's gross earnings would have been if he had not been injured minus what his actual gross earnings are times two-thirds. The prior statute was simply unfair. This change is welcome.

8. Wage Differential Limitations Placed

Section 8(d)(1) providing for wage differential benefits is amended. The calculation of wage differential remains the same but a cap is imposed on the length of time that an individual can receive wage differential benefits. The new Act provides "for accidental injuries that occur on or after September 1, 2011, an award for wage differential under this subsection shall be effective only until the employee reaches the age of 67 or five years from the date the award becomes final, whichever is later."

Comment: This represents a significant change in the statute as to wage differential claims. Many claimants have been aggressively pursuing wage differential awards because courts have stated that wage differential awards are payable for life.

Further, it is very difficult to change a wage differential award once it is entered and becomes final. Pursuant to our statute, even if a wage differential claimant subsequently earns more than his wage at the time of the accident, an employer is not entitled to change the wage differential award unless the employer can also show there has been a significant change in the claimant's physical condition.

This section of the Act will most strongly favor employers dealing with claimants in their 50s and early 60s. We routinely have been seeing claims where 60-year old claimants allege wage differential and were faced with paying wage differential benefits for a 20-year life expectancy even though the claimant never intended to work for more than another five years. Limiting wage differential awards until age 67 is eminently fair. Please note that the cap on wage differential awards was not changed. The maximum wage differential award is still equal to the state average weekly wage which essentially means that wage differential awards are uncapped.

Please further note that the 5 year cap only goes into effect on the date the award is final. Therefore, in order to get the benefit of the 5 year cap, employers should force trials on older workers in order to achieve final awards. We could easily see petitioner's attempting to delay resolution of claims in an effort to extend any potential award.

9. Carpal Tunnel Cases – New limitations – Reduction in the Value of a Hand for Carpal Tunnel Cases

Section 8(e)(9) relating to hand injuries is amended. The number of weeks of PPD for the loss of use of the hand is reduced from 205 weeks back down to 190 weeks (the same as pre-2/1/06), but only for carpal tunnel syndrome cases caused by repetitive or cumulative trauma.

The new act further states that if a claim involving the hand injury is for carpal tunnel syndrome as a result of repetitive trauma or cumulative trauma, the permanent partial disability award "shall not exceed 15% loss of use of the hand, except for cause shown by clear and convincing evidence and in which case the award shall not exceed 30% loss of use of the hand."

Comment: This is probably the most bizarre new section in the statute. In 2005, the legislature increased the number of weeks of permanent partial disability associated with all the different body parts by 7.5%. This was an unjustified and unreasonable increase. I had thought the legislature might roll back all of the permanent disability sections under 8(e) but they chose not to do it except for hand injuries involving carpal tunnel syndrome caused by repetitive trauma. Strangely, they also put a cap on the PPD associated with repetitive/cumulative trauma carpal tunnel syndrome cases. They capped it at 15% loss of use of the hand. For extraordinary cases, the award could be as high as 30% of a hand.

For all other hand injury cases and even for carpal tunnel cases caused by a traumatic instead of a repetitive motion injury, the value of a hand is still 205 weeks.

In certain ways, this makes sense because the standard award in a carpal tunnel case has historically been in the range of 15% to 20% loss of use of the hand.

However, in other ways, this section makes no sense at all. The legislature is mandating in new Section 8.1b that the Commission use AMA guidelines to evaluate PPD. Therefore, it does not make sense to assign PPD in repetitive trauma carpal tunnel cases at 15% loss of use of the hand. Under AMA guidelines, a standard carpal tunnel release would justify an award more in the range of 5% loss of use of the hand. This makes me wonder whether any of the legislatures actually looked to see what carpal tunnel cases are worth under AMA guidelines.

Admittedly, the statute states that the permanent disability award shall not exceed 15% loss of use of the hand. This will give us the opportunity to argue that carpal tunnel cases should be less than 15% loss of use of the hand. Nevertheless, it is extremely likely that virtually all compensable (and surgical) carpal tunnel cases will be awarded 15% loss of use of the hand based on 190 weeks (28.5 weeks).

10. Preferred Provider Program

The statute adds a new section 8.1(a) entitled Preferred Provider Program. This new section creates the authority for employers to create and use a Preferred Provider Program as part of their workers' compensation program in order to control medical costs.

In order to use a Preferred Provider Program, the employer has to obtain approval for the program from the Illinois Department of Insurance. The Preferred Provider Program obviously has a number of different requirements to it. It is required that the provider network "include an adequate number of occupational and non occupational providers." The network "shall include an adequate number and type of physicians or other providers to treat common injuries experienced by injured workers in the geographic area where the employees reside." Further, "medical treatment for injuries shall be readily available at reasonable times to all employees." Further, "physician compensation shall not be structured in order to achieve the goal of inappropriately reducing, delaying or denying medical treatment or restricting access to medical treatment. The program must be set up in such a way as to prohibit any administrator or provider from benefiting by reducing necessary medical treatment."

If the employer has a Preferred Provider Program, an employee must choose a doctor from the panel.

If an employee seeks treatment within the Preferred Provider Program, they are entitled to choose a network provider and receive treatment from that network provider along with any referrals from that network provider. Additionally, they are entitled to choose a second network provider and get treatment from the second provider along with any referrals from that second network provider. Essentially, an employee has a right to choose two different doctors from the panel.

Importantly, the Act states “An employer shall not be liable for services determined by the Commission not to be compensable. An employer shall not be liable for medical services provided by a non-authorized provider when proper notice is provided to the injured worker.”

Treatment by a specialist who is not a member of the Preferred Provider network can be permitted on a case by case basis if the medical provider network does not contain a physician who can provide the approved treatment and if the claimant has complied with any preauthorization.

Significantly, Section 8.1(a)(d) provides “except as provided in subsection (a)(4) of Section 8, upon a finding by the Commission that the care being rendered by the employee’s second choice of provider within the employer’s network is improper and inadequate, the employee may then choose a provider outside of the network at the employer’s expense. The Commission shall issue a decision on any petition filed pursuant to this Section within five working days.”

Opting Out

An employee is not required to treat with a doctor in the Preferred Provider Program. Section 8(a)(4) of the Act contains an “opt out” provision. It states “Subsequent to the report of an injury by an employee, the employee may choose in writing at any time to decline the preferred provider program, in which case that would constitute one of the two choices of medical providers to which the employee is entitled under subsection (a)(2) or (a)(3).”

Consequently, an employee can opt out of the Preferred Provider Program, but if he does he has only one free choice of doctor and not two choices as he did under the old Act. Further, if the claimant starts treating with a doctor before he reports a work injury, that one doctor becomes petitioner’s only choice of doctor. Presumably, after he reports the injury and he wants to change doctors, he would be required to choose from the panel.

Comment: This is a significant section of the Act which imposes new rules and regulations involving the choice of medical care. The section creates an excellent opportunity for employers to reduce the medical costs. The Preferred Provider Program sounds a lot like a panel of physicians program. There has been a provision in the Act providing for panel physicians program for years but it was hardly ever used because the Commission would never approve them. We worked with a number of employers over the years trying to get panel physician programs approved but we met with great resistance from the Commission. Importantly, this new Preferred Provider Program statute does not require Commission approval but instead places the onus for approval on the Illinois Department of Insurance. Certainly, the Department of Insurance is more familiar with these types

of circumstances. Certainly, this section of the Act is intended to be used by employers regularly rather than infrequently. We fully expect all employers and carriers will take advantage of this provision.

Employers were pushing to eliminate free choice of medical. This section does not eliminate free choice of medical but it certainly reduces it. Moreover, it gives the employer first choice of medical. The employee must accept the employer's choice or else reject it in writing. Once the employee rejects the employer's choice and seeks treatment on his own, he is limited to only one choice of physician and referrals from that physician. The mechanics of this system are somewhat complicated and I fully expect challenges from petitioner's bar.

Please note that this section will only apply to accidents after September 1, 2011.

11. Determination of Permanent Partial Disability

A new section of the Act has been added addressing the issue of permanent disability evaluations. With the addition of Section 8.1(b), for the first time, the legislature is giving direction to the Commission in how to assess permanent partial disability. With respect to accidents occurring after September 1, 2011, the statute provides that permanent partial disability shall be established using the following criteria:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: "loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. **The most current addition of the American Medical Association's 'Guides to the Evaluation of Permanent Partial Impairment' shall be used by the physician in determining the level of impairment.**"

The statute further provides:

(b) "In determining the level of permanent partial disability, the Commission shall base its determination on the following factors:

- (i) the reported level of impairment pursuant to subsection (a);
- (ii) the occupation of the injured employee;
- (iii) the age of the claimant at the time of the injury;
- (iv) the employee's future earning capacity and
- (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinate of disability. 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."

Comment: This statutory language represents a compromise between employers and employees as to permanent disability ratings. The employer groups were pushing for strict adherence to AMA guidelines. Labor and trial lawyers did not want any guidelines. Labor groups were happy with the way the Commission was currently assigning permanent disability. From an employer's standpoint, Illinois assessments as to permanent disability were ridiculous. The permanent disability awards were purely historic and had no relationship to actual disability. The Commission could award whatever they wanted for PPD. Any appeals to the courts were useless as the courts always deferred to the Commission as to PPD stating that awards of PPD were "within the unique province of the Commission."

This statute will inject some objective measurements into the permanent disability calculation. The AMA guidelines in evaluating permanent partial disability should result in significantly lower percentage awards of permanent partial disability. However, it is clear from the statute that the Commission is not absolutely required to follow the AMA guidelines. The guidelines are simply a factor in evaluating permanent partial disability. Nevertheless, the Commission will find itself in a difficult position if it does not come close to the percentage of disability set forth in the AMA guidelines. Courts should be skeptical of any Commission decisions where the award of disability is significantly greater than the AMA guidelines. In the event the Commission awards significantly more than the percentage from the guidelines, employers should challenge the award in the courts. As indicated in the statute, to the extent the Commission does not follow the guidelines, they must explain in writing why they did not.

This means that all parties must become very familiar with the AMA guidelines and the rating mechanism used by the guidelines. All cases involving injuries after September 1, 2011 must be evaluated with a completely different mindset than cases which have occurred prior to that date. Employers should expect to receive significant savings with respect to the permanent partial disability aspect of their claims.

12. Medical Fee Schedule – Amendments and Reductions

Prior to February 1, 2006, Illinois never had a fee schedule for medical bills. The Fee Schedule enacted February 1, 2006 was enacted with the reported intent that it was going to be a cost savings tool for employers. That was simply false. The medical fee schedule did not result in significantly lower costs. Workers' compensation medical costs have remained extraordinarily high. The new statute imposes a significantly more restricted fee schedule. Additional authority and directions are given to the Commission with respect to the fee schedule. The Act provides:

"The Commission shall establish and maintain fee schedules for procedures, treatments, products, services, emergency room, ambulatory surgical treatment centers accredited ambulatory surgical treatment facilities prescriptions filled and dispensed outside of a licensed pharmacy, dental services, and professional services."

Further effective, January 1, 2012, instead of analyzing non-hospital fees based on geozip, the Fee Schedule is based for non-hospital services into just four regions,

1. Cook County;

2. DuPage, Kane, Lake and Will Counties;
3. Bond, Calhoun, Clinton, Jersey, Macoupin, Madison, Monroe, Montgomery, Randolph, St. Clair and Washington Counties; and
4. All other counties of the State.

With respect to hospital fees, the State is broken down into 14 regions.

With respect to any fees that are scheduled, the maximum allowable payment is reduced to 70% of the Fee Schedule amount.

The reimbursement rate for any unscheduled fees, which is currently set at 76% is reduced by 30% down to 53.2%. Implants shall be reimbursed at 25% above the net manufacturer's invoice price less rebates plus reasonable shipping charges. Additionally, prescriptions are limited to a fee schedule that shall not exceed the Average Wholesale Price (AWP) plus a dispensing fee of \$4.18.

Comment: These fee schedule changes represent perhaps the most significant cost reductions in the statute from an employer's standpoint. Workers' compensation reimbursements to doctors and hospitals were higher than any other reimbursements, certainly much higher than Medicare or any medical insurance reimbursement.

It is hard to estimate the extent of the employer's costs savings by these fee schedule reductions as medical providers will likely become more innovative with their charges. Certainly, we cannot reasonably expect that employer's costs savings will immediately drop by 30% because employers generally were not all paying for reimbursement based exactly on maximum amounts allowable under the Fee Schedule. However, this should represent a significant benefit to employers. This is especially true if you combine the Medical Fee Schedule reductions with the imposition of the Preferred Provider Program.

The revisions close some gaps in the Medical Fee Schedule that led to numerous abuse especially involving prescriptions, implants and ambulatory surgery center fees.

13. Additional Medical Fee Changes

Section 8.2(d)(1) is amended with respect to payment of medical bills. Medical bills are now required to be paid within 30 days instead of 60 days so long as the claim contains substantially all the required data elements necessary to adjudicate the bills.

A new section 8.2(d)(2) is added. It requires the employer to provide written notification within 30 days if a bill is being denied or payment is being delayed because of insufficient information.

Section 8.2(d)(3) is amended. It provides that medical providers can charge interest if a bill is not paid within 30 days at a rate of 1% per month. It provides any required interest payments be made within 30 days after payment.

Comment: These additional provisions place greater emphasis on paying bills promptly. The legislature decided to decrease the reimbursement to the medical providers but they are insisting that

the insurance company pay the bills faster. Written notification of denial or delay in payment is now required by statute rather than by Commission rule.

14. Electronic Claims Processing

A new Section 8.2(a) has been added. It is entitled Electronic Claims and it requires that the Department of Insurance adopt rules to “(1) Ensure that all health care providers and facilities submit medical bills for payment on standardized forms. (2) Require acceptance by employers and insurers of electronic claims for payment of medical services. (3) Ensure confidentiality of medical information submitted on electronic claims for payment of medical services.”

This provision is to be effective January 1, 2012 and employers are required to accept electronic claims on or before June 30, 2012.

Comment: More and more employers and carriers are moving away from paper filings. This section of the statute essentially helps everyone. Doctors will prefer to submit invoices electronically. Employers need to make sure that they get all the proper information they need in order to pay a bill. Everyone needs to make sure that they comply with HIPAA so that medical records are not improperly disseminated. This is a legislative win/win but it imposes a lot more responsibility for the Department of Insurance.

15. Utilization Review – Amendments and Enforcement

When the statute was amended February 1, 2006, for the first time it included utilization review provisions. The statute defined utilization review and gave employers the right to use utilization review but it did not impose any requirement that the Commission actually use utilization review reports in rendering their decisions. In fact, since February 1, 2006, there are very few Commission decisions which actually deny medical treatment based on utilization review reports.

This new statute modifies the utilization review provisions in an effort to bolster the importance and effectiveness of utilization review.

The statute is amended. Section 8.7 describing utilization review programs adds paragraph (i).

Paragraph (i) states that if the employer uses utilization review, then the medical provider (1) “shall make reasonable efforts to provide timely and complete reports of clinical information needed to support a request for treatment. If a provider fails to make such reasonable efforts, the charges for the treatment of service may not be compensable nor collectable by the provider or claimant from the employer, the employer’s agent, or the employee. The reporting obligations of providers shall not be unreasonable or unduly burdensome.”

The new section further provides (2) written notice of utilization review decisions are to be provided to the medical provider and the employee. (3) Medical bills under this section can only be denied on the grounds that the extent and scope of medical treatment is excessive and unnecessary.

Most importantly, the statute further provides (4) **“When a payment for medical services has been denied or not authorized by an employer, or when authorization for medical services is denied pursuant to utilization review, the employee has the burden of proof to show by a preponderance of the evidence that a variance from the standards of care used by the person or entity performing the utilization review pursuant to Subsection (a) is reasonably required to cure or relieve the effects of his or her injury.”**

The statute further provides that the medical professional responsible for the utilization review in the final stage has to be available for either an interview or deposition in this State. The interview may be via telephone, video conference or other electronic means. If the professional is available for a video deposition, the employer must bear the burden of the cost.

Clearly, the statute bolsters the use of utilization review. However, the change in the statute does not mandate the Commission to adopt a utilization review finding. The statute is changed and now provides “An admissible utilization review shall (instead of will) 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 the determination of the reasonableness and necessity of the medical bills or treatment.”

Comment: My experience with utilization review reports is that I find many of them to be well written and convincing. The UR physicians review medical records and make analyses and recommendations consistent with nationally recognized guidelines for medical treatment. However, my experience with the Commission is that they generally ignore or reject utilization review decisions. It is useless to have a piece of evidence that the Commission simply ignores.

This change in the statute shows a clear direction from the legislature that the Commission has to take utilization review more seriously. The Arbitrators and Commissioners cannot simply ignore utilization review reports but must seriously consider them and make rulings based on the evidence rather than simply relying on unreasonable medical treatment records. The statute does not go far enough in forcing the Commission to adopt utilization review conclusions but at least it is a step in the right direction. Employers should use Utilization Review more in an effort to control unnecessary treatment including especially surgeries and wasteful chiropractic and physical therapy treatments.

16. Intoxication and Drug Use – Rebuttable Presumption Defense

The legislature has amended Section 11 of the Workers’ Compensation Act and for the first time imposed a statutory framework for disputing and denying drug and alcohol cases.

The new paragraph in the statute states “No compensation shall be payable if (i) the employee’s intoxication is the proximate cause of the employee’s accidental injury or (ii) at the time the employee incurred the accidental injury, the employee was so intoxicated that the intoxication constituted a departure from the employment.”

Admissible evidence on this issue includes evidence of the concentration of either alcohol, cannabis or other drugs in an employee’s blood, breath or urine at the time of the accidental injury. The

statute states that if at the time of the accidental injuries the employer can prove an alcohol level of 0.08%, or if there is evidence of impairment as a result of the use of cannabis or other drugs, then **“there shall be a rebuttable presumption that the employee was intoxicated and that the intoxication was the proximate cause of the employee’s injury.”**

The statute further provides that the employee can overcome the rebuttable presumption by presenting admissible evidence that the intoxication was not the sole proximate cause or the proximate cause of the accidental injuries.

Comment: Employers have been frustrated for years because they have been forced to pay for injuries suffered while a claimant was drunk or high on drugs. The Commission and the courts have always imposed an extremely high standard on employers to prove that the accident was solely caused by the intoxication. Alternatively, the employer was required to prove that the intoxication was so great that the employee could not have performed his job duties and therefore, he was not in the course and scope of his employment. This change in the statute represents a dramatic shift in the legislature’s attitude in favor of employers. Unfortunately, proof of intoxication or drug use is not an absolute defense. However, if the employer has evidence of intoxication or drug use, that evidence is sufficient to deny a case. Once the employer develops evidence showing an alcohol level at .08% or more, the statute creates a rebuttable presumption that the employee was intoxicated and the intoxication was the proximate cause of the injury. The burden then shifts to the employee to present evidence that his intoxication was not the cause of his accidental injuries.

Importantly, the statute does not completely change the compensability of cases involving intoxication but intoxication cases should be a lot easier to win than ever before. The legislature is clearly sending a message to the Commission that intoxication and drug use cases should be much more carefully considered than before. The fact that an employer can prove intoxication by proving an alcohol reading at .08% is a huge benefit. There have been many cases where the Commission has ruled in favor of a claimant who was clearly intoxicated and had a blood alcohol level close to .2 and yet still received compensation.

17. Arbitrators and Commissioners – Rules, regulations and terminations

Sections 13 and 14 of the Act are amended to impose new rules, regulations and guidelines for Commissioners and Arbitrators. All Arbitrators and Commissioners are to have extensive training upon appointment including training on fraud, evidence-based medicine, AMA guidelines and black lung cases. Twenty hours of professional training are required every two years for Commissioners and Arbitrators.

Pursuant to an amendment to Section 14, all Arbitrators currently serving are terminated effective July 1, 2011. However, all incumbent Arbitrators can continue all their duties until they are either reappointed or their successors are appointed. Future Arbitrators will be appointed for only three years terms. Arbitrators are appointed by the Governor and must be approved by the Senate. Arbitrators are going to be appointed on rotating terms. Twelve will be appointed with terms expiring July 1, 2012, 12 will be appointed with terms expiring July 1, 2013, and any additional Arbitrators will be appointed at terms expiring July 1, 2014. All new Arbitrators are required to be lawyers.

Furthermore, the new statute provides that the Commission shall assign no fewer than three Arbitrators to each hearing site. The Commission has to randomly assign cases at each hearing location to the three different Arbitrators. Additionally, no Arbitrator can serve for more than two years at any location.

Comment: The furor over a few Arbitrators was one of the primary motivating factors in creating this legislation. The State was embarrassed by the actions of certain Arbitrators as reported extensively by the Belleville News Democrat. The State was embarrassed by almost ten million dollars in settlement to guards and other employee at the Menard State Prison. Nevertheless, the decision to terminate all of them is a drastic action. Many are very good and should keep their jobs. The termination of all gives the right to Governor Quinn to appoint all new ones. I am not pleased to give him that power.

We have complained for years that the assignment of a single Arbitrator to a downstate location was unfair. The legislature has now mandated at least three Arbitrators have to be assigned to each hearing location. This will produce logistical difficulties. It is going to require a lot of travel on the part of certain Arbitrators. It may require more attorney travel as well since attorneys will have to appear on different days before different Arbitrators at the same location.

I would expect that the Commission will decrease the number of downstate hearing locations and force claimants to travel further to hearing locations. The provision will certainly lead to more fairness in the downstate awards. The current system has been eminently unfair to employers. Certain employers who have plants in areas where there was an unfavorable Arbitrator assigned and have suffered for years. Some of the downstate Arbitrators had maintained their assignments for more than ten years. This system will restore some element of fairness to the hearings.

18. Attorney Gift Ban

A new section of the Act was added, Section 16(b). It prohibits any attorney appearing before the Commission to provide compensation or any gift to any person in exchange for a referral of a client. A gift means any item of value with the exception of cash, food or drink up to \$75.00 in value for a day.

Comment: It is unclear from this statute what the legislature was intending to prohibit. However, the ban applies to both petitioner and respondent's attorneys. Both are prohibited from giving any gifts to anyone more than \$75.00 in a day for referral of any business.

19. Claims by Workers Compensation Commission Employees sent to be heard by Independent Arbitrator

Section 18.1 is added to the statute. It provides that all claims made by current and former employees of the Commission are assigned to be heard by an independent Arbitrator not employed by the Commission. The decision of the independent Arbitrator becomes the decision of the Commission.

Comment: The legislature has been embarrassed not only by actions by the Arbitrators but also claims made by the Arbitrators and employees of the Commission for which significant compensation was paid by the State. Some Arbitrators have had multiple claims against the Commission.

There was a concern that Arbitrators were rewarding their friends and co-employees with awards of compensation. This is a good provision. It does not affect employers overall but eliminates the taint associated with having co-employees make awards to each other at the cost of tax payers.

20. Fraud penalties - Defined

Section 25.5 is amended to impose greater penalties for fraud. The penalties are as follows: If the value of the fraud is \$300.00 or less, the violation is a Class A misdemeanor. If the violation is greater than \$300.00 but less than \$10,000.00, it is a Class 3 felony. If it is more than \$10,000.00 but less than \$100,000.00, it is a Class 2 felony. If it is more than \$100,000.00, it is a Class 1 felony. In addition to criminal penalties, anyone convicted of fraud is responsible for restitution, including court costs and attorney's fees.

Comment: It never hurts to strengthen the fraud provisions of the Act. It is important that the fraud provisions be actively pursued to conviction. It is still rare to see a criminal conviction for workers' compensation fraud. The local State's Attorneys have not demonstrated much interest in pursuing WC fraud cases.

CONCLUSION

This bill represents true workers' compensation reform. This bill will decrease employer workers' compensation costs in Illinois. The extent of the workers' compensation costs savings is yet to be determined. Some analysts have predicted employer savings at \$500 million to \$700 million but those estimates are likely optimistic. Although the bill makes a number of substantive changes, a number of the substantive changes will only be truly significant if the Commission and the courts interpret the changes in a manner favorable to the employer.

It must be remembered that this was a Democratic bill. This was not a bill drafted by employer groups or even supported by employer groups. It was not a bill supported by Republicans. Almost all Republicans voted against the bill.

Republicans and employer groups wanted a bill that would decrease the number of claims by changing the standard of causation. Republicans wanted a bill that decreased the amount of compensation benefits to be paid to claimants. This bill decreases the potential compensation to be paid to claimants slightly. However, benefit rates were not changed; no new caps were placed on benefits except for wage differential claims.

The most major cost savings for employers as a result of this bill involves medical payments. The medical fee schedule is strengthened significantly by cutting the caps on reimbursements by 30%. That single change will represent the biggest savings to employers with respect to this bill. The effect of this change will be immediate as it will apply to medical treatment on and after September

1, 2011. Many of the other changes will be less dramatic as they will only apply to cases involving accidents on and after September 1, 2011.

Employer rights are strengthened when it comes to Utilization Review. Employer rights are strengthened with the ability to create a Preferred Provider Program. The more control given to Employers with respect to controlling medical costs are extremely valuable and should serve to end a significant amount of medical abuse in the system.

The most significant change in the Act from a compensation standpoint is the introduction of AMA guidelines into the determination of permanent partial disability. This will change the nature of practice at the Commission. It will force both parties to obtain medical reports estimating permanent partial disability based on AMA guidelines. Parties will be forced to incur extra IME costs to create evidence as to the proper rating pursuant to the AMA Guidelines. It will fall to the Commission as to whether to award only the amount identified by the doctor pursuant to the guidelines or whether to award petitioner more based on the other factors set forth in the statute. We can expect significant litigation in the short term until the parties see how the Commission and Courts will rule on these issues.

Employers are vowing to fight for more workers' compensation reform and further reductions in benefits. However, I believe it is extremely unlikely to see any further legislation in the Workers' Compensation arena in the near future. The Democrats are exhausted by the effort it took to get this bill passed. They will have little tolerance for more complaints from employers that the system is unfair after this major overhaul. It will take some time for this legislation to go into effect and for the legislature to see what affect the changes have on the system and employers' costs.

For now, employers should work hard to put together their preferred provider programs and have good utilization review programs in place to take full advantage of the benefits given to the employer in the Act. Employers and carriers should familiarize themselves with AMA guidelines and determine how best to use the guidelines to reduce permanent disability payments.

Effective September 1, 2011, it will be a brave new world for participants in the workers' compensation system. We should prepare suitably to handle the multiple issues that will arise from the legislative changes.