Below the Red Line

Heyl Royster
Workers' Compensation Newsletter

A Newsletter for Employers and Claims Professionals *September 2011*

A WORD FROM THE PRACTICE GROUP CHAIR

September 1, 2011, has now arrived and from this point forward, all new workers' compensation accidents will be subject to all of the provisions that were signed into law by Governor Quinn on June 28, 2011. As many of you who have heard our "house call" presentations on these changes know, we believe that employers and their representatives have an opportunity to make a favorable impact with these statutory changes in the defense of workers' compensation claims.

Tom Crowley, who handles workers' compensation claims from our Rockford and Chicago offices, is our author this month. Tom discusses the defense tool of utilization review, which was originally enacted as part of the 2006 legislative changes. We believe this tool was sharpened with the 2011 amendments and we, as a firm, plan to use the new utilization review process to your benefit. If done correctly, utilization review shifts the burden of proof to the petitioners and their attorneys to establish that certain treatment was or is reasonable and necessary. We look forward to this fight.

More procedural changes will be coming. In this issue we also identify the new workers' compensation arbitration hearing sites and note the elimination and consolidation of others. Each venue will now have three arbitrators assigned to it. We will advise you further when more information on these venue changes is released.

For the time being, however, please do not let your opponents and the other "talking heads" in the workers' compensation system tell you that it is business as usual. There is real opportunity with many of these changes and as a firm we plan to aggressively push favorable changes when handling claims at the Workers' Compensation Commission.

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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:

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We look forward to stopping by!

This Month's Author:

Tom Crowley is an attorney in the firm's Rockford office. He concentrates his practice in workers' compensation and tort litigation. Tom has successfully arbitrated numerous claims before the Illinois Workers' Compensation Commission. He is a past Chair of the Winnebago County Bar Association Workers' Compensation Section.

NEW DOWNSTATE ARBITRATION REGIONS ANNOUNCED

As directed by House Bill 1698 (Public Act 97-18), the new downstate arbitration regions will take effect on January 1, 2012. Three arbitrators will appear at each hearing site, and cases will be randomly assigned among them. To accommodate this change, the arbitrators will return to 90-day continuance cycles.

Region/Hearing sites

- Collinsville, Herrin, Mt. Vernon
- Quincy, Springfield, Urbana
- Bloomington, Kewanee, Peoria
- Geneva, Joliet, Ottawa
- Rockford, Waukegan, Woodstock
- Wheaton (three Chicago arbitrators will be assigned to appear in Wheaton.)

As you can see, eight of the former 23 venues are closing (Danville, Decatur, DeKalb, Galesburg, Kankakee, Mattoon, Rock Falls, Rock Island), and one new venue, Kewanee, is being created.

The Commission is in the process of reassigning cases to these regions and corrected notices will be sent out this fall. Also, a new accident location table will be posted soon on the Commission site. Any partially tried cases will stay with the original arbitrator.

We will keep you updated – which arbitrators will cover which dockets and which HRVA offices will cover particular calls – as information develops. Look for more details in our subsequent newsletters.

Past issues of
Below the Red Line
are available under the
"Resources" section of our website
www.heylroyster.com

AMENDMENTS TO THE UTILIZATION REVIEW PROVISIONS AND WHAT THEY MEAN FOR YOUR CLAIMS HANDLING

Part of the workers' compensation reform legislation signed into law on June 28, 2011 by Governor Quinn involved amendments to the utilization review provisions of Section 8.7. While the majority of the amendments became effective on July 1, 2011, the amended utilization review provisions take effect on September 1. This amendment applies to all health care services provided or proposed to be provided on or after that date, regardless of the date of accident. 820 ILCS 305/8.7. This issue of our newsletter focuses on the recent amendments affecting Section 8.7.

As background, one of the goals of the prior 2005 amendments to the Act was to reduce the medical costs associated with workplace injuries. To accomplish this goal, two amendments were added via the 2005 amendments; one involved the use of medical fee schedules to control the costs of medical services, and the second involved medical utilization reviews to control the reasonableness, necessity, and frequency of the treatment. Together, these provisions work to keep overall costs down and to ensure that physicians do not simply add more treatment or increase the frequency of the treatments to recoup expenses curtailed by the fee schedules.

A Utilization Review (UR) involves the evaluation of proposed or already-provided health care services to determine the appropriateness of both the level of health care services medically necessary and the quality of health care services provided to a patient. This review includes an evaluation of the efficiency, efficacy, and appropriateness of treatment, hospitalization, or office visits based on medically accepted standards. 820 ILCS 305/8.7(a) (2011).

To illustrate how these provisions are intended to work together, the provisions should cap both the costs and frequency, necessity, and reasonableness of medical treatment. A medical fee schedule that reduced non-physical medicine charges to $50.00 per visit from $100.00 per visit would not be useful if the provider was free to perform 10 treatments instead of five. Studies show that without utilization review, 30 to 50 percent of the savings from using the medical fee schedule will be lost as medical providers figure out how to get around the medical fee schedule.

The 2005 Version

The current version of the Act, as passed in 2005, defines a utilization review as:

> [T]he evaluation of proposed or provided health care services to determine the appropriateness of both the level of health care services medically necessary and the quality of health care services provided to a patient, including evaluation of their efficiency, efficacy, and appropriateness of treatment, hospitalization, or office visits based on medically accepted standards. The evaluation must be accomplished by means of a system that identifies the utilization of health care services based on standards of care or nationally recognized peer review guidelines as well as nationally recognized evidence based upon standards as provided in this Act. Utilization techniques may include prospective review, second opinions, concurrent review, discharge planning, peer review, independent medical examinations, and retrospective review (for purposes of this sentence, retrospective review shall be applicable to services rendered on or after July 20, 2005). Nothing in this Section applies to prospective review of necessary first aid or emergency treatment.
>
> 820 ILCS 305/8.7(a) (2005).

When making retrospective reviews, Section 8.7 states that utilization reviews shall be based solely on the medical information available to the attending physician or ordering provider at the time the health care services were provided. According to Section 8.7(i), a utilization review will be "considered by the Commission, along with all other evidence and in the same manner as all other evidence, in the determination of the reasonableness and necessity of the medical bills."

If an employer's denial of medical services under Section 8(a) complies with a Utilization Review Accreditation Commission (URAC) utilization review program, Section 8.7(j) creates "a rebuttable presumption that the employer shall not be responsible for payment of additional compensation, pursuant to Section 19(k) of this Act." 820 ILCS 305/8.7(j). If, however, the denial or refusal to authorize does not comply with a URAC utilization review program and does not comply with all other requirements of this section, then that will be considered by the Commission along with all other evidence, and in the same manner as all other evidence in the determination of whether the employer may be responsible for the payment of additional compensation pursuant to Section 19(k) of the Act.

The 2011 Amendments

The 2011 amendments to Section 8.7 strengthen the utilization review and give employers more options for controlling and challenging past and future medical treatment. Everyone on the defense side hopes that this amendment will result in lower medical costs and shorter treatment periods for employees alleging workplace injuries, and a faster return to work. Changes from the old utilization review section include:

1. UR providers will now register with the Department of Insurance rather than with the Department of Financial and Professional Regulation.
2. Upon written notice that the employer wishes to invoke the UR 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 and provided to the provider and employee.
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 standard 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 in this State for interview or deposition; or must be available for deposition by telephone, video conference or other remote electronic means. The expense of interview and deposition shall be paid by the employer.
8. Admissibility of 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.

Of these modifications, perhaps the two most significant changes are that the employees and treating providers are required to participate in the utilization review process (or risk having the charges not be collectable from the employer or the employee if the provider fails to cooperate), and that once the 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 shifts to the employee to show that a variance from national standards of care are necessary in this specific case.

A Brief Overview Of The Utilization Review (UR) Process

The Utilization Management Organization (UMO) establishes and implements a three-step process to determine if a proposed medical treatment or service is medically necessary. Any appropriate person, such as a provider, state regulator, or the injured worker, may initiate the process.

Licensed health professionals, such as nurses, perform the first step – initial clinical review. If the proposed service cannot be approved during initial clinical review, then the case is referred to step two of the process – peer clinical review. A physician who is qualified to render a clinical opinion about the proposed medical service generally must perform peer clinical review. However, if the treating provider is a non-physician, then a similar provider may also perform peer clinical review. For example, if the treating provider is a chiropractor, then peer clinical review may be performed by a chiropractor. Regardless of the type, a provider who performs peer clinical review must be available to discuss their review determination with the treating provider.

As with initial clinical review, if peer clinical review results in a certification, then the utilization management process ends for that case. However, if peer clinical review results in a non-certification, the treating provider and the injured worker have the right to access step three of the process – appeals consideration. Appeals must be considered by clinical peers that are board-certified and who are in the same profession and a similar specialty that typically manages the medical condition under review. Either the injured worker or the treating provider may initiate appeals consideration. For cases involving ongoing or imminent medical care, the organization provides for an expedited appeals consideration mechanism.

Throughout the utilization management process, the UMO utilizes explicit clinical review criteria based on sound clinical principles and processes, reviewed and revised on a periodic basis. Upon request, the UMO discloses to the injured worker or treating provider the criteria upon which a non-certification decision was based.

The amended utilization review statute itself does not specifically outline the criteria to be used for utilization review, other than to require that utilization reviewers certify compliance with URAC accreditation. (www.urac.org). One set of nationally recognized standards for use in utilization review is contained in Occupational Disability Guidelines. *Official Disability Guidelines 2011* (ODG), now in its 16th edition, provides up-to-date, evidence-based disability duration guidelines and benchmarking data covering every reportable condition. We have also seen utilization review vendors and practitioners base their opinions and reviews on the guidelines of the American College of Occupational and Environmental Medicine physicians (ACOEM).

Types of Utilization Review

Prospective – Before the Treatment

Prospective utilization review typically applies to physical therapy, chiropractor, and pain center-type treatment and serves as pre-certification for recommended procedures, such as surgery. It does not apply to emergency room treatment (for obvious reasons). It is used to determine whether the recommended treatment is "appropriate."

Examples of prospective treatment might be:

- Is a hospital admission appropriate;
- Are expensive/invasive treatments necessary (e.g.; artificial disc replacements, lumbar fusions, repeat surgeries);
- Is chiropractic, physical therapy, occupational therapy and work hardening reasonable and necessary;
- Pain management;
- High cost diagnostic tests (e.g.; a discogram);
- Is the place of care appropriate;
- Determine if the duration of care is appropriate.

Utilization review is best for all parties when it is prospective.

Concurrent Utilization Review

This is an assessment of ongoing treatment and might include second opinions, discharge planning, and assessments of the duration and frequency of care, particularly in chiropractic and physical therapy care.

Retrospective Utilization Review

The Illinois statute and URAC guidelines are similar in that retrospective utilization review is available, but the medical information reviewed during the utilization review process must be "the same" information the treating doctor had available at the time the decision was made. This is perhaps the "least desirable" type of utilization review, as one would assume the Illinois Workers' Compensation Commission does not want to deny or reduce bills after they have been incurred.

Independent Medical Evaluation (IME) vs. Utilization Review?

A common question involves the difference between use of Independent Medical Evaluations (IMEs) and the Utilization Review (UR) process. There is some degree of overlap, but there are some important differences that warrant discussion.

In a nutshell, here are some of the more notable differences:

- An IME focuses on causation and relatedness;
- An IME addresses impairment and disability (PPD);
- An IME addresses return to work;
- A Utilization Review focuses solely on the reasonableness, necessity, and frequency of treatment.

Although the primary purpose of an IME may be to address causation, the IME physician can also address the appropriateness and scope of treatment.

Utilization Review providers, however, must be URAC certified and not all IME physicians meet that certification, and having a URAC certified provider offer a report containing a conclusion that the medical treatment that occurred or is recommended is not certified can operate to shift the burden to the claimant to show why the deviation from medical standards is warranted. There is no provision for burden shifting when an IME physician disputes past or future treatment.

If the employer denies payment or refuses to authorize treatment pursuant to a utilization review program that complies with the requirements of the Act, there exists a rebuttable presumption that the employer will not be liable for penalties under Section 19(k) of the Act. This is not the case with an IME report that opines that past treatment or recommended future treatment is not reasonable or necessary.

Utilization Review Reports and Opinions Should Contain Clear, Concise Reasoning and Make Clear Citations to Medical References Used as Bases for the UR Determinations

After the 2005 amendments to the Workers' Compensation Act, we have seen many companies enter the Utilization Review market in Illinois. We have seen many reports generated since the 2005 amendments which are not clear, not well reasoned, and/or contain inadequate bases. As a result, many arbitrators and/or the Commission itself can and will discredit a utilization review opinion. A review of recent Commission decisions will show the necessity of a well reasoned, clear, authoritative utilization review report.

A troubling case is *Garcia v. Executive Mailing Service*, 09 I.W.C.C. 0310 (April 2, 2009). There, the claimant sustained a low back strain and underwent physical therapy, transforaminal injections, facet joint injections, a lumbar medial branch nerve block, and an IDET procedure with no long term benefit. The arbitrator denied payment for the charges related to the IDET procedure, the discogram, the transforaminal injections, facet injections and physical therapy after a certain cutoff point, based on employer's utilization review report. The Commission reversed the arbitrator's decision with respect to the IDET and discogram procedures, both of which had been severely criticized by the UR report. Without specifying any basis for its conclusion, the Commission found the utilization review criteria regarding the discogram and IDET procedure may be "a bit too strict." According to the Commission, the utilization review discounted the IDET procedure because there was a lack of precise proof of its efficacy and also non-certified the discogram due to the lack of documentation of consistent and overwhelming evidence of pathology. The Commission found this overly rigid since a discogram is primarily a diagnostic tool, and it would be difficult to find consistent and overwhelming evidence of pathology without a discogram.

The *Garcia* decision was recently affirmed by the Appellate Court, Workers' Compensation Commission Division, in an unpublished Rule 23 order. This ruling seems to be a results

driven decision by the Commission since in rejecting the UR report, they actually criticized the nationally recognized standards used by the utilization review physician.

Recent decisions offer a somewhat clearer picture of what should be contained in a utilization review in order to persuade an arbitrator or Commissioner. In *Lorena v. Elite Staffing*, 11 I.W.C.C. 0494 (May 19, 2011), the Commission affirmed the arbitrator's rejection of the UR opinions because the report did not cite to any guidelines whatsoever in the non-certification letter. Moreover, the employer failed to offer the full clinical Peer Clinical Review Reports. This left the arbitrator with little to rely upon when considering the utilization review reports versus the treating physicians' treatment.

In *King v. RGIS Inventory Specialists*, 11 I.W.C.C. 0579 (July 8, 2011), the UR report opinions were rejected by the arbitrator, and subsequently affirmed by the Commission. There, the UR physician was apparently given only one medical evidentiary record or radiograph to study supposedly complying with URAC guidelines. That record happened to be the employer's second Section 12 IME physician report. The recently amended version of the utilization review section clearly states that in making retrospective reviews, the utilization review programs shall base reviews solely on the medical information available to the attending physician or ordering provider at the time the services were delivered. 820 ILCS 305/8.7(e)(2) (2011).

Similarly, in *Wilcox v. Professional Transportation*, 11 I.W.C.C. 544 (June 17, 2011), the Commission affirmed the arbitrator's rejection of a UR report. The utilization review physician stated in his non-certification regarding the request for prospective shoulder arthroscopy and possible SLAP repair, "the information submitted for review is lacking sufficient information to fully evaluate the request." The utilization review physician did not have records concerning the claimant's physical therapy, injections or home exercise program and even stated in his report "further information is needed." It is hard to imagine an employer admitting such a utilization report into evidence at arbitration, and actually expect the arbitrator to rely on such an exhibit to support a denial of prospective medical treatment. On a positive note, however, while penalties and fees were awarded by the arbitrator, these were reversed by the Commission.

Finally, in *Galvan v. Moo and Oink*, 11 I.W.C.C. 0598 (June 20, 2011), the arbitrator did partially rely on the employer's utilization review report to deny prospective treatment in the form of continued physical therapy after a lateral menisectomy and synovectomy of claimant's left knee after an undisputed work place accident.

To date there have been no published utilization review decisions rendered by the Appellate Court or Supreme Court. There have been nine decisions specifically addressing utilization review by the Workers' Compensation Commission since January 1, 2010. Of these nine decisions, utilization review non-certification was rejected by a majority of the Commissioners in six cases (three were 2-1 decisions containing dissents by either Commissioner Lamborn or Lindsay). One of the three zero rejections dealt with a retrospective utilization review which attempted to deny responsibility for treatment which had been previously authorized.

Penalties were affirmed in only one of the nine decisions on an unanimous holding. Procedurally, however, that case is unique and dealt primarily with whether one could avoid payment of prospective medical ordered in a prior 8(a) proceeding via utilization review. *Hubbard v. United Airlines*, 11 I.W.C.C. 0052, 2011 WL 566693 (Jan. 14, 2011).

The decisions rejecting a utilization review non-certification contained phrases like: "the treating physician is more persuasive;" the utilization reviewer did not "explain the guidelines," (*Hunt v. City of Springfield*, 10 I.W.C.C. 0459 (May 7, 2010)); the utilization review is "internally inconsistent and contains questionable conclusions," *Hamilton v. Renshaw d/b/a Dairy Queen*, 08 IL.W.C. 23164, 11 I.W.C.C. 0226, 2011 WL 1451945 (March 4, 2011); or that the utilization reviewer "did not comment on or consider the opinion of the treating doctor," *Avila v. Elite Staffing*, 09 W.C. 49465, 11 I.W.C.C. 0217, 2011 WL 1451936 (March 1, 2011).

In the cases in which a non-certification of treatment by utilization review was upheld, one dealt with chiropractic treatment and the others with massage therapy, both 3-0 decisions. *Masso v. Frontline Transportation*, 10 I.W.C.C. 0314, 2010 WL 1544674 (March 26, 2010); *Pinnell v. State of Illinois, Department of Transportation*, 11 I.W.C.C. 0218, 2011 WL 1451937 (March 3, 2011). It appears that the utilization report as opposed to evidence depositions were admitted in most of these cases, apparently without objection. In only three of the nine was the complete utilization review appeal process followed.

Thoughts When Considering Using the UR Process

As you evaluate whether to use the UR process for your claim, keep these thoughts in mind. While prospective utilization review is possible, this approach requires the cooperation of the petitioner and permission for the UR physician to contact the treating doctor. Although the statute permits a URAC utilization review, and URAC utilization reviews

contemplate contact with the treating doctor, at least during the appeals process, it is likely that some petitioner's counsel will object to such contact based on the physician/patient privilege doctrine which, according to the *Hydraulics, Inc. v. Industrial Comm'n*, 329 Ill. App. 3d 166, 768 N.E.2d 760 (2d Dist. 2002), prohibits direct communication between respondent and treating physicians.

Also, as we stated earlier, the conclusions of a URAC accredited utilization review are not dispositive as to the reasonableness and necessity of medical treatment. Section 8.7(i) clearly states that a utilization review "will be considered by the Commission, along with all other evidence and in the same manner as all evidence, in the determination of the reasonableness and necessity of the medical bills or treatment." *Hardy v. Murray Developmental Center*, 07 WC 48727, 09 I.W.C.C. 0725, 2009 WL 2516197 (July 15, 2009). This differs from a typical URAC utilization review wherein the URAC determination after an appeal process (which may be initiated by the claimant or the treating provider) is final and dispositive.

Equally problematic is the fact that URAC accredited utilization review reports may not be automatically admissible under the Illinois Workers' Compensation Act. Section 8.7(i) indicates that the Commission "will" consider utilization review along with all other evidence and in the same manner as other evidence in the determination of the reasonableness and necessity of medical bills or treatment. At Heyl Royster we have taken the position that "will" indicates that the reports go into evidence. The claimant's bar, however, has argued that the phrase says "will" as opposed to "shall" and the reference to it being considered like all other evidence is indicative that depositions may be required. This would be a burden on the system, as it is not unusual for the URAC examining physicians and specialists to be out of state. This issue has yet to be resolved by the Appellate Court, although the "spirit" of the utilization review provisions agreed to by the parties should favor the admissibility of the reports. The fact that the employer is required to use a comprehensive and highly-respected "URAC" utilization review should add credibility to the report's conclusions.

Another obstacle to UR reports is the so-called "treating doctor mystique" and the deference the Commission has afforded to the opinions and recommendations of treating doctors. While case law states that there is no bias in favor of treating physicians, the cases nevertheless lean in that direction.

Additionally, retrospective utilization review must be based on the same information that was available to the treating physician. Section 8.7(e).

With respect to utilization reviews as a whole, there are two caveats: UR reports cannot be considered with respect to the issues of causal relationship or TTD benefits, *Chamorro v. Workforce Staffing*, 07 IL.W.C. 38033, 09 I.W.C.C. 0055, 2009 WL 382139 (Jan. 16, 2009); likewise, UR reports cannot be used to deny payment of treatment previously approved by the employer, *Garcia v. Scrub, Inc.*, 04 IL.W.C. 50180, 10 I.W.C.C. 0051, 2010 WL 516031 (Jan. 15, 2010).

Conclusions

Certainly there is a need to closely monitor and control medical costs in workers' compensation cases. While the 2005 amendments to the Act lowered the fee schedule amounts collectable by medical providers for treatment of workers' compensation injuries, in the end we have not seen a reduction in medical costs, but rather lengthier treatment and more creative billing and coding practices by the medical billing professionals.

The recent amendment to the utilization review section of the Act gives the employer more potent options to dispute past and future medical treatment for alleged work-related injuries. The treating providers are now required to comply with the UR process or risk their charges being denied, and the burden now shifts to the claimant when treatment is denied based on a proper utilization review.

As noted herein, it is vitally important to have utilization reviews done correctly. URAC accreditation and guidelines should be strictly adhered to. Also, insurers and claims handlers should insist that the UR report's conclusions and reasoning are clearly explained by the reviewing medical professional, including citation to references relied on by the reviewing professional, and why those guidelines are applicable to the care and treatment they are reviewing. Moreover, when obtaining a UR report, the potential that the UR provider may be scheduled for a deposition in Illinois must also be considered. With the implementation of the new utilization review section, it is hoped that medical costs will be reduced and injured workers will be returned to work in a more timely fashion.

Should you have any questions concerning utilization reviews or any other aspect of the Workers' Compensation Act, please feel free to contact any of our workers' compensation attorneys across the State.

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