Below the Red Line

HEYL ROYSTER

Workers' Compensation Update

"We've Got the State Covered!"

A Newsletter for Employers and Claims Professionals — *February 2013*

A Word From The Practice Group Chair

It comes as no surprise 2013 is progressing rapidly, and it is already February. Our practice in the workers' compensation industry is hectic, so there is little time to slow down. 2013 promises to be a year of continued change in the workers' compensation arena. We have already seen some important changes from the federal government and from various state administrative agencies impacting our practice.

In this edition of Below the Redline, you will see a brief summary from Bruce Bonds regarding some developments from the Illinois Department of Insurance on the issue of utilization review. Also, the SMART Act was signed into law by President Obama in January, and Brad Peterson has provided a summary on how this will impact our work with CMS. On all fronts, workers' compensation claims practice is becoming more complex. We currently have many more defenses at our disposal to help reduce workers' compensation costs, but at the same time, additional expertise is necessary to take advantage of those defenses, and fully protect the interests of employers and insurers.

At Heyl Royster, we take pride in helping you, our clients, remain on the cutting edge of these complex developments. We work to keep you educated through numerous avenues. Please note in this edition we are announcing the 2012/2013 publication of *Illinois Workers' Compensation Law*. This treatise from West publishing is authored by my partners, Bruce Bonds and Kevin Luther, and represents the most comprehensive analysis available of Illinois workers' compensation law. I am impressed by the fact it helps me daily in my practice, but is also structured in a way that is helpful to the non-lawyer.

We also continue with our effort to keep you informed through various presentations and seminars. While our upcoming presentations would be too lengthy to list, I do want to give you early notice of our firm's annual workers' compensation seminar, which will take place in Bloomington, Illinois, on the afternoon of Wednesday, May 22, 2013. Please mark the date as additional information and invitations will be forthcoming. As always, be aware of our willingness to travel to your location to present individualized seminars and workshops on various workers' compensation topics. Our schedules are filling with these in-house presentations, and we would be happy to meet with you if it would be helpful.

Lastly, I am proud of the depth and scope of this newsletter published on a monthly basis. This month's article by Joe Guyette references some challenging trends we are seeing with the Appellate Court. I hope you find these newsletters helpful, and if you have suggestions for future content, please do not hesitate to contact me. We hope to meet your needs as we all attempt to maneuver the increasingly complex world of workers' compensation claims.

Craig S. Young
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In this issue . . .

UTILIZATION REVIEW: MUST IT BE PERFORMED WITHIN THE STATE OF ILLINOIS?

Answer: NO!

Andrew Boron, the Director of the Illinois Department of Insurance issued a Bulletin on December 20, 2012, which indicated that, "UR functions are further restricted and that they must be performed within the State of Illinois." The Illinois Workers' Compensation Commission linked to this memo on its website on January 3, 2013, creating a great deal of consternation amongst employers, insurance carriers and third party administrators. Subsequently, Director Boron issued a new Bulletin on January 18, 2013 (Company Bulletin No. 2013-01) superseding the prior Bulletin and indicating that utilization review services were prohibited from conducting their activities "off-shore." Workers' compensation was not directly addressed in the memo but Yvonne Clearwater of the Department of Insurance confirmed to me via e-mail that utilization review functions may be performed outside of Illinois so long as they are performed within the Continental United States. Unfortunately, to date the Department of Insurance has not issued a further clarification on this matter nor has the Illinois Workers' Compensation Commission linked to the superseding memo.

Bruce Bonds - Urbana Office

Bruce is a partner in our Urbana office. He concentrates in workers' compensation defense and is a frequent speaker on issues relating to the 2011 Amendments.

SMART ACT MEDICARE REFORMS BECOME LAW

On Thursday, January 10, 2013, President Obama signed into law the SMART Act, which provides for significant reforms to the Medicare conditional payment process. CMS will now be required to provide parties with binding conditional payment amounts prior to settlement and further allows for the review and appeal of conditional payment disputes. The Act also amends the SCHIP Reporting Act with regard to potential penalties. Key provisions to the Act include the following:

Determination of Conditional Payment Amount

The claimant or applicable plan (insurers) will be allowed to notify the Secretary for HHS within 120 days before the reasonably expected date of settlement, judgment, award or other payment. Upon notification the parties will be able to obtain a statement of the conditional payment amount through a website to be created by HHS. Where notice is provided to HHS within 120 days of settlement, judgment, award or other payment, CMS will have 65 days to produce a conditional demand letter. CMS may seek a 30 day extension of that deadline. Once the conditional payment amount is downloaded during this period the conditional payment amount shall be deemed the final conditional payment amount.

Reconsideration of Conditional Payment Amount

If the claimant, representative or applicable plan disagrees with the conditional payment amount they may seek review by providing CMS with documentation identifying the discrepancies and further provide a proposal to resolve the discrepancy. In essence, the claimant, representative or applicable plan would submit documentation as to what they believe the proper conditional payment amount should be. The Secretary of HHS will have 11 business days upon receipt of such documentation and proposal to determine whether there is a reasonable basis to amend its conditional payments claim. If the Secretary of HHS does not make such a determination within 11 business days, then the proposal submitted by the claimant, representative or applicable plan shall be deemed accepted by HHS.

If the Secretary of HHS determines within 11 business days that there is not a discrepancy, then the Secretary must respond by providing documentation and show good cause why they are not agreeing to the proposal. The Act also requires that the Secretary of HHS establish an alternative manner in which to resolve the discrepancy.

Appeal

The Secretary of HHS is required under the SMART Act to promulgate regulations setting forth a right of appeal and an appeals process under which the claimant representative or applicable plan may appeal the conditional payments determination.

Threshold Excluding Conditional Payment Reimbursement

Conditional payment reimbursement and mandatory reporting will not apply to any settlement, judgment or award from liability insurance arising from an alleged physical trauma based incident that falls below a single threshold amount to be calculated by the Secretary of HHS. The threshold will not apply to claims involving ingestion, implantation or exposure. The threshold amount will be calculated by the Secretary of HHS based upon the estimated cost of collection incurred by the United States for conditional payments arising from liability insurance.

SCHIP Reporting Fines and Penalties

The current $1,000 a day penalty for violations of Mandatory Insurance Reporting (Section 111) is amended to provide that insurers "may" be subject to a civil money penalty up to $1,000 for each day of non-compliance as opposed to "shall" be subject to such penalty. The SMART Act further provides for an exception to penalties where the plan is able to show that it made good faith efforts to identify the beneficiary for Section 111 reporting purposes but was unable to identify the claimant as a Medicare beneficiary.

Three Year Statute of Limitations

Conditional payments recovery will be subject to a three year statute of limitation calculated from the date of receipt of notice of the settlement, judgment, award or other payment made, *i.e.*, Section 111 reporting.

Social Security and HIC Numbers

The SMART Act modifies requirements with regard to use of Social Security numbers and HIC numbers for purposes of mandatory insurance reporting. This provision takes effect 18 months after enactment, however, an extension may be sought by HHS as it explores alternatives to the use of Social Security and HIC numbers.

Brad Peterson - Urbana Office

Brad is a partner in our Urbana office and focuses his work on handling workers' compensation defense and addressing Medicare Set Aside and Social Security-related issues.

FEATURE ARTICLE:

A DISTURBING TREND IN RECENT WC APPELLATE DECISIONS

Interpretation of the Workers' Compensation Act is primarily accomplished by the Illinois Appellate Court, Workers' Compensation Commission Division. The Commission is bound by this court's findings, since decisions on workers' compensation issues by the Supreme Court are exceedingly rare. As a result, appellate court decisions interpreting the Act play a unique role in shaping our practice.

Recently, two appellate court cases interpreting the Workers' Compensation Act relied on a dictionary to complete this critical task. In doing so, the appellate court either overlooked or ignored several important statutory construction rules, resulting in decisions that defy precedent and further complicate the practice of workers' compensation law.

Standards of Review and Rules for Statutory Construction

The standard of review utilized by the appellate court depends upon the nature of the issue being appealed. Where the issue involves a disputed factual question, the appellate court will reverse the Commission only where its decision is against the manifest weight of the evidence. For a finding to be against the manifest weight of the evidence, "an opposite conclusion must be clearly apparent." *University of Illinois v. Industrial Comm'n*, 365 Ill. App. 3d 906, 910 (1st Dist. 2006). Indeed, the question asked by the appellate court is whether the Commission's decision is supported by competent evidence. *University of Illinois*, 365 Ill. App. 3d at 911-12. This standard is generally very difficult for an appealing party to overcome. Unless the

Commission's decision is nearly completely without support, the decision is likely to be upheld.

The standard used by the appellate court in evaluating a legal question, however, is very different. Legal issues and matters of statutory construction are questions of law, which are reviewed *de novo*. *Advincula v. United Blood Services*, 176 Ill. 2d 1, 12 (1996). Under this standard, the appellate court gives no deference to the Commission's ruling and is free to interpret the Act based on the rules of statutory interpretation.

The rules for statutory interpretation are well settled. The primary rule of statutory construction, to which all other canons and rules are subordinate, is "to ascertain and effectuate the true intent and meaning of the legislature." *Wisnasky-Bettorf v. Pierce*, 2012 IL 111253, ¶ 16. In interpreting a statute, "[a] court must give the legislative language its plain and ordinary meaning." *Wisnasky-Bettorf*, 2012 IL 111253, at ¶ 16. Assuming the language of the statute is plain, clear and unambiguous, "and if the legislative intent can be ascertained therefrom, it must prevail and will be given effect by the courts without resorting to other aids for construction." Further, "[t]he statute should be evaluated as a whole; each provision should be construed in connection with every other section." *Id.* Finally, where possible, statutes should be construed so that no term is rendered superfluous or meaningless. *Id.*

Exceptions by Dictionary Definition?

With these principles in mind, a critical question arises. If interpretation of the Act is so critical and the interpretation rules so well-settled, why is it necessary to resort to a dictionary? That is the open question following the 2012 decisions in *Will County Forest Preserve District* and *W.B. Olson*. In the first case, the appellate court referenced the dictionary definition of an "arm" in deciding the value of a shoulder injury. In the second case, the court looked to a different dictionary and used the definition of a medical "practitioner" in order to limit the scope of independent medical examinations.

The case of *Will County Forest Preserve Dist. v. Illinois Workers' Compensation Comm'n*, 2012 IL App (3d) 110077WC, is well known by workers' compensation practitioners, but for all the wrong reasons. The case has been discussed in this newsletter (*March, 2012*), and has been analyzed and criticized by many since its release. The *Forest Preserve District* case involved a right shoulder injury for which the arbitrator made an award of 25 percent loss of use of a person as a whole. The Commission adopted the arbitrator's decision and the circuit court affirmed.

On appeal, the employer argued that an award based on the loss of use of a person as a whole was improper, because the claimant failed to establish his injuries prevented him from "pursuing the duties of his usual and customary line of employment" given that he had returned to his regular job with no modification to his job duties. The employer contended the award should have been based on a percentage loss use of an arm, pursuant to Section 8(e)(10) of the Act.

The appellate court upheld the award based on a person as a whole because the plain language of the Act establishes that the arm and shoulder are distinct parts of the body. Therefore, if the claimant sustained an injury to his shoulder, an award for a percentage loss of use of an arm would be improper. The court relied upon the claimant's medical records to support its findings, noting those records clearly established an injury to the shoulder, as opposed to his arm.

The appellate court's analysis curiously focused on the definition of an arm from *Stedman's Medical Dictionary*, which defined the arm as, "[t]he segment of the upper limb between the shoulder and the elbow; commonly used to mean the whole superior limb." *Stedman's Medical Dictionary*, 127 (27th Ed. 2000). The appellate court concluded that, "[t]his definition clearly indicates that the shoulder is not part of the arm." *Will County Forest Preserve Dist. v. Illinois Workers' Compensation Comm'n*, 2012 IL App (3d) 110077WC, at ¶19.

This decision seemingly ignored decades of Commission and court precedent, where shoulder injuries were awarded based on a percentage loss of use of an arm. Further, and perhaps even more important, this decision means that employers can no longer take a credit for subsequent shoulder injuries. Section 8(e)(17) of the Act allows a respondent to take a credit for a prior award to almost any body part. 820 ILCS 305/8(e)(17). However, an exception exists where the prior award was based on a percentage loss of use of a person as a whole. A shoulder claim that is settled or awarded based on a percentage loss of use of a person as a whole would *preclude* an employer from being able to take a credit on a subsequent injury to the same shoulder or arm.

The *Will County Forest Preserve District* case has been widely criticized by both petitioners' and defense attorneys. There was no striking need for a change in the classification of shoulder injury claims and the appellate court's reliance

on *Stedman's Medical Dictionary* appears inconsistent with the rules of statutory interpretation.

The attention garnered by the *Will County Forest Preserve District* case makes the subsequent opinion issued in *W.B. Olson, Inc. v. Illinois Workers' Compensation Commission* 2012 IL App (1st) 113129WC, even more confusing. In *W.B. Olson,* the Appellate Court, Workers' Compensation Division, held that an employer is not entitled to a functional capacity evaluation (FCE) as part of an independent medical examination. In doing so, the court largely based its decision on the dictionary definition of a medical "practitioner." Rather than resolving a question on a confusing issue, this *W.B. Olson* is more likely to cause further confusion and litigation regarding a claimant's ability to return to work.

The claimant in *W.B. Olson* sustained an injury to his right knee on February 1, 2006, while attempting to push a wheelbarrow down a plank at a construction site. He later underwent two arthroscopic procedures, but continued to have pain in his right knee. The employer sent the claimant for an IME with Dr. Mark Levin, who suggested a functional capacity evaluation and possible work hardening.

The claimant attempted to return to work in a light duty position, but was unable to complete the drive into the employer's office, due to his knee pain. After a course of work hardening, the claimant again attempted to drive to work for a light duty position. He was still unable to complete the drive, and his physician provided him with a note that advised him to avoid prolonged driving.

Given his inability to complete the drive necessary for the light duty position, the claimant began looking for jobs within his restrictions, as well as preparing for the GED examination.

After over a year and a half of the claimant's unsuccessful search for alternate employment, the employer obtained an updated IME with Dr. Tonino, who opined that the claimant, who had no limitations on his ability to drive, could return to work as a truck driver. Dr. Tonino referenced the restrictions previously authorized by treating physician, but further recommended a functional capacity evaluation be performed to assess the claimant's current limitations. The appellate court's decision observed that Dr. Tonino believed the FCE would be "a more reliable objective indication" of the claimant's abilities.

Based on Dr. Tonino's findings, the employer suspended benefits and the matter proceeded to a Section 19(b) hearing. The arbitrator found that the claimant had made a good faith effort to find employment, and was participating in an appropriate vocational rehabilitation program. Further, the arbitrator allowed the claimant to continue with his vocational rehabilitation program, without taking the additional steps recommended by the employer's witnesses, including the recommended functional capacity evaluation.

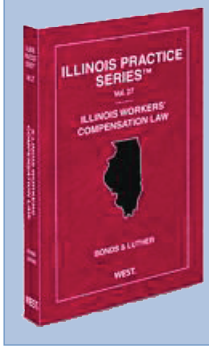
The employer reviewed the decision to the Commission, which upheld it with only minor modifications. The Commission further concluded that it was "unnecessary and inappropriate to order either a repeat FCE or formal vocational rehabilitation," because the program being utilized by the claimant was sufficient. The circuit court confirmed the Commission's decision, and the employer appealed the case to the appellate court.

Three primary issues were raised before the appellate court. First, the employer argued the claimant should not be entitled to an award of further "vocational-rehabilitation benefits." Second, it argued that the Commission erred in awarding maintenance benefits. Both arguments were summarily dismissed by the appellate court, citing the "manifest weight of the evidence" standard. In both instances, the court explained the Commission's decisions were supported by competent evidence.

The employer's final argument focused on the Commission's refusal to order the claimant to undergo an updated functional capacity evaluation, as recommended by Dr. Tonino. The appellate court noted this was a question of statutory construction, allowing for *de novo* review.

With regard to this issue, the employer presented two separate arguments. First, it contended that a functional

Heyl Royster is pleased to announce that two of our partners, Bruce Bonds and Kevin Luther, have authored Illinois Workers' Compensation Law, 2012-2013 edition (Vol. 27, Illinois Practice Series, West). The book, which can be obtained at store.westlaw.com, provides a full overview of Illinois Workers' Compensation law and practice including the 2011 Amendments to the Illinois Workers' Compensation Act, and is a "must" for risk managers and claims professionals.



capacity evaluation should have been allowed pursuant to Section 12 of the Act. In rejecting this argument, the appellate court noted that the relevant portions of the Act stated that, "An employee shall be required, if requested by the employer, to submit himself for examination to a duly qualified *medical practitioner* or surgeon selected by the employer." 820 ILCS 305/12. The court focused on the limitation of an examination by a "medical practitioner or surgeon."

Ultimately, the court looked to *Dorland's Illustrated Medical Dictionary*, which defined a medical "practitioner" as "one who has complied with the requirements and was engaged in the practice of medicine." *Dorland's Illustrated Medical Dictionary,* 1248 (25th ed. 1974). The court contrasted that definition with the entry for "physical therapist," which was defined as a "person skilled in the techniques of physical therapy and qualified to administer treatment prescribed by a physician under his supervision." *Dorlands*, 1597. The court concluded that, "a physical therapist does not fall within the meaning of a 'medical practitioner' as specified in Section 12." *W.B. Olson, Inc.*, 2012 IL App (1st) 113129WC, ¶45.

The employer's second argument was based on its constitutional right to due process. Specifically, it argued that its due process rights were violated because an inability to obtain an FCE denied "a meaningful hearing and a 'level playing field' on which to defend claims." *Id.* at ¶ 48. The appellate court observed that the "fundamental purpose of the Act is to afford protection to the employees by providing them with prompt and equitable compensation for their injuries." *Id.* at ¶ 50. Further, the court found that the portions requiring a claimant to "submit to an examination by a doctor chosen by his or her employer, under section 12 of the Act, clearly is designed to provide the employer with a meaningful hearing and a 'level playing field'." According to the appellate court, the employer's due process rights were not violated "merely because a section 12 examiner lacks authority to require additional FCE testing."

Excluding the arguments and analysis on due process, the court's decision in *W.B. Olson* is primarily based on the differences in the definitions of the words "practitioner" and "physical therapist." The appellate court felt that the definitions established that a physical therapist was "clearly not a medical practitioner." The court did not explain how it reached this conclusion, or further explain the differences in the definitions. Given the education, training and certification that ***is*** required to become a physical therapist, an argument can certainly be made that the definition of a medical practitioner could be applied to a physical therapist. To the extent that the definitions are different, they do not seem to suggest that some overlap is impossible.

There are a number of different theories the court could rely upon in interpreting Section 12 of the Act, without having to invoke dictionary definitions. It seems doubtful that the author of those definitions contemplated their use in interpreting the Illinois Workers' Compensation Act. Of interest, the *W.B. Olson* court did not even use the same medical dictionary it utilized in *Will County Forest Preserve*.

The court's exclusion of physical therapists in the category of professionals contemplated by Section 12 is inconsistent with other portions of the Act, and the practice of medicine. The court's decision seems to assume that each portion of an IME is completed by a doctor. In practice, necessary information from vitals to grip strength to range of motion measurements is often taken by nurses and therapists. That information is then utilized by a physician in reaching conclusions regarding causation or the need for additional treatment. This is no different than the process that would take place in a functional capacity evaluation, where a physician would utilize the results of the evaluation to offer opinions regarding the claimant's ability to return to work.

Other sections of the Act seem to require the involvement of nurses, therapists, and other staff in gathering relevant information. Specifically, Section 8.1(b) of the Act dictates the use of AMA disability ratings in the determination of permanent partial disability. That section requires a licensed physician to prepare the impairment report, but also requires certain measurements to be taken, where relevant. Specifically, that section of the Act references loss of range of motion, loss of strength, measured atrophy of tissue mass consistent with an injury, and other measurements that establish the nature and extent of a disability impairment rating. Realistically, it is unlikely the physician will be taking all these measurements without the assistance of other individuals. There does not seem to be any important distinction between the therapist's ability to measure range of motion for an AMA rating, and taking that same measurement for purposes of a functional capacity evaluation.

Excluding functional capacity evaluations from Section 12 examinations will lead to more arbitrary opinions regarding a claimant's ability to return to work. Often, a treating surgeon will place "permanent" restrictions on a claimant's ability to work based on nothing more than a brief meeting in an exam room. As a result, the employer

is left to either establish that it can accommodate those restrictions, or obtain an IME report to contradict the permanent restrictions. Without the benefit of a functional capacity evaluation, an employer's IME physician is left to make an equally arbitrary conclusion regarding the claimant's limitations.

Where both parties have obtained reports outlining the claimant's work restrictions, they proceed to trial at which time the arbitrator is forced to assess which set of arbitrary restrictions are appropriate. It is entirely possible that a binding decision could be made about a claimant's ability to return to work, without involving anyone with firsthand knowledge of his job requirements or a single objective measurement.

A functional capacity evaluation can be beneficial to both parties, and reduce wasted time and additional litigation. If a job position requires frequent lifting of 35 lbs., for instance, the claimant's ability to do that work can be evaluated prior to an attempted return to the workplace. Without making that determination prior to a return to work, the claimant risks re-injury and an entirely new workers' compensation claim is possible.

Appeals: Risk or Reward?

These two recent opportunities to interpret the Workers' Compensation Act missed the mark and arrived at decisions based on the extensive use of a dictionary. Of course, the results in these cases do not mean that further appeals should be avoided. Indeed, the only way to limit, or even reverse, the appellate court's recent decisions is to give the court additional opportunities to interpret the Workers' Compensation Act.

The 2011 amendments to the Workers' Compensation Act were designed, in part, to improve the business climate in the State of Illinois. The primary focus of the Act remains compensating injured workers, but we need to provide the appellate court with opportunities to interpret these amendments in our favor. While we hope we will continue to see employer-friendly interpretations of the Act going forward, we need to do our part in getting these cases to the appellate court in the best position for success.

We invite you to contact any of our workers' compensation attorneys listed on the following page with any questions or concerns regarding your Illinois workers' compensation case, from accident investigation through trial and appeal. Brad Elward, a partner in our Peoria office, focuses a large portion of his practice on workers' compensation appeals across the State. He has appeared before the circuit court appellate court in dozens of cases and frequently speaks on workers' compensation-related appellate matters. If our firm can assist you with your appeal, please contact Brad.

Joe Guyette - Urbana Office

Joe began his career with Heyl Royster, clerking in the Urbana office. Following graduation from law school, he joined the firm's Urbana office as an associate in August of 2004. During law school, he served as Articles Editor for the University of Illinois Journal of Law, Technology & Policy.

Joe concentrates his practice in the areas of workers' compensation defense, professional liability and employment matters. Joe devotes a portion of his practice to representing the firm's clients at depositions of plaintiffs and fact witnesses in asbestos personal injury matters.

Joe has taken several bench and jury trials to verdict, and has drafted and argued numerous dispositive motions. Joe has handled workers' compensation arbitration hearings at venues throughout the state, and has argued multiple cases before the Workers' Compensation Commission. Joe regularly handles depositions of expert witnesses and treating physicians in both civil and workers' compensation matters.

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. This newsletter is compliments of Heyl Royster and is for advertisement purposes.

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Workers' Compensation Practice Group

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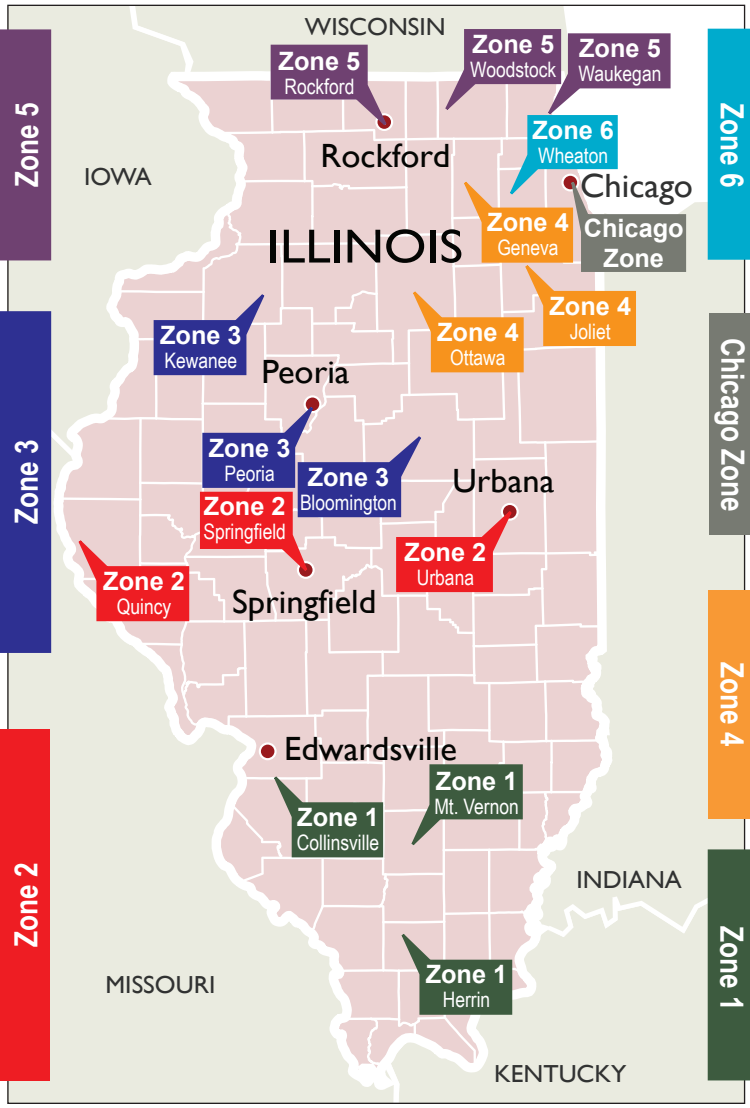

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