LEGISLATION UPDATE

HEYL ROYSTER

WORKERS' COMPENSATION NEWS FLASH

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June 2011

A WORD FROM THE PRACTICE GROUP CHAIR

On May 31, 2011, amendments to the Illinois Workers' Compensation Act were passed by the Illinois General Assembly. Governor Quinn is expected to sign the legislation into law but it is not clear at present if he will exercise his line item veto power to strike some provisions. Although the Governor has 60 days in which to sign the legislation, it is likely that it will be signed before the end of the month as some of the provisions take effect on July 1, 2011. We at Heyl Royster are happy to provide this summary of the changes contained in the legislation along with the effective date for each provision as it currently stands, emphasizing as previously stated that the changes are not final and do not become actual law until signed by Governor Quinn.

At this point we are endeavoring to provide you with a summary of the changes with minimal editorializing. Once the bill becomes law, our attorneys would be happy to visit you in person, to provide in-house presentations or "house calls," to provide insight as to what these changes mean to you in your claims handling and strategies for taking advantage of the new provisions.

To schedule your visit, please contact Kevin Luther at kluther@heylroyster.com, Bruce Bonds at bbonds@heylroyster.com or Craig Young at cyoung@heylroyster.com. We look forward to stopping by!

Kevin J. Luther
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HRVA Makes House Calls!

If you or your organization is interested in a presentation on the recent Amendments to the Workers' Compensation Act and how they will affect your claims handling, Heyl Royster would be happy to visit. To schedule your "house call" please contact:

Kevin Luther
kluther@heylroyster.com

Bruce Bonds
bbonds@heylroyster.com

Craig Young
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We look forward to stopping by!

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Employee Leasing Company, Fraud, Noncompliance, Fines, Penalties, and Insurance Reporting/Premium Adjustment

Topic: Employee Leasing Company (ELC)

Statute: 820 ILCS 305/4(a-2)

Effective Date: Upon becoming law

Every Employee Leasing Company, as defined in Section 15 of the Employee Leasing Company Act shall at a minimum provide the following information to the Illinois Workers' Compensation Commission ("IWCC") or any entity designated by the IWCC regarding each workers' compensation insurance policy issued to the ELC:

1. Any client company of the ELC listed as an additional named insured;
2. Any informational schedule attached to the master policy that identifies any individual client company's name, FEIN, and job vocation;
3. Any certificate of insurance coverage document issued to a client company specifying the identity and status of the client, as well as the coverage information.

Topic: Workers' Compensation Insurance Noncompliance

Statute: 820 ILCS 305/4(d)

Effective Date: Upon becoming law

An investigator with the Illinois Workers' Compensation Commission Insurance Compliance Division may issue a citation to an employer that is not in compliance with its obligation to have workers' compensation insurance. The amount of the fine shall not be less than $500 and shall not exceed $2,500. An employer issued a citation must pay the fine and provide to the IWCC proof that it obtained the required workers' compensation insurance within ten days after the citation was issued. After the knowing and willful failure of an employer to comply with the citation issued by an investigator with the Illinois Workers' Compensation Commission Insurance Compliance Division, the Commission may assess additional civil penalties.

Topic: Gift Ban

Statute: 820 ILCS 305/16(b)

Effective Date: Upon becoming law

An attorney appearing before the Commission shall not provide compensation or any gift to any person in exchange for the referral of a client involving a matter to be heard before the Commission except for a division of a fee between lawyers who are not in the same firm in accordance with Rule 1.5 of the Code of Professional Responsibility. Gift means any gratuity, discount, entertainment, hospitality, loan, forbearance, or any other tangible or intangible item having monetary value, including, but not limited to, cash, food and drink, and honoraria except for food or refreshments not exceeding $75 per person in value on a single calendar day, provided that food or refreshments are (1) consumed on the premises from which they were purchased or prepared or (2) catered. Violation of this section is a Class A misdemeanor.

Topic: Unlawful Acts/Penalties

Statute: 820 ILCS 305/25.5

Effective Date: Upon becoming law

It is unlawful for any person, company, corporation, insurance carrier, healthcare provider, or other entity to intentionally present a bill or statement for the payment for medical services that were not provided. Sentences for violating this section are as follows: If the value of the property is $300 or less, it is a Class A misdemeanor; if the value of the property is more than $300 but not more than $10,000, it is a Class 3 felony; if the value of the property is more than $10,000 but not more than $100,000, it is a Class 2 felony; if the violation is more than $100,000, it is a Class 1 felony. A person convicted under this section shall be also be ordered to pay monetary restitution to the insurance company or self-insured entity or any other person for any financial loss sustained as a result of the violation of the section, including court costs and attorney fees. An insurance company, self-insured entity, or any other person suffering financial loss sustained as a result of a violation may seek restitution, including court costs and attorney fees in a civil action in a court of competent jurisdiction.

The fraud insurance non-compliance unit shall report violations to the "Special Prosecutions Bureau of the Criminal Division of the Office of the Attorney General" or to the state's attorney of the county in which the offense allegedly occurred, either of whom has authority to prosecute viola-

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tions under this section. The primary insurance shall have authority to issue a subpoena to a medical provider. The fraud and insurance non-compliance unit shall implement a system utilizing advance analytics inclusive of predictive modeling, data mining, social network analysis, and scoring algorithms for the detection and prevention of fraud, waste, and abuse on or before January 1, 2012.

The fraud and insurance non-compliance unit shall also provide a report to the President of the Senate, Speaker of the House of Representatives, Minority Leader of the House of Representatives, Minority Leader of the Senate, Governor, Chairman of the Commission, and Director of Insurance on or before July 1, 2012, and annually thereafter. The fraud and insurance non-compliance unit shall submit a written report on an annual basis identifying information regarding all proceedings under this section.

Topic: Recalculation of Workers' Compensation Premium Rates

Statute: 820 ILCS 305/29.1

Effective Date: Upon becoming law

On the effective date of this amendment, the Director of Insurance shall immediately direct in writing any workers' compensation rate setting advisory organization to recalculate workers' compensation advisory premium rates and assigned risk pool premium rates so that these premiums incorporate the provisions of the amendments and to publish such rates on or before September 1, 2011.

Topic: Insurance Oversight

Statute: 820 ILCS 305/29.2

Effective Date: Upon becoming law

The Department of Insurance shall annually submit to the Governor, the Chairman of the Commission, the President of the Senate, the Speaker of the House of Representatives, the Minority Leader of the Senate, and the Minority Leader of the House of Representatives a written report that details the state of the workers' compensation insurance market in Illinois. The report shall be completed by April 1 of each year beginning in 2012

UR, Fee Schedule, Payment of Medical, Implants

Topic: Assignment of Medical Bills and Receivables

Statute: 820 ILCS 305/8(a)

Effective Date: Upon becoming law

Change/Clarification in the law:

The medical fee schedule shall govern payments of medical bills "even if a health care provider sells, transfers, or otherwise transfers, or assigns an account receivable for procedures, treatments or services covered under this Act."

Topic: Medical Fee Schedule

Statute: 820 ILCS 305/8.2

Effective Date of Changes: September 1, 2011

Changes in the law:

1. Out-of-state treatment shall be reimbursed at the lesser of that state's fee schedule, or the fee schedule amount for the region in which the employee resides.
2. Medical implants shall be reimbursed 25% above the net manufacturer's invoice price, less rebates, plus actual reasonable and customary shipping charges.
3. The maximum allowable payment under the fee schedule will be 70% of the fee schedule amount adjusted yearly by the Consumer Price Index for all goods and services (CPI-U).
4. Prescriptions filled and dispensed outside of a licensed pharmacy will be subject to the fee schedule that shall not exceed the average wholesale price (AWP) plus a dispensing fee of $4.18.
5. Payments to providers for treatment shall be made within 30 days (down from 60 days) upon receipt of the bills, as long as the claim contains substantially all of the required data necessary to adjudicate the bill. Where the claim does not contain the requisite data, the employer or insurer shall provide written notification explaining the basis for the denial, and describing any additional necessary information to the provider within 30 days of receipt of the bill. Interest will accrue at 1% per month in the case of non-payment to a provider within 30 days of receipt of the bill.

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6. For services not covered by the fee schedule, reimbursement shall occur at 53.2% of charges.

7. Effective January 1, 2012, fee schedule amounts shall be grouped into new geographic regions with 4 regions for non-hospital fee schedule amounts, and 14 regions for hospital fee schedule amounts.

What it means:

The 2005 amendments to the Illinois Workers' Compensation Act capped charges for workers' compensation treatment under a new medical fee schedule at 90% of the 80th percentile of charges (subject to some exceptions where charges for treatment were to be paid at 76% of the charge), with annual increases pegged to the Consumer Price Index for all goods and services (CPI-U) and some of the much higher Consumer Price Index for medical services (CPI-N). It has become apparent that the medical fee schedule as enacted in 2005 did not create the desired savings. Medical expenditures constitute between 50 and 60% of all workers' compensation outlays, and Illinois has the second highest reimbursement for medical services of any state in the country. In an effort to save as much as 300 to 500 million dollars per year going forward, the changes in the 2011 amendments would take the original fee schedule amount and reduce it by 30%. For services not covered by the fee schedule (the so-called 76% of POC services), that 76% would be reduced to 53.2%, all effective September 1, 2011. Annual increases would still be limited to the Consumer Price Index for all goods and services.

To simplify the cumbersome system of 29 geozips implemented in the 2005 amendments, non-hospital services would be grouped into four regions (apparently similar to those used for Medicare reimbursements) as follows:

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 in the state.

Fourteen regions would be used for hospital fee schedules presumably at the request of the Illinois Hospital Association. These regions would become effective January 1, 2012.

Subsequent to the 2005 amendments, concern was raised with respect to the charges for medical implants, such as prosthetics, orthotics, pacemakers, and the like. As these were not covered by the fee schedule, some providers charged 200 to 300% over cost. Effective September 1, 2011, the providers of implants would be reimbursed at 25% over the net manufacturer's invoice price, less rebates, plus actual reasonable and customary shipping charges.

To partially recompense for this reduction in the amounts which medical providers will be permitted to charge, the time period in which payments should be made has been reduced under the 2011 amendments from 60 days from receipt of the bill, to 30 days. Where the employer or insurer does not have significant information to properly adjudicate the bill, they must provide written notification within 30 days of that fact, and outline the information necessary to properly adjudicate. Interest at 1% per month commences 30 days after receipt of the bill.

The 2011 amendments also bring the out-of-state providers within the fee schedule specifically indicating that reimbursement will be made at the lesser of that state's fee schedule, or the fee schedule for the region in which the employee resides. If no fee schedule exists in the state, the provider shall be reimbursed at the lesser of the actual charge or the fee schedule in the region where the employee resides.

Topic: Utilization Review

Statute: 820 ILCS 305/8.7

Effective Date of Changes: All health care services provided or proposed to be provided on or after September 1, 2011

Changes in the law:

1. Utilization review providers will register with the Department of Insurance rather than the Department of Financial and Professional Regulation.

2. The 2011 amendments provide that upon written notice that the employer wishes to invoke the utilization review process the provider shall submit to utilization review and make all reasonable efforts to provide timely and complete reports of clinical information needed to support such a request.

3. If the provider fails to make such reasonable efforts, the charges for the treatment or services **may not** be compensable nor collected from the employer, the employer's agent, or the employee.

4. Written notice of utilization review decisions, including the clinical rationale, shall be furnished to the provider and the employee.

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5. The employer may deny payment or refuse to authorize payment of services where an accredited utilization review program has determined that the extent and scope of medical treatment is excessive and unnecessary.

6. Where payment has been denied pursuant to utilization review, the employee has the burden to show by a preponderance of the evidence that a variance from the standards of care used by utilization review is reasonably required to treat his or her injury.

7. The medical professional responsible for reviewing the final stage of the utilization review or appeal must be available for interview or deposition, either in person or by telephone or videoconference. The expense of interview and the deposition method shall be paid for by the employer.

8. Finally, the 2011 changes indicate that an "admissible" utilization review shall 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 and the determination of the reasonableness and necessity of the medical bills or treatment.

What it means:

Although the medical fee schedule deals with the amount which the providers may charge for treatment, utilization review addresses the reasonableness, necessity and frequency of treatment. The medical fee schedule, which strictly limited the amount which doctors can charge would not be effective if there was no concurrent limit on the frequency and type of treatment. It has become clear since the 2005 amendments that arbitrators and commissioners do not completely understand the importance of utilization review, and that it is evidence-based medicine as opposed to simply the opinion of a local treating doctor. Decisions to date suggest that the Commission treats utilization review as being little more than an independent medical evaluation under Section 12, and are still relying heavily on the so-called "treating doctor mystique" in rendering their decisions. While the 2005 amendments mandated that a URAC accredited utilization be performed and created a rebuttal presumption against penalties when such a process is followed, the Commission does not require employees and medical providers to complete the process, including all appeals. Moreover, issues with regard to the admissibility of the reports and the need for depositions has further diluted the use of utilization review.

The codifications going forward still contain ambiguities, especially insofar as what is an "admissible" utilization review. However, the 2011 amendments would require the cooperation of employees and providers where utilization review is requested in writing, would provide that should the provider not cooperate, the charges may not be collectable, and that where an employer has denied payment based on a utilization review finding that the extent and scope of treatment is excessive and unnecessary, the burden of proof in essence shifts to the employee to show that a variance from national standards of care are necessary in this specific case.

The deposition process is also provided for, which suggests that the reports will not in and of themselves be admissible.

PPO Networks, TPD Change, Codification of "Accident"

Topic: Codification of the Causation Standard

Statute: 820 ILCS 305/1(d)

Effective Date: Immediately upon becoming law

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 the employment.

This represents a new addition to the Act. This codifies causation in workers' compensation cases within the State of Illinois. This aspect of workers' compensation claims has never been codified before, however, this is exactly the standard which has been utilized based upon case law precedent. It is unlikely that this will change the very liberal interpretation of causation currently being used by Illinois Courts. In effect Illinois remains an "any cause" state as far as causation is concerned. In order to recover an injured employee needs only to show that that accident was "a" cause of his injuries and not "the" cause or even the "primary" cause.

Topic: Calculation of Temporary Partial Disability Benefits

Statute: 820 ILCS 305/8(a)

Effective Date: Immediately upon becoming law

When the employee is working light duty on a part-time basis or full-time basis and earns less than he or she would be earning if employed in the full capacity of the job or jobs, then the employee shall be entitled to temporary partial

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disability benefits. Temporary partial disability benefits shall be 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 in which he or she was engaged at the time of accident and the gross amount which he or she is earning in the modified job provided to the employee by the employer or in any other job that the employee is working.

The amendment pertaining to this Section of the Act changes one word only; it gets rid of the word "net" and changes it to "gross." This change is for the benefit of the employer because it cuts down on the amount of temporary partial disability benefits (TPD) which the injured employee will receive. In the case of this amendment to the Act it would best to utilize an example in order to illustrate how this amendment will affect workers' compensation claims.

If we assume the injured employee had an average weekly wage of $1,000.00 per week and that injured worker suffered a compensable claim, he would be paid a temporary total disability rate of $666.67 per week if he was taken off work completely as a result of his compensable injury. If at some point during the course of the pending claim involving the injured employee he is allowed to go back to work on a light duty basis but has yet to reach maximum medical improvement he might be entitled to temporary partial disability.

If the injured employee returns to work at modified duty and is only able to earn $400.00 per week (as opposed to $1,000.00 per week), then we subtract: $1,000.00 minus $400.00 which would leave a balance of $600.00. The $600.00 figure would be multiplied by two-thirds and yield a figure of $400.00 as the TPD rate.

Under the old method we subtracted the net wage earnings. If we assume the employee netted $300.00 after taxes were subtracted from the light duty earnings, then the balance would be $700.00. Multiplying that figure by two-thirds equals $466.67, which would have been the TPD rate under the old method.

Topic: Preferred Provider Organizations / PPO's

Statute: 820 ILCS 305/8(a)4

Effective Date: Immediately upon becoming law

> The following shall apply for injuries occurring on or after the effective date of this amendatory Act of the 97th General Assembly 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 employers shall, in writing, on a form promulgated by the Commission, inform the employees 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).

This amendment to the Act deals with the use of preferred provider organizations (PPO's). If at the time of a work related accident, the employer has in place a PPO pursuant to Section 8.1(a) of the Act then the following will apply:

- The employer will be provided an IWCC form to provide notification to the injured employee of the PPO/program effect at the time of the accident in question.
- After the injured employee files his first report of injury, the injured employee may choose, in writing, at any time, to decline the use of the PPO/program offered by the employer but in doing so the injured employee uses up one of his or her two choices of physicians pursuant to the Act.
- Before the injured employee fills out the first report of injury, when that same employee chooses non-emergency treatment from a provider who is not within the PPO/program provided by the employer, that choice of treatment would constitute one of the employee's choices of medical providers pursuant to the Act.

The IWCC will provide, on its website, a form which the employers must use once they become aware of an accident suffered by one of their employees if that employer has in place, at the time of the alleged injury, a PPO program. One of the side effects of not filling out such a report is that the injured employee is not aware of the program and therefore if that same employee declines to use that medical provider/program then the injured employee still has two choices of physicians instead of using up one. Therefore, it is in the employer's best interest to have these forms filled

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out right away and turned into the proper sources which should include the IWCC and the injured employee (and if that injured employee is represented by counsel, then also to his attorney of record).

Please be aware this aspect of the Act will not limit the injured employee's ability to obtain emergency treatment following an accident. This deals with non-emergency treatment only. It is important to review the treatment and history in order to determine if it was truly "emergent" in nature. If it is not, even if the treatment took place at a hospital's emergency department, then the treatment may still be limited by this Section of the Act.

Topic: Creation of Preferred Provider Programs

Statute: 820 ILCS 305/8.1(a)

Effective Date: Immediately upon becoming law

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 3701 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) 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.

This new aspect of the Act outlines the provisions required for a PPO to follow to obtain approval by the Illinois Department of Insurance. Under the provisions of the Act the employer under the PPO is considered the "insured" and the employee is the "beneficiary."

The PPO must have as part of its program, and in its network adequate occupational and non-occupational medical providers. Within the network the PPO must provide an adequate number of and different type of physicians who have the ability to treat common work injuries in the geographic area where the employee lives. Further, the employee must

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have treatment access which will be timely in nature as part of this network. If complaints are made because the PPO does not make good on these statutory obligations then the Director of Insurance may deny approval of the PPO once it is determined the criteria outlined above has not been met by the PPO.

Employers should seek PPO programs which understand their industry so that the medical providers available will understand the types of jobs being performed, the types of injuries typically incurred, as well as the availability transitional work opportunities and return to work programs.

Arbitrator + Commissioner Training, Qualifications, Appointments, Ethics, Advisory Board

Topic: Changes in Arbitrator's Terms, Qualifications and Assignments of Members of the Illinois Workers' Compensation Advisory Board

Statute: 820 ILCS 305/13.1(d)

Effective Date: When statute becomes law

The terms of all of the members of the workers' compensation advisory board are terminated on the effective date of the act. The act provides that it will become effective upon becoming law. In other words, the terms of every member of the Workers' Compensation Commission advisory board will end when the Governor signs the reform legislation. Considerations on the terms of arbitrators make it likely that the workers' compensation reform legislation will be signed by the Governor sometime in June, 2011. The Governor has 30 days from the effective date of the act to appoint new members to the workers' compensation advisory board. The Governor's appointments are subject to Senate approval.

Topic: Changes in Terms of Arbitrators

Statute: 820 ILCS 305/14

Effective Date: July 1, 2011

The term of all arbitrators, including arbitrators currently on administrative leave, will terminate at the close of business on July 1, 2011. Incumbent arbitrators shall continue to exercise all of their duties until the arbitrator is reappointed or the arbitrator's successor is appointed.

New arbitrators will be appointed by the Governor. The newly constituted advisory board is to provide the Governor with recommendations as to candidates for the position of arbitrator and can make recommendations to the Governor. The Governor's appointments are subject to Senate approval. Newly appointed arbitrators are required to be licensed attorneys in the State of Illinois with one exception: any arbitrator who served as an arbitrator before the reform legislation and who was not an attorney may be reappointed as an arbitrator even if that person is not a licensed Illinois attorney.

All new arbitrator appointments will be subject to three year terms. The new arbitrators will be appointed on staggered terms with the first set of 12 to expire July 1, 2012, the next 12 to expire on July 1, 2013 and the remaining arbitrators to expire on July 1, 2014. When an arbitrator's term expires, the Chairman of the Commission will evaluate the arbitrator's performance and may recommend that the Arbitrator be appointed to another term by the full Commission. New arbitrators are held to a new standard of conduct in new section 1.1 of the act. The section requires that commissioners and arbitrators will decide cases promptly, efficiently and fairly without bias or prejudice. They are also to be unswayed by partisan interests, public clamor, or fear of criticism. While these standards have generally been expected of commissioners and arbitrators, they have never been spelled out specifically in the act. The act also includes requirements for continuing education of arbitrators, including becoming knowledgeable about the application of AMA disability rating guidelines, utilization review and detection of fraud.

The Workers' Compensation Commission is directed to assign no fewer than three arbitrators to each hearing site. The Commission is required to establish a procedure to make sure that arbitrators assigned to each hearing site are assigned cases on a random basis. Other than Chicago, no arbitrator may hear cases at any hearing site for more than two years in any three year term. The method by which the assignment of arbitrators to hearing sites and randomness of cases assigned to them is not spelled out in the reform legislation. How that will be applied is entirely up to the Workers' Compensation Commission. Summary - The terms of every arbitrator in the State of Illinois will come to an end on July 1.

Appointment of all new arbitrators, or reappointment of current arbitrators, lies with the discretion of the Governor with advice from the new advisory board and review and consent by the Senate. Downstate hearing sites will be significantly different under the reform legislation than they have been in the past. Downstate dockets currently have a single arbitrator assigned to cover the docket. That single arbitrator in many cases has handled the docket for a num-

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ber of years. Each downstate docket will now have three arbitrators assigned to the docket and cases will be assigned randomly to one of the arbitrators. The means and methods of how the Commission will implement this requirement are not outlined in the legislation and remain to be seen. The additional requirement that an arbitrator not handle a docket for more than two years means that each downstate docket will see a number of different arbitrators.

Disability Evaluation (AMA Impairment), CTS Calculation, Wage Differential

Topic: Determination of Permanent Partial Disability

Statute: 820 ILCS 305/8.1(b)

Effective Date: Applicable to all injuries occurring on or after September 1, 2011

Amended Section 8.1b(a) establishes that in determining permanent partial disability an impairment rating shall be utilized. The impairment rating shall be included in a written report prepared by a physician licensed to practice medicine and the impairment rating shall include an evaluation of medically defined and professionally appropriate measurements of impairment, including but 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 amendment states that the most current edition of the American Medical Associations Guides to the Evaluation of Permanent Impairment shall be utilized by the physician in determining the level of impairment.

Amended Section 8.1b(b) further establishes that in determining the level of permanent partial disability, the Commission shall base its determination not only on the reported level of impairment pursuant to subsection (a), but also on: the occupation of the injured employee; the age of the employee at the time of the injury; the employee's future earning capacity; and evidence of disability corroborated by the treating medical records. The amendment states that no single enumerated factor shall be the sole determination of disability and the relevance and weight of any factor used in addition to the level of impairment as reported by the physician, must be explained by the Commission in its written order.

This amendment is intended to incorporate businesses' desire to include the AMA Guides in determination of permanent partial disability. Although the statutory language makes it clear that the AMA rating shall be used by the physician in determining the level of impairment, the final level of impairment established by the physician includes other elements. Most importantly, the statutory language makes it clear the impairment rating is one of only several factors which will be incorporated into the final permanent partial disability award. Along with the impairment rating, the traditional factors used to award permanent partial disability, including the employee's occupation, age, future earning capacity, and evidence of disability in the medical records will be considered.

While the ultimate impact of this change in statutory language is uncertain, several factors are clear. First, under current law, evidence of impairment, including AMA ratings are inadmissible. This amendment not only allows for the admission of impairment ratings, but requires an impairment rating in every case, and further requires that in arriving at that impairment rating, the doctor shall use the AMA Guides. The impairment rating remains, however, only one of several factors which will be used in arriving at the ultimate permanent partial disability. The other factors to be consider include those factors which have traditionally been considered in evaluating disability. While it is hoped the inclusion of the impairment rating as a factor to be considered will lower permanency amounts, great discretion will continue to rest with the Arbitrators and Commissioners with regard to permanency.

The amendment is also unclear as to how the impairment rating will be determined from an evidentiary standpoint. Although it is required that the impairment rating be made in writing by a licensed physician, there is no designation as to which physician will make the determination. Presumably, this will become the subject of IME opinions, along with any impairment rating which may be developed through the treating physician.

Topic: Carpal Tunnel Syndrome

Statute: 820 ILCS 305/8(e)(a)

Effective Date: Accidents Occurring On or After Effective Date of Amendatory Act

An amendment to the Act codifies certain changes to permanency awards in carpal tunnel cases. In accidental injuries involving carpal tunnel syndrome due to repetitive trauma or cumulative trauma, the total number of weeks

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available for permanency is reduced from 205 weeks to 190 weeks. The amendment further clarifies that the permanent partial disability shall not exceed 15% loss of use of the hand, except for cause shown by clear and convincing evidence. In no event shall the award exceed 30% loss of use of the hand. Presumably, this should reverse the trend for permanency awards in standard carpal tunnel cases to creep into the 17.5% to 20% of the hand range. Petitioners will obviously be attempting to show good cause as to why the awards should exceed 15% of the hand, so clear documentation of good results in carpal tunnel cases will be important.

Topic: Limits on Wage Differential Awards

Statute: 820 ILCS 305/8(d)(1)

Effective Date: Applicable to all injuries occurring on or after September 1, 2011

Amendment to Section 8(d)(1) of the Act provides that a wage differential award 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. This amendment changes existing law, which makes a wage differential award effective for the injured employee's life.

The practical impact of this language should be a significant limitation on wage differential awards, which have become more prolific in recent years, and contributed to the increased cost of permanency resolutions. Not only will the number of years for which an 8(d)(1) award will be paid be limited, but settlements will be positively impacted. Petitioners will no longer be able to place on the table large present cash dollar figures for wage differential awards projected over the course of a petitioner's lifetime. Lump sum settlements on wage differential cases should become more reasonable.

From a strategy standpoint, it will become more necessary for the employer to push aggressively for resolution of a potential wage differential case. This language indicates a wage differential award will be effective for a minimum of five years. When a petitioner is approaching the age of 67, the petitioners' attorneys may try to drag out a case for an extended period of time in order to project the five year period farther into the petitioner's life span. Prompt closure of potential wage differential cases will begin the clock ticking on the five year limitation, which begins on the date the award becomes final.

INTOXICATION

Topic: Injuries Occurring While Intoxicated

Statute: 820 ILCS 305/11

Effective Date: Applicable to all injuries occurring on or after September 1, 2011

Section 11 of the Illinois Workers' Compensation Act was amended to reduce the instances when an employee can recover for injuries received while intoxicated. The amendment provides that if an employee's intoxication is the proximate cause of the employee's accidental injury, or the employee was so intoxicated that the intoxication constituted a departure from employment, no compensation is owed by the employer. Evidence of the concentration of alcohol or controlled substances in the employee's blood, breath, or urine at the time of injury is admissible in any workers' compensation hearing to determine whether the employee was intoxicated at the time of the injury. If such testing shows 0.08% or more by weight of alcohol in the employee's blood, breath or urine, or if there is any evidence of impairment due to intoxication or the illegal use of a controlled substance, there shall be a rebuttable presumption that the employee was intoxicated and that the intoxication was the proximate cause of the employee's injury. An employee's refusal to submit to testing of blood, breath or urine, also gives rise to a **rebuttable presumption** that the employee was intoxicated and that the intoxication was the proximate cause of the injury.

Any testing performed under this section of the Act must be performed by an accredited or certified testing laboratory. If the laboratory is not so accredited or certified, the test results are not admissible to determine whether the employee was intoxicated at the time of the injury.

The Workers' Compensation Commission is charged with responsibility for adopting rules for sample collection and testing. By law the rules must ensure that: (1) there is compliance with the National Labor Relations Act regarding collective bargaining agreements in the sample collection and testing; (2) samples are collected and tested in conformance with national standards for the privacy of the individual being tested and in a manner reasonably calculated to prevent substitutions; (3) that split testing procedures are utilized; (4) that the sample collection is documented; (5) that the sample collection storage and transportation is performed in a manner reasonably likely to preclude the probability of contamination or alteration; and (6) that chemical

analysis of blood, urine, breath or other bodily substances are performed according to nationally scientifically accepted analytical methods.

This amendment may make it more difficult for an intoxicated worker to recover workers' compensation benefits. Presently, by case law, an employer must prove that an injured worker was so intoxicated that the intoxication was the sole cause of the accident, or that the intoxicated worker was so intoxicated, it constituted a departure from employment in order to deny benefits. While the new codified standard and the old case law standard are similar, the addition of the rebuttable presumption where there is proof of 0.08% or more by weight of alcohol in the employee's blood, breath or urine, will make the defense of these cases easier. There is no presumption that the intoxication was the proximate cause of the accident if testing shows a blood alcohol level of 0.08%.

With the amendment in place, employers should make post accident drug and alcohol testing mandatory. It is imperative that the testing laboratory be certified and accredited as required by the amendment. It is further imperative that the laboratory conduct the tests in accordance with the rules which are to be adopted by the Illinois Workers' Compensation Commission.

Collective Bargaining Pilot Program-ADR

Topic: Collective Bargaining Pilot Program

Statute: 820 ILCS 305/4b (not to be confused with section 4(b) which is unrelated)

Effective Date: Upon becoming law

Authorizes the Director of the Department of Labor to designate two labor organizations from the construction industry to participate in a Collective Bargaining Pilot Program. The labor organizations and construction employers will be permitted to enter into a collective bargaining process to establish certain obligations and procedures relating to workers' compensation claims. Any collective bargaining agreement will not diminish or increase a construction employer's or construction employee's entitlement to benefits pursuant to the Illinois Workers' Compensation Act. However, the parties to the collective bargaining agreement will be permitted to agree to workers' compensation obligations and procedures in the following areas:

1. The creation of an alternative dispute resolution system to supplement, modify or replace the procedural or dispute resolution provisions of the Workers' Compensation Act.
2. Formulation of an agreed list of medical providers who may be the exclusive source of any treatment for work related injuries.
3. The use of a limited list of impartial physicians to perform independent medical examinations.
4. The development of a light duty or modified duty return to work program.
5. The use of a limited list of individuals and companies to provide vocational rehabilitation or retraining programs.
6. The establishment of joint labor and management safety committees and safety procedures.

The Commissioner is to record any settlements under these provisions.

It is unclear how popular this change may become. While the process may be slightly different, it is noteworthy that the benefits rewardable cannot be greater or less than those otherwise available in the Act.

HRVA Makes House Calls!

If you or your organization is interested in a presentation on the recent Amendments to the Workers' Compensation Act and how they will affect your claims handling, Heyl Royster would be happy to visit. To schedule your "house call" please contact:

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We look forward to stopping by!

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