2011 AMENDMENTS – A VIEW FROM THE TRENCHES

I. PREFERRED PROVIDER PROGRAMS..............................................................G-3

II. THE “SYSTEM” AS VIEWED FROM THE TRENCHES ..................................................G-6
   A. Appointments.........................................................................................G-6
   B. News from the Venues..............................................................................G-6
      1. 19(b) Hearings.....................................................................................G-6
      2. Venue Procedures:...............................................................................G-6
      3. Pro se Settlements.................................................................................G-7
      4. General Observation About Downstate Venues..................................G-7

III. UTILIZATION REVIEW: POTENTIAL PITFALLS..............................................G-7
   A. Which Guidelines Must Be Used to Evaluate Treatment?.....................G-7
   B. Cooperation with Utilization Review.......................................................G-8
   C. Is a Utilization Review Required Before Treatment May Be Denied?........G-8
   D. Burden of Proof: Section 8.7(4).............................................................G-9
   E. Depositions.............................................................................................G-9
   F. Penalties..................................................................................................G-9
   G. Utilization Review Appeals......................................................................G-9
   H. Must All Utilization Review Functions Be Performed within the State of Illinois? G-10
   I. Can I Obtain a Utilization Review and a Section 12 IME?......................G-10
   J. Is the Utilization Review Determination Dispositive?..............................G-10
   K. Beware of Petitioner’s Counsel Laying in the Weeds!...........................G-11
   L. Conclusions and Observations Regarding the Use of Utilization Review From the Trenches G-11

The cases and materials presented here are in summary and outline form. To be certain of their applicability and use for specific claims, we recommend the entire opinions and statutes be read and counsel consulted.
2011 AMENDMENTS – A VIEW FROM THE TRENCHES

As we approach the two-year anniversary of the implementation of the 2011 Amendments to the Illinois Workers’ Compensation Act, we are beginning to be able to discern the practical effect of these amendments on our day-to-day practice.

I. PREFERRED PROVIDER PROGRAMS

By way of background, the 2011 Amendments created a program called “PPPs” or Preferred Provider Program which are networks to be utilized for the treatment of work related injuries. The intent of PPPs was to give the employer some measure of control over where the employee seeks treatment and to help ensure that the treatment rendered for work related injuries is cost effective and improved outcomes. The amendments mandated the following requirements for all PPPs:

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 delay or denying medical treatment or restricting access to medical treatment.
5. Before entering into any agreement, the program shall establish terms and conditions that must be met by non-institutional providers, wishing to enter into an agreement with the program. These terms and conditions may not discriminate unreasonably against or among non-institutional providers.

At its most basic, the PPP must be in place at the time of the accident; the employer will provide a written list of physicians in the program to an injured worker upon notice of the injury. The employer is then responsible for the payment of all medical expenses and referrals from the PPP physician. If an employer does not establish a PPP, the injured worker retains the right to the choice of two physicians (similar to the law prior to the 2011 Amendments). The injured worker also has the right to decline the program in writing. The employee is then limited to the choice of only one physician.

If an injured worker believes the medical care provided by the PPP physician has been inadequate or improper, he can file a written petition with the Illinois Workers’ Compensation Commission. Within five days of hearing, the commission must render a decision regarding the
case. If it is determined that the care has been inadequate or improper, then the injured worker’s choice of physician is reinstated.

Although the use of PPPs became effective immediately upon the Governor’s signature back in the summer of 2011, the Department of Insurance spent nearly two years establishing rules to govern the implementation and use of Preferred Provider Programs. These rules have been published and were effective as of March 4, 2013. They can be accessed via links from the commission website at www.iwcc.il.gov. There are currently only six workers’ compensation Preferred Provider Programs who have sought and obtained approval from the Illinois Department of Insurance. They are as follows:

- Corvel Healthcare Corp.
- Coventry Healthcare Workers’ Compensation, Inc.
- HFN, Inc.
- Quality First Medical Centers, Inc.
- Aetna Workers’ Compensation Access, LLC
- Continental Indemnity Co.

When the injured employee notifies the employer of the injury, or files a claim for workers’ compensation with the employer, the employer must notify the employee of their right to be treated by a physician of his/her own choice from the preferred provider network and a method by which the list of participating network providers may be accessed. The commission has created a form to provide this notice.
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 8.1(a). 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 therefrom. 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 wcc.infoquestions@illinois.gov, or check the Commission's website at www.iwcc.il.gov/.

Received by: ________________________________________________

Signature

__________________________________________________________

Name (please print)

__________________________________________________________

Date

IWCC 10/18/11
Although PPPs were provided for by the statute nearly two years ago, their use is in its infancy. Experience gained from employers operating in other states suggest that PPPs may result in reduced employer costs while delivering higher quality and improved medical results. Whether that is true or not remains to be seen.

II. THE “SYSTEM” AS VIEWED FROM THE TRENCHES

A. Appointments

Chairman Mitch Weisz who had headed the Illinois Workers’ Compensation Commission since March 22, 2010 was not reappointed by the Governor. On March 25, 2013, Governor Quinn appointed commissioner Michael Latz as chairman. Chairman Latz was formerly a “public” commissioner. At the time of his appointment he used a statement indicating:

I am honored to serve as chairman and grateful for this opportunity. I will do everything in my power to make the workers’ compensation program successful and to continue implementing the legislative reform. I will enthusiastically work to ensure that claims are resolved fairly and promptly. Please feel free to e-mail me at michael.latz@illinois.gov or call at 312-814-6560.

Prior to his appointment to be chairman, Latz had served as a commissioner since October 2011.

Governor Quinn also renewed the appointments of business commissioners Mario Basurto and Ruth White, as well as the employee representative, commissioner Tyrrel. Former commissioner Yolaine Dauphin was not reappointed and with the promotion of former commissioner Latz, there are now two “public member” commissioner slots open on the commission.

B. News from the Venues

1. 19(b) Hearings

Many downstate arbitrators are now requiring pre-trial hearings before proceedings on any emergency hearing filed under section 19(b).

2. Venue Procedures:

Many downstate arbitrators are attempting to streamline the process on the docket call days by use of a system of cards carrying letters and numbers, rather than having attorneys stand in long lines for extended periods of time. Under the current system, especially in Zone 2, attorneys will take a numbered card from the stack which will represent their “place in line” for routine and non-contested matters, and a “lettered” card from a stack which will give them their “place in line” for contested matters, pre-trial matters or any other non-routine matters.
3. Pro se Settlements

Pro se settlements are generally reviewed at 1:00 p.m. on the date of the docket call and with the exception of extremely small dockets (such as Quincy), there are no cases arbitrated on the date of the docket call.

The attorneys in our practice group are often asked whether a settlement or proposed settlement with a pro se will be approved. The answer is “depends on the arbitrator.” Some arbitrators will aggressively insist on higher settlement amounts, notwithstanding an AMA rating. Others will more or less “rubber stamp” virtually any agreement.

Under the current system, although each case must be formally filed and assigned a “WC” number before being presented for contract approval, a pro se petitioner can be presented for contract approval before any arbitrator presiding at the venue to which their case has properly been assigned. In a “close case,” please contact us to discuss when and before whom you might wish to present your pro se petitioner for settlement approval.

4. General Observation About Downstate Venues

With the elimination of a number of downstate venues, there are significantly more cases assigned to each docket than prior to the 2011 Amendments. In most instances, no cases are arbitrated on the docket call day.

The consolidation has also caused a fair amount of inconvenience for the parties and their attorneys. For example, a petitioner who lives and was injured in Danville, Illinois, now part of Zone 2, would have their case venued in Urbana. It is possible, however, that should they wish to proceed on an emergency hearing under section 19(b), they might have to request a hearing in Quincy, Illinois, on the opposite end of the state, depending on where the arbitrator to whom the case has been assigned is presiding that particular month.

III. UTILIZATION REVIEW: POTENTIAL PITFALLS

Under Section 8.7 of the Amendments to the Workers’ Compensation Act, “utilization review means the evaluation of proposed or provided healthcare services to determine the appropriateness of both the level of healthcare services medically necessary and the quality of healthcare services provided to a patient . . . the evaluation must be accomplished by means of a system that defines the utilization of healthcare services based on standards of care of nationally recognized peer review guidelines, as well as nationally recognized treatment guidelines on evidence base medicine based upon standards as provided in this Act . . .”

A. Which Guidelines Must Be Used to Evaluate Treatment?

There are a number of different guidelines for evaluating the efficacy of treatment. To date, Illinois has not adopted or accepted any specific set of guidelines.
1. Many of the “guidelines” themselves are proprietary and can only be viewed if purchased.

2. Beware of doctors retained to perform utilization reviews based on one set of guidelines or another if they do not follow those same guidelines in their practice!

B. Cooperation with Utilization Review

Section 8.7 further indicates “upon receipt of written notice that the employer, the employer’s agent or insurer which is to invoke the utilization review process, the provider of medical, surgical, or hospital services shall submit to the utilization review following the procedural guidelines.”

The provider shall make reasonable efforts to provide timely and complete reports of clinical information needed to support a request for treatment. If the provider fails to make such reasonable efforts, the charges for the treatment or service may not be compensable nor collectable by the provider or petitioner from the employer, the employer’s agent, or the employee. The reporting obligations of provider shall not be unreasonable or unduly burdensome.

- What does this mean?
- What is a failure to make a “reasonable effort” that would support a denial of payment?
- What obligations placed on a provider would be considered “unreasonable” or “unduly burdensome?”

C. Is a Utilization Review Required Before Treatment May Be Denied?

Section 8.7 further indicates:

(i)(3) An employer may only deny payment of or refuse to authorize payment of medical services rendered or proposed to be rendered on the grounds that the extent and scope of medical treatment is excessive and unnecessary in compliance with an accredited utilization review program under this Section.

1. The petitioner’s counsel will argue that the reasonableness and necessity of treatment cannot be attacked via an IME/Section 12 examination, but only under a utilization review as provided in this Section.

2. Note that this section does not use the typical words “reasonable and necessary,” however. It refers to deny in treatment which is “excessive and unnecessary.”
3. Be careful: If you deny treatment without a utilization review, you may have waived the issue and subjected your insured penalties.

D. Burden of Proof: Section 8.7(4)

When a payment for medical services has been denied or not authorized by the employer or when authorization for medical services is denied pursuant to utilization review, the employee has the burden of proof to show by a preponderance of the evidence that a variance from the standards of care used by the person or entity performing the utilization review pursuant to subsection (a) is reasonably required to cure or relieve the effects of her injury.

- What evidence must a petitioner marshal to show by a preponderance of the evidence that a variance is necessary?
- At a minimum, must petitioner provide the utilization review to the treating physician and obtain a report outlining the reasons for the need for the variance?

E. Depositions

The 2011 Amendments address the process by which a deposition can be taken of the utilization review medical professional. It further indicates “the expense of interview and the deposition method shall be paid by the employer.”

- What does this mean?
- Some plaintiffs’ attorneys claim they are entitled to attorney’s fees and expenses for taking the deposition.

F. Penalties

A valid utilization review report may shield the employer from the imposition of penalties but it is not dispositive on the issue of the reasonable necessity of the treatment. Section 8.7 clearly states “[a]n 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 in the determination of the reasonableness and necessity of the medical bills or treatment.”

G. Utilization Review Appeals

The utilization review process provides for at least two levels of appeal where treatment has been denied or non-certified. Both the plaintiff and the treating physician may initiate those appeals. Is the plaintiff required to exhaust their appeal remedies before seeking hearing on the reasonableness and necessity of proposed treatment?

- NO! Although this would be common sense, strictly interpreted, the act does not require that all appeals be exhausted before seeking hearing under section 19(b).
H. Must All Utilization Review Functions Be Performed within the State of Illinois?

- **NO!** Although the Director of Department of Insurance issued a bulletin on December 20, 2012 reporting to require all utilization review functions be performed in the State of Illinois, this was subsequently clarified in a subsequent bulletin of January 19, 2013 to indicate that utilization review functions can be performed anywhere in the continental United States.

I. Can I Obtain a Utilization Review and a Section 12 IME?

- **YES!** In serious cases it would be wise to do so. Recommended practice would be to obtain a utilization review and submit that report along with all of the other medical records to your examining physician for comment. This should enhance the credibility of the utilization review report and might be a way of getting it into evidence without the need for a deposition under a utilization review doctor.

J. Is the Utilization Review Determination Dispositive?

- **NO!** Pursuant to section 8.7(j)(5):

  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 in the determination of the reasonableness and necessity of the medical bills or treatment. Nothing in this Section shall be construed to diminish the rights of employees to reasonable and necessary medical treatment or employee choice of health care provider under Section 8(a) or the rights of employers to medical examinations under Section 12.

But do not accept petitioner’s argument that the utilization review should not carry significant weight. As former Arbitrator Giordano stated in *Albert v. Roadway Express*, 05 IL.W.C. 22555, 08 I.W.C.C. 0216, 2008 WL 728102 (Feb. 25, 2008), where some treatment was approved and other treatment was denied (2:1), he:

> [P]resumes that the Legislature, applying URAC guidelines in the Statute, did not intend to give complete deference to opinions of treating physicians over that of examining physicians. Otherwise, the creation of utilization review programs would be meaningless and have no real effect on the determination of the appropriateness of the level of care and the treatment that is provided.

Arbitrators, commissioners, judges and even members of the petitioners’ bar need to be reminded of this! Moreover, the *Guides to the Evaluation of Permanent Impairment*, Sixth Edition themselves indicate “although treating physicians may perform impairment ratings on their patients, it is recognized that they are not independent, therefore, maybe subject to greater
“scrutiny.” While that refers to AMA evaluations and not utilization reviews, the bias remains the same.

**K. Beware of Petitioner’s Counsel Laying in the Weeds!**

The recent appellate court decision of *Edmar Heating and Cooling v. IWCC*, 2011 IL App (2d) 101250WC-U, in a Rule 23 order provided an interesting real world example of the type of thing that often happens at arbitration. Although the employer had sent petitioner’s counsel a letter four months prior to the hearing communicating its intent to introduce a utilization report into evidence during the hearing, petitioner did not indicate that he was objecting to the report until the employer’s counsel moved to introduce it at the hearing. The employer argued that the petitioner had waived any objection to the admission of the report by oscillatory conduct and that the report should have been admitted. The appellate court disagreed, eventually holding that “no response is not the same as acquiescence.” As a practical matter, the employer could have and should have moved for a continuance so the author of the report could testify and be cross examined at the hearing. Unfortunately, in this case the employer failed to do so. Accordingly, the commission’s decision to exclude the report was found by the appellate court not to be an abuse of discretion.

**L. Conclusions and Observations Regarding the Use of Utilization Review From the Trenches**

1. There is a significant amount of over treatment and perhaps even more since the effective date of the 2011 Amendments which reduced medical provider compensation by an additional 30 percent.

2. Utilization review non-certification has a stronger chance of being followed by the commission and courts when it addresses physical medicine treatment such as chiropractic care and physical therapy.

3. Generally speaking, utilization review non-certification is less likely to prevail where surgery and other invasive treatments are recommended and there is credible evidence of chronic pain or other disability.

4. It is important to use high quality utilization review performed by doctors who are of the same qualification as treating doctors, who are well versed in treatment standards, write thorough reports and are experienced at giving deposition testimony.
Bruce is a past Chair of our state-wide workers' compensation practice group and has spent his entire legal career with Heyl Royster beginning in 1982 in the Peoria office. He concentrates his expertise in the area of workers' compensation, third-party defense of employers, and employment law. He served as a technical advisor to the combined employers group in the negotiations which culminated in the 2005 revisions to the Illinois Workers' Compensation Act. More recently, Bruce worked as a technical advisor to the Illinois Chamber of Commerce as well as a number of Illinois legislators and State agencies in the process that resulted in the 2011 Amendments to the Illinois Workers' Compensation Act.

Bruce was appointed by Mitch Weiss, Chairman of the Illinois Workers' Compensation Commission, to a committee of attorneys who reviewed and made recommendations for revisions to the Rules Governing Practice before the Workers' Compensation Commission.

With extensive experience before the Illinois Workers' Compensation Commission, Bruce has defended employers in thousands of cases during the course of his career. As a result of his experience and success, his services are sought by self-insureds, insurance carriers, and TPAs.

Bruce is an Adjunct Professor of law at the University of Illinois College of Law where he has taught Workers' Compensation Law to upper-level students since 1998.

Bruce has co-authored a book with Kevin Luther of the firm's Rockford office entitled *Illinois Workers' Compensation Law, 2009-2010 Edition*, which was published by West. The book provides a comprehensive, up-to-date assessment of workers' compensation law in Illinois. The 2012-2013 Edition of this treatise was published in October of 2012, and is scheduled to be updated annually.

Bruce is a frequent speaker on workers' compensation issues at bar association and industry-sponsored seminars.

Bruce has served as Vice-Chair of the ABA Committee on Employment, Chair of the Illinois State Bar Association Section Council on Workers' Compensation, and currently serves on the Employment Law Committee of the Chicagoland Chamber of Commerce and the Illinois Chamber of Commerce Workers' Compensation Committee. He has been designated as one of the "Leading Lawyers" in Illinois as a result of a survey of Illinois attorneys conducted by the *Chicago Daily Law Bulletin*; another survey published recently by *Chicago* magazine named Bruce one of the "Best Lawyers in Illinois" for 2008.

**Professional Recognition**
- Martindale-Hubbell AV Rated
- Inducted as a Fellow in the College of Workers' Compensation Lawyers
- Selected as a Leading Lawyer in Illinois. Only five percent of lawyers in the state are named as Leading Lawyers.
- Named to the Illinois Super Lawyers list (2012-2013). The Super Lawyers selection process is based on peer recognition and professional achievement. Only five percent of the lawyers in each state earn this designation.

**Professional Associations**
- Illinois State Bar Association (Past Chair Workers' Compensation Law Section Council)
- Champaign County Bar Association
- Illinois Association of Defense Trial Counsel (Member, Workers' Compensation Committee)
- Defense Research Institute
- Illinois Self-Insurers Association

**Court Admissions**
- State Courts of Illinois
- United States District Court, Central District of Illinois
- United States Court of Appeals, Seventh Circuit
- United States Supreme Court

**Education**
- Juris Doctor, Washington University School of Law, 1982
- Bachelor of Arts-Finance, University of Illinois, 1979