Below the Red Line

Heyl Royster

Workers' Compensation Newsletter

A Newsletter for Employers and Claims Professionals — *July 2009*

A Word from the Practice Group Chair

The author of our July issue of *Below the Red Line* is Brad Peterson of our Urbana office. Those of you who have worked with Brad or have attended our seminars know that he, along with Jim Voelker of our Peoria office, are our internal "go to" attorneys when complex Medicare Set Aside (MSA) issues arise in the settlement of workers' compensation or civil litigation claims which our office is handling. Both Brad and Jim have written extensively on MSA topics and are available to you for consultation on difficult MSA questions should the need arise.

We hope that you will enjoy the month of July while it lasts. Our advice this month, in addition to Brad's comments, is to make sure you take some time off and, if you play outside, don't forget to use sun block!

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This Month's Author:

Brad Peterson concentrates his practice in the defense of workers' compensation and various aspects of civil litigation, ranging from construction litigation to insurance coverage issues. In the course of his work, Brad has become an expert on issues of Medicare Set Aside trusts in both workers' compensation and civil litigation claims. He has written and spoken frequently on this issue. He was one of the first attorneys in the state of Illinois to publish an article regarding the application of the Medicare Secondary Payer Act to workers' compensation claims, "Medicare, Workers' Compensation and Set Aside Trusts," *Southern Illinois Law Journal* (2002).You can reach Brad at bpeterson@heylroyster.com.

WINNING STRATEGIES IN REPETITIVE TRAUMA

Repetitive trauma claims have been a staple of workers' compensation claims since the landmark decision in ***Peoria County Belwood Nursing Home v. Industrial Comm'n***, 115 Ill. 2d 524, 505 N.E.2d 1026 (1987). In the traditional sense, repetitive trauma claims were meant to address scenarios where the claimant sustained a work-related injury not as the result of a specific, identifiable trauma, but as the result of subjecting certain parts of the body to repetitive movements throughout the employment. Common claims involved repetitive injuries to the wrist, such as carpal tunnel syndrome, and to the arm, such as cubital tunnel syndrome, and to various areas of the back. However, since the 1980s, the scope of repetitive trauma injuries has expanded to encompass claims for alleged injuries arising during a variety of work tasks from standing and walking to multi-activity jobs – those where the claimant does not regularly repeat the same task but performs several similar tasks.

As shown by two recent decisions, the Workers' Compensation Commission has now denied repetitive trauma claims when the evidence shows that the petitioner engaged in various activities throughout the course of the work day. In ***Holyfield v. Hart, Schaffner & Marx***, 09 IWCC 0122 (Feb. 2, 2009), the Commission affirmed the denial of benefits where evidence illustrated that the petitioner's work activities were, in fact, varied. The claimant had bilateral arthritis to her knees with a resulting surgery. The petitioner logged rolls of material by removing information tags and inputting the information into the employer's data base. She would also test fabric by cutting squares and testing them with a foot activated press. Duties also included answering the phone, retrieving computer print outs, walking two blocks to a fax machine and walking to the main office twice a day. Although her duties included some squatting, kneeling and walking, the arbitrator concluded that her job activities varied and she therefore failed to prove that her knee condition was caused by her employment activities. The Commission affirmed, specifically noting that the petitioner's work activities were varied.

Holyfield suggests that the Commission might be reining it some claims that were previously deemed compensable. ***Holyfield*** also illustrates the importance of acquiring detailed job descriptions of repetitive trauma claimants. Such job descriptions should be reviewed with the employee's manager or supervisor to confirm accuracy with regard to the actual duties performed by the employee.

While an analysis of the petitioner's specific job duties is vital to prevailing on a repetitive trauma claim, it is also necessary for a medical opinion to hold weight with the arbitrator or Commission. Frequently, treating physicians and IME physicians render opinions on causal connection in repetitive trauma cases without setting forth a detailed analysis of the petitioner's job duties. Failure to detail the petitioner's job duties can be fatal to the credibility of the physician. Such was the case in ***Hollen v. Lake, County of/Health Department***, 08 IWCC 1414 (Dec. 10, 2008).

In ***Hollen***, the petitioner was a substance abuse counselor who claimed that repetitive note taking and typing caused right epicondylitis. The petitioner's treating physicians' records were silent on the issue of causal relationship to her work activities. However, petitioner's IME physician examined the claimant and reviewed her medical records and opined that her condition of ill-being was directly related to her employment. This opinion was contradicted by a respondent's IME doctor.

In denying compensation, the arbitrator specifically noted that the report of the petitioner's IME physician contained nothing about the petitioner's job description nor any other information reflecting an accurate understanding of the petitioner's actual work duties. The arbitrator's decision was affirmed by the Commission.

Hollen highlights the importance of insuring that the respondent's IME physicians set forth details of the petitioner's job duties in their actual reports. General references to job titles or classifications will be *insufficient* to support the physicians' opinions. Conversely, the reports presented by petitioner's counsel purporting to establish causal connection should also be scrutinized with regard to the detail provided as to the petitioner's job duties. Likewise, the progress notes of treating physicians that purport to establish causal connection should further be reviewed as to whether the physician has noted any degree of familiarity with the petitioner's actual job duties. Simply stated, where a report fails to detail the petitioner's job duties, the opinion should be determined to lack credibility.

MANDATORY MEDICARE REPORTING

SCHIP Extension Act

The Medicare/Medicaid and SCHIP Extension Act (P.L. 110-173) became effective in December 2007. The new statute created mandatory reporting requirements for claims involving Medicare beneficiaries. These reporting requirements

constitute a further effort by Medicare to enforce the Medicare Secondary Payer Act, 42 U.S.C. §1395y(b)(2).

The entities responsible for complying with the reporting requirements for §111 are referred to as Responsible Reporting Entities (RREs). RREs include, but are not limited to, workers' compensation, auto liability and liability insurers. The information provided through the notice will allow the Center for Medicare and Medicaid Services (CMS) to identify "primary payers" that Medicare's payments would be secondary to. In addition to Medicare claims processing, the information is also acquired for possible MSP recovery actions and identifying claims where Medicare may, in fact, hold a lien for prior conditional payments. Notification to Medicare will be undertaken by the responsible reporting entity and provided to the CMS Coordination of Benefits Contractor (COBC). Technical aspects of the data submission process will be managed by the COBC.

Responsible Reporting Entities

Responsible Reporting Entities (RRE) are defined as follows:

> APPLICABLE PLAN – In this paragraph, the term 'applicable plan' means the following laws, plans or other arrangements, including the fiduciary or administrator for such law, plan or arrangement;
>
> - Liability Insurance (including self-insurance).
> - No fault insurance;
> - Workers' compensation laws or plans
> - 42 U.S.C. 1395y(b)(8)

Third-party administrators may be contractually assigned to meet the reporting requirements on behalf of insurers or self insureds. Any contractual assignment by the RRE to a third-party administrator does not, however, limit the overall responsibility of the RRE for compliance with the Act.

Registration

RREs were required to register with CMS and begin testing prior to June 30, 2009. Testing will be undertaken through December 31, 2009, and compliance through the production of data will begin in January 2010.

Triggers to Reporting

The RREs are to report only with respect to Medicare beneficiaries. If a reported individual is not a Medicare beneficiary or CMS is unable to validate a particular Social Security number or Health Insurance Claim Number then the reporting will be rejected by CMS.

Workers' compensation claims will be reported when there is an ongoing payment responsibility for medical expenses (ORM). Where the RRE has an ongoing responsibility for medical bills, they must report two events. They must report when that responsibility has been assumed (medical bill paid) and when that responsibility has been terminated. CMS has indicated the RRE may submit a termination date for "ongoing responsibility for medical" (ORM) if they acquire a signed statement from the injured individual's treating physician that they will require no further medical items or services associated with the claimed injuries. MMSEA Section 111 "Medicare Secondary Payer Mandatory Reporting User Guide version 1.0, March 16, 2009."

REPORTING THRESHOLDS

Medical Expenses Threshold

Medicare publications refer to the insurer's ongoing responsibility for medicals (ORM). There is no minimum dollar threshold for reporting the assumption/establishment of ORM for liability insurance. All such claims will need to be reported.

For workers' compensation claims, the ongoing responsibility for medicals are excluded from reporting through December 31, 2010, when all of these criteria are met;

- Medicals only
- Lost time of no more than seven calendar days
- All payments have been made directly to the medical provider
- Total payment does not exceed $600.

Total Settlement Threshold

Medicare publications do not refer specifically to the "total amount of settlement" but rather to the "total payments" obligations to the claimant (TPOC). *See* MMSEA Section 111 "Medicare Secondary Payer Mandatory Reporting User Guide version 1.0, March 16, 2009." Reporting thresholds for liability

and workers' compensation with regard to the total payment obligations to the claimant are as follows:

a) For TPOCs, dates July 1, 2009, through December 31, 2010, amounts of $0.00-$5,000.00 dollars are exempt from reporting except as specified in (d) below;

For TPOCs, dates of January 1, 2011, through December 31, 2011, amounts of $0.00-$2,000.00 dollars are exempt from reporting except as specified in (d) below;

For TPOCs, dates of January 1, 2012, through December 31, 2012, amounts of $0.00-$600.00 are exempt from reporting except as specified in (d) below;

Where there are multiple TPOCs reported by the same RRE on the same record, the combined amounts must be considered in determining whether or not the reporting exception threshold is met. For TPOCs involving a deductible where the RRE is responsible for reporting both in a deductible in any amount above the deductible, the threshold applies to the total of these two figures. CMS Alert for Liability Insurance (including self insurance), no fault, and workers' compensation, March 20, 2009.

Closed Cases

If an insurer had an "ongoing responsibility for medical" (ORM) that was assumed prior to July 1, 2009, and continued as of that date then the RRE must report this individual. For such cases an extension was allowed until October 2010, to report.

If the ORM was assumed prior to July 1, 2009, and the claim was closed or removed from current claims records prior to January 1, 2009, the RRE is not required to identify and report that ORM under the requirement for reporting. CMS MMSEA Section 111 "Medicare Secondary Payer Mandatory Reporting User Guide version 1.0, March 16, 2009."

MEDICARE RESOURCES

Resources are available through the CMS website with regard to the SCHIP Extension Act and reporting requirements. These resources include links to the MMSEA §111 User Guide as well as Memoranda regarding implementation of §111.

- http://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPUserGuide031609.pdf
- http://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPInterim120508.pdf
- http://www.cms.hhs.gov/MandatoryInsRep/03_Liability_Self_No_Fault_Insurance_and_Workers_Compensation.asp#TopOfPage

This site contains downloads of User Guide and Interim Record Layout as of December 5, 2008.

We urge you to contact us with any questions concerning the handling of repetitive trauma claims or for assistance in interpreting the complex requirements of the SCHIP Extension Act.

For More Information

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The cases or statutes discussed in this newsletter are in summary form. To be certain of their applicability and use for specific situations, we recommend that the entire opinion be read and that an attorney be consulted. This newsletter is compliments of Heyl Royster and is for advertisement purposes.