Preferred Provider Programs in Illinois
An Introduction 6/13/13

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Introduction

Due to the 2011 Illinois Workers Compensation reform act, employers now have, for the first time, the ability to direct their injured workers into a “Workers’ Compensation Preferred Provider Program” for their medical treatment. Even though the act was signed into law June of 2011 it wasn’t until March 2013 that the IWCC (Illinois Workers Compensation Commission) introduced the required approval process to become a Preferred Provider under the reformed law.

Approval of the PPP administrators are through the Department of Insurance but administration of the PPP requirements with be through the Workers Compensation Commission.

In addition to the approval process the required employer notification forms that are necessary in order to participate have just been released. The 3 PPPs that have been approved so far are CorVel Corporation, HFN and Coventry Health Care. An employer must elect an approved PPP Administrator to participate.

Included herein are the forms which are necessary for an employer to participate.

The employee must be notified of the program on the form that was promulgated by the IWCC. The forms must be given to the injured employee at the time of the accident/loss. In addition, they must be posted throughout the workplace or job site.

The purpose of the legislation is to help employers control medical costs while still providing their employees high quality medical care and still providing employees some ability to choose their medical provider.

Without a PPP, employees have free choice of medical providers limited to a maximum of 2 different choices along with any referrals from those two choices.

With a PPP, Employees have 2 choices of medical providers from within the employer’s network. If the commission finds that the injured workers second choice of physician has NOT provided adequate care then the injured worker can choose a medical provider outside of the PPP (Preferred Provider Program).

Employees may opt out of the program but must do so in writing. This however constitutes a choice in physicians.

If an injured worker chooses non-emergency care prior to the report of an injury that also constitutes a choice in physicians.

The Illinois Department of Insurance as a part of the approval process for the aforementioned networks has reviewed each applicant to make certain that the medical provider has the suitable degree of practice and center of attention on industrial/
occupational medicine. Evaluating the medical providers will be based upon medical quality and patient outcome measures.

This is a benefit to employees as the goal for treatment should result in medical care which addresses the injured workers specific injury. It benefits employers as its intent is to provide employees with timely and suitable care to get the injured employee back to work and back to pre-injury status as quickly and efficiently as possible.

STATUTORY AUTHORITY – the new section of the Act

(820 ILCS 305/8.1a)

Sec. 8.1a. Preferred provider programs. Starting on the effective date of this amendatory Act of the 97th General Assembly, to satisfy its liabilities under this Act for the provision of medical treatment to injured employees, an employer may utilize a preferred provider program approved by the Illinois Department of Insurance as in compliance with Sections 370k, 370l, 370m, and 370p of Article XX-1/2 of the Illinois Insurance Code. For the purposes of compliance with these Sections, the employee shall be considered the "beneficiary" and the employer shall be considered the "insured". Employers and insurers contracting directly with providers or utilizing multiple preferred provider programs to implement a preferred provider program providing workers' compensation benefits shall be subject to the above requirements of Article XX-1/2 applicable to administrators with regard to such program, with the exception of Section 370l of the Illinois Insurance Code.

(a) In addition to the above requirements of Article XX-1/2 of the Illinois Insurance Code, all preferred provider programs under this Section shall meet the following requirements:

(1) The provider network shall include an adequate number of occupational and non-occupational providers.

(2) The provider 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.

(3) Medical treatment for injuries shall be readily available at reasonable times to all employees. To the extent feasible, all medical treatment for injuries shall be readily accessible to all employees.

(4) 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.
(5) Before entering into any agreement under this Section, a program shall establish terms and conditions that must be met by noninstitutional providers wishing to enter into an agreement with the program. These terms and conditions may not discriminate unreasonably against or among noninstitutional providers. Neither difference in prices among noninstitutional providers produced by a process of individual negotiation nor price differences among other noninstitutional providers in different geographical areas or different specialties constitutes unreasonable discrimination.

(b) The administrator of any preferred provider program under this Act that uses economic evaluation shall file with the Director of Insurance a description of any policies and procedures related to economic evaluation utilized by the program. The filing shall describe how these policies and procedures are used in utilization review, peer review, incentive and penalty programs, and in provider retention and termination decisions. The Director of Insurance may deny approval of any preferred provider program that uses any policy or procedure of economic evaluation to inappropriately reduce, delay or deny medical treatment, or to restrict access to medical treatment. Evaluation of providers based upon objective medical quality and patient outcome measurements, appropriate use of best clinical practices and evidence based medicine, and use of health information technology shall be permitted. If approved, the employer shall provide a copy of the filing to all participating providers.

(1) The Director of the Department of Insurance shall make each administrator's filing available to the public upon request. The Director of the Department of Insurance may not publicly disclose any information submitted pursuant to this Section that is determined by the Director of the Department of Insurance to be confidential, proprietary, or trade secret information pursuant to State or federal law.

(2) For the purposes of this subsection (b), "economic evaluation" shall mean any evaluation of a particular physician, provider, medical group, or individual practice association based in whole or in part on the economic costs or utilization of services associated with medical care provided or authorized by the physician, provider, medical group, or individual practice association. Economic evaluation shall not include negotiated rates with a provider.

(c) Except for the provisions of subsection (a)(4) of Section 8 and for injuries occurring on or after the effective date of this amendatory Act of the 97th General Assembly,
an employee of an employer utilizing a preferred provider program shall only be allowed to select a participating network provider from the network.

An employer shall be responsible for:

(i) all first aid and emergency treatment;

(ii) all medical, surgical, and hospital services provided by the participating network provider initially selected by the employee or by any other participating network provider recommended by the initial participating network provider or any subsequent participating network provider in the chain of referrals from the initial participating network provider; and

(iii) all medical, surgical, and hospital services provided by the participating network provider subsequently chosen by the employee or by any other participating network provider recommended by the subsequent participating network provider or any subsequent participating network provider in the chain of referrals from the second participating network provider.

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.

(1) When the injured employee notifies the employer of the injury or files a claim for workers' compensation with the employer, the employer shall notify the employee of his or her right to be treated by a physician of his or her choice from the preferred provider network established pursuant to this Section, and the method by which the list of participating network providers may be accessed by the employee, except as provided in subsection (a)(4) of Section 8.

(2) Consistent with Article XX-1/2 of the Illinois Insurance Code, treatment by a specialist who is not a member of the preferred provider network shall 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 employee has complied with any pre-authorization requirements of the preferred provider network. Consent for the employee to visit an out-of-network provider may not be unreasonably withheld. When a non-network provider is authorized pursuant to this subparagraph (2), the non-network provider shall not hold an employee liable for costs except as provided in subsection (e) of Section 8.2.

(3) The Director shall not approve, and may withdraw
prior approval of, a preferred provider program that fails to provide an injured employee with sufficient access to necessary treating physicians, surgeons, and specialists.

(d) 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 or 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 5 working days.

(e) The Director of the Department of Insurance may promulgate such rules as are necessary to carry out the provisions of this Section relating to approval and regulation of preferred provider programs.
(Source: P.A. 97-18, eff. 6-28-11.)

COORDINATION WITH SECTION 8(a) - see additions to Section 8(a)

(820 ILCS 305/8) (from Ch. 48, par. 138.8)
Sec. 8. The amount of compensation which shall be paid to the employee for an accidental injury not resulting in death is:

(a) 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, limited, however, to that which is reasonably required to cure or relieve from the effects of the accidental injury, even if a health care provider sells, transfers, or otherwise assigns an account receivable for procedures, treatments, or services covered under this Act. If the employer does not dispute payment of first aid, medical, surgical, and hospital services, the employer shall make such payment to the provider on behalf of the employee. The employer shall also pay for treatment, instruction and training necessary for the physical, mental and vocational rehabilitation of the employee, including all maintenance costs and expenses incidental thereto. If as a result of the injury the employee is unable to be self-sufficient the employer shall further pay for such maintenance or institutional care as shall be required.

Every hospital, physician, surgeon or other person rendering treatment or services in accordance with the provisions of this Section shall upon written request furnish full and complete reports thereof to, and permit their records to be copied by, the employer, the employee
or his dependents, as the case may be, or any other party to any proceeding for compensation before the Commission, or their attorneys.

Notwithstanding the foregoing, the employer's liability to pay for such medical services selected by the employee shall be limited to:

(1) all first aid and emergency treatment; plus

(2) all medical, surgical and hospital services provided by the physician, surgeon or hospital initially chosen by the employee or by any other physician, consultant, expert, institution or other provider of services recommended by said initial service provider or any subsequent provider of medical services in the chain of referrals from said initial service provider; plus

(3) all medical, surgical and hospital services provided by any second physician, surgeon or hospital subsequently chosen by the employee or by any other physician, consultant, expert, institution or other provider of services recommended by said second service provider or any subsequent provider of medical services in the chain of referrals from said second service provider.

Thereafter the employer shall select and pay for all necessary medical, surgical and hospital treatment and the employee may not select a provider of medical services at the employer's expense unless the employer agrees to such selection.

At any time the employee may obtain any medical treatment he desires at his own expense. This paragraph shall not affect the duty to pay for rehabilitation referred to above.

NEW SECTION OF 8(a)

(4) The following shall apply for injuries occurring on or after June 28, 2011 (the effective date of Public Act 97-18) and only when an employer has an approved preferred provider program pursuant to Section 8.1a on the date the employee sustained his or her accidental injuries:

(A) The employer shall, in writing, on a form promulgated by the Commission, inform the employee of the preferred provider program;

(B) 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); and

(C) Prior to the report of an injury by an employee, when an employee chooses non-emergency treatment
from a provider not within the preferred provider program, that would constitute the employee's one choice of medical providers to which the employee is entitled under subsection (a)(2) or (a)(3).

RULES - effective 3/4/13

Joint Committee on Administrative Rules

ADMINISTRATIVE CODE

TITLE 50: INSURANCE
CHAPTER I: DEPARTMENT OF INSURANCE
SUBCHAPTER z: ACCIDENT AND HEALTH INSURANCE
PART 2051 PREFERRED PROVIDER PROGRAMS

- Section 2051.210 Purpose
- Section 2051.220 Definitions
- Section 2051.230 Administrators Not to Assume Underwriting Risk
- Section 2051.240 Registration, Renewals and Appeals
- Section 2051.250 Fees
- Section 2051.260 Administrator Requirements
- Section 2051.270 Organizational Requirements
- Section 2051.280 Health Care Preferred Provider Program Payor Agreements
- Section 2051.285 Workers' Compensation Preferred Provider Program Payor Agreements
- Section 2051.290 Health Care Preferred Provider Program Administrator Provider Agreements
- Section 2051.295 Workers' Compensation Preferred Provider Program Administrator Provider Agreements
- Section 2051.300 Requirements for Agreements with Other Administrators
- Section 2051.310 Health Care Preferred Provider Program Administrator Network Availability and Adequacy Requirements
- Section 2051.315 Workers' Compensation Network Availability and Adequacy Requirements
- Section 2051.320 Discounted Health Care Services Plan Requirements
- Section 2051.330 Insurer Requirements
- Section 2051.340 Fiduciary and Bond Requirements
- Section 2051.350 Maintenance of Records
- Section 2051.360 Advertising and Solicitation
- Section 2051.370 Examination

- Section 2051.APPENDIX A Health Care Preferred Provider Program Administrator Registration Form
- Section 2051.APPENDIX B Discounted Health Care Services Plan Only Registration
- Section 2051.APPENDIX C Insurer Filing Requirements
- Section 2051.APPENDIX D Workers' Compensation Preferred Provider Program Administrator Registration Form
- Section 2051.APPENDIX E Illinois or NAIC Biographical Affidavit
- Section 2051.APPENDIX F Preferred Provider Program Administrator Bond/Fiduciary

AUTHORITY: Implementing Article XX½ of the Illinois Insurance Code [215 ILCS 5/Art. XX½] and the Workers’
NETWORK REQUIREMENTS

An Internet website and toll-free number for beneficiaries (injured workers) to access regarding current lists of preferred Providers.
50 Illinois Adm. Code 251.315 (a)(5)

Preferred provider lists requested by phone sent within three working days.
50 Illinois Adm. Code 251.315 (a)(5)

Internet website addresses shall be prominently displayed on all advertisements, marketing materials, brochures and if applicable, identification cards.
50 Illinois Adm. Code 251.315 (a)(5)

Primary treating physician and hospital health care services for emergency health care services.

Primary Treating and hospital health care services for emergency health care services are within 30 minutes or 15 miles of each covered employee’s residence.

Occupational health services and specialist providers are within 60 minutes or 30 miles of a covered employee’s residence.

Non-emergency services

Ensure that an appointment for initial treatment is available within three business days after the WC PPP administrator’s receipt of a request for treatment within the PPP.

For treatment of common injuries experienced by covered employees, based on the type of occupation or industry in which the covered employee is engaged, ensure that an appointment is available within twenty business days after the WC PPP administrator’s receipt of a referral to a specialist within the PPP.

The PPP allows for Coverage Outside the PPP under the following scenarios:
50 Illinois Adm. Code 251.315 (b)(1)(G)

A covered employee authorized by the employer to temporarily work or travel for work outside the preferred provider program geographic service area when the need for medical care arises;
A former employee whose employer has ongoing workers’ compensation obligations and who permanently resides outside the preferred provider program geographic services area; and

A covered employee who decides to temporarily reside outside the preferred provider program geographic service area during recovery.

**Injured Worker and Employer Rights**

The employer shall select and pay for all necessary medical, surgical and hospital treatment and the employee may not select a provider of medical services at the employer's expense unless the employer agrees to such selection.

At any time the employee may obtain any medical treatment he desires at his own expense.

Except as provided in 820 ILCS 305/8(a)(4), 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 or 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 5 working days.

**PPP Employee Opt Out**

If the injured worker (IW) opts out of the PPP in writing, the IW forfeits one of their choices they are allowed to make related to selecting a provider to treat their injury.

An IW that opts out of their employer’s PPP in writing only has one (1) choice of treating provider remaining.

If they exercise that choice, any further change will be at the employer’s discretion, including directing that IW back to a PPP provider.

Employers are responsible for keeping all forms on file and tracking employees opt out.

Employers may also elect to proceed without the benefit of the PPP.

**Frequently Asked Questions Regarding Workers’ Compensation Preferred Provider Programs (WC PPPs)**

1. *What are the requirements for obtaining approval of the WC PPP?*

Current PPP registration would require each applicant to meet the provisions of:

a. 215 ILCS 5/370 k (Registration);
b. 215 ILCS 5/370l (Fiduciary and bonding – where applicable);
c. 215 ILCS 5/370m (Program requirements);
d. 820 ILCS 305/8.1a(a)(1) (Occupational and non-occupational network adequacy);
e. 820 ILCS 305/8.1a(a)(2) (Physician and provider network adequacy appropriate for treating injured workers);
f. 820 ILCS 305/8.1a(a)(4) (Prohibition on inappropriate economic credentialing);
g. 820 ILCS 305/8.1a(a)(5) (Prohibition against unreasonable discrimination in terms of noninstitutional provider agreements);
h. 820 ILCS 305/8.1a(b) (Description of any economic evaluation policies and procedures); and
i. Applicable sections of 50 IAC 2051 which implement the above referenced statutory references.

2. Are the networks composed of doctors and facilities?

Yes. WC PPP networks may also be specialty networks.

3. Will an employer be allowed to select doctors from a specific group, or will they be forced to select all doctors from a given group when choosing that group?

To the extent that an employer desires to directly contract with individual providers (Section 8.1a), they may establish terms and conditions that must be met as long as such terms and conditions do not unreasonably discriminate against or among noninstitutional providers (Section 8.1a(a)(5)).

To the extent that an employer desires to directly contract with a WC PPP to use a “nested network” (a network which is a smaller component of the whole and such restricted network has been approved by the Department), the employer would also have that statutory flexibility.

4. Do specialty networks, such as pharmacy and physical therapy fall within the WC PPP? How will these networks be handled?

Specialty networks fall within the WC PPP and will be handled in the same manner as other providers.

5. Will current occupational medicine providers be required to join a WC PPP in order to qualify as a preferred provider?

Yes.

6. What are the requirements for employee notification of the WC PPP? Is the DOI working with the Commission to establish this form?
These requirements are stated in 820 ILCS 305/8(4)(A). The DOI is cooperating with the IWCC in developing the form to be used.

7. What confidentiality restrictions will apply to required WC PPP filings?

PPP filing documents will be handled similarly to other provider network filings with regard to both subpoenaed material and material requested under a Freedom of Information Act request. Section 8.1a(b)(1) of the Workers’ Compensation Act requires the Director not to publicly disclose any filed information determined to be confidential, proprietary, or a trade secret.

8. Will provider reimbursement rates be held confidential?

Yes.

9. Will a WC PPP administrator be notified when a request is made for a copy of their filing?

Not as a routine matter. Such a request would fall under FOIA standards and requirements. (5 ILCS 140/1).

10. How will the Department handle WC PPP renewals?

The procedure is outlined in 50 IAC 2051.240 – Registration, Renewals, and Appeals.

11. Will an employer have to register as a WC PPP Administrator if they utilize more than one WC PPP?

Yes, if they are the entity which directly contracts with multiple WC PPPs.

12. Will WC PPPs have additional or alternative registration, fiduciary or bonding requirements than those in law and regulation?

Not currently.

13. What late payment standards will apply, given that there is one standard in the Insurance Code and another in the Workers’ Compensation Act?

Standard rules of legislative construction will apply to resolve any apparent conflict.

14. Section 370m(2) requires that notice be given to beneficiaries of “any limitations or exclusions” to coverage. Must notice be given of all possible defenses under the WC Act?

No. Disclosures should provide notice to beneficiaries of possible financial liability if their WC claim is determined to be non-compensable.
15. Section 370m(4) requires that notice be given of a complaint procedure. Will there be a required DOI complaint procedure?

Notice must be given to beneficiaries of any complaint procedure, if one exists.

16. Section 370m(5) requires disclosure of “deductible and coinsurance” amounts. These don’t apply in WC, what should we do?

If there are none, then there are none to disclose.

17. What will be the parameters used by the Department to define an “adequate number of occupational and non-occupational providers”, an “adequate number and type of physicians”, “availability and accessibility of care”?

We will solicit comments from interested parties and promulgate best practice standards.

18. 50 IAC 2051.280(b) requires that an employee be charged no more in out-of-pocket expenses in the event of necessary out of network care. Will this be applied to WC PPPs?

Yes. Employees should not be penalized for networks that would otherwise be inadequate.

SAMPLE NOTICE

Notice of Our Workers’ Compensation Preferred Provider Program (PPP)

This information is being provided to you to explain your rights and responsibilities should you have an accident at work.

Illinois law allows our company to offer healthcare services to employees for workers’ compensation injuries through a Preferred Provider Program (PPP). The Illinois Department of Insurance has approved our network of medical providers for treatment of work related injuries. The Department of Insurance requires our PPP network to meet standards for geographic accessibility, adequacy of medical providers and other factors important to assuring the adequacy of care to our injured employees. You may choose to be treated by any of the medical providers of your choice in our PPP subject to the limitations described below. Our list of PPP medical providers is attached or you may access the list of the medical providers in our PPP at ________________.

After your report of an injury to us, you may in writing to us decline your participation in the PPP. Should you decline participation in the PPP, the law provides that your declination of participation constitutes one of the two choices of medical providers to which you are otherwise entitled to. You may also decline treatment from our PPP at any time throughout your treatment for this work-related injury. However, that declination will also constitute one of your two choices of medical providers unless the Illinois
Workers’ Compensation Commission determines that the medical treatment provided to you by our PPP is inadequate.

In addition, the law provides if, prior to report of an injury, you are provided non-emergency treatment from a medical provider not within the PPP, that treatment would constitute one of the two choices of a medical provider to which you are otherwise entitled to. Please be advised that our company may not be required to pay for medical treatment you receive from medical providers outside or beyond your two choices of medical providers and subsequent referrals.

If our PPP does not provide a medical provider who can provide an approved medical treatment, a medical provider not a member of the PPP may be used at our expense if you have complied with our PPP’s pre-authorization requirements for use of the medical provider who is not a member of the PPP.

For additional information regarding our program requirements, please review the attached materials that we are required to provide you pursuant to Section 370m (215 ILCS 5/370m) of the Illinois Insurance Code.

If you are injured on the job...IN CASE OF EMERGENCY SEEK IMMEDIATE MEDICAL ATTENTION AT THE NEAREST EMERGENCY FACILITY. Immediately report your injury to your supervisor/manager or contact:

Employer: _____
Contact name: _____
Address: _____
Telephone _____

I am in receipt of this notice:

Name (print) _____________________________________________________
Signature: _______________________________________________________
Date: ___________________________________________________________

IWCC 10/18/11

SAMPLE NOTICE
Employer name/letterhead

NOTICE OF PREFERRED PROVIDER PROGRAM
FOR WORKERS’ COMPENSATION MEDICAL CARE
Underlined spaces are fill-in-the-blank fields.
____ (employer) has received your report of a work-related injury. Please be advised that we have established a Preferred Provider Program (PPP) for medical treatment for workers’ compensation cases, pursuant to the Illinois Workers’ Compensation Act (820 ILCS 305/8(a) and 8.1a). Our PPP has been approved by the Illinois Department of Insurance as required under the Act.

____ (employer) recommends that you obtain your medical care from the PPP network for any work-related injury because we believe it will provide good treatment for you. You may decline to be treated by providers in our PPP now or at any time throughout your treatment for this work-related injury. Such declination must be made to us in writing, and will count as one of your two choices of medical providers. We may not be required to pay for medical services outside or beyond your two choices of medical providers and the chain of referrals there from. However, not receiving treatment from our PPP will not be considered a choice of physicians if: 1) there is no medical provider in the PPP that provides treatment you need and you comply with all pre-authorization requirements; or 2) the Illinois Workers’ Compensation Commission has determined that the treatment provided to you by our PPP is inadequate.

To obtain the list of medical providers in the PPP, _____. To decline participation in the PPP, you must do so in writing; direct it to ____. If you have questions about the employer’s PPP network, please contact _____.

If you have any questions about your rights under the law, please call the Public Information Unit at the Illinois Workers’ Compensation Commission at 312/814-6611, toll-free 866/352-3033, email the IWCC at infoquestions.wcc@illinois.gov, or check the Commission’s website at www.iwcc.il.gov.

Received by:

________________________________________
Signature

_______________________________________
Name (please print)

_______________________________________
Date
CONCLUSION

The PPP is intended as an employer benefit. It is intended to cut medical costs by allowing employers to negotiate fees with providers to include them on the lists to be approved WC providers. Medical providers presumably will agree to lower prices to keep WC business they might otherwise lose.

Another significant benefit is the ability to limit free choice of medical. The goal is to cut out the bad medical providers from the system as much as possible. The list should deter treatment from bad providers who overcharge and overtreat.

Remember the PPP statute did not change the existing statute. It only added to it. All rights and defenses that the employer had under the old statute still apply. Medical treatment must be causally related to the accident. Treatment even from a PPP doctor must be reasonable and necessary. We still maintain the right to an IME/Records Review/Utilization Review.

Privacy rights are not changed – a doctor who is part of the PPP is still subject to the same privacy restrictions as before. We can request records in writing – BUT we can’t seek ex parte reports especially as to accident/causation issues.

We will have some new and different issues to deal with – but we should be able to exercise more medical control and have better treatment outcomes. This will be a challenge to claimant attorneys who are used to controlling medical treatment. We must make sure to comply with statutory requirements.