Below the Red Line

Workers' Compensation Update

"We've Got the State Covered!"

A Newsletter for Employers and Claims Professionals — *November 2015*

A Word From The Practice Group Chair

Once again, the holidays have arrived rapidly, and we all begin to focus on year-end activities. At Heyl Royster, this is always a busy time, but also a time to pause and be thankful. Most important, we are thankful for the relationship we have with you, our clients. We cherish that relationship, we thank you for the opportunity to serve, and look forward to continuing our work with you in 2016.

In this month's edition of Below the Red Line we highlight both the old and the new. Medicare will always be at the forefront of our concern and Brad Peterson offers additional insights on Medicare Advantage plans. We also update you on some developments regarding requirements for AMA impairment ratings as well as some Social Security Administration news. As these varied issues demonstrate, the workers' compensation world will be ever changing and we will continue to strive to keep you up-to-date.

We hope the season is joyous for you and your family and carries with it some time for relaxation. If there is anything we can help you with on your claims, please do not hesitate to contact any of our attorneys.

Craig S. Young
Chair, WC Practice Group
cyoung@heylroyster.com

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Did You Know...

Heyl Royster can obtain quick approval of *pro se* settlements anywhere in the state due to our ability to obtain one day filings through our Chicago office? Please feel free to contact any of our Heyl Royster workers' compensation attorneys throughout the state and we will coordinate your filing with our Chicago office.

IDENTIFYING AND SATISFYING CONDITIONAL PAYMENTS BY MEDICARE ADVANTAGE PLANS

When settling a claim involving a Medicare beneficiary, parties to the settlement are well aware of their obligation to contact the Center for Medicare and Medicaid Services (CMS) and determine whether Medicare has made any conditional payments for medical expense related to the workers' compensation claim. Once inquiry is made, the Center for Medicare and Medicaid Services provides the parties with a conditional payments demand. Unfortunately, CMS does not coordinate with Medicare Advantage plans and as such, the conditional payments demand from CMS does not include any medical bills that may have been paid under a Medicare Advantage plan.

Part C of the Medicare statute allows for the creation of the Medicare Advantage program. Medicare Advantage (MA) organizations are private insurers who contract with Medicare to provide coverage to Medicare beneficiaries. Beneficiaries who choose coverage under Part C are covered by the private insurer as opposed to the Federal Center for Medicare and Medicaid Services. The MAs are paid a fixed amount from Medicare for each enrollee and directly administer benefits to the insureds.

Do Medicare Advantage organizations have the same rights of recovery as CMS under the Medicare Secondary Payer Act 42 U.S.C. § 1395y(b)(2)?

Federal regulations indicate that Medicare Advantage organizations have the same rights of recovery under the Medicare Secondary Payer Act as does Medicare (the Center for Medicare and Medicaid Services) 42 C.F.R. 422.108(f). Section 108 provides:

> (b) Responsibilities of the MA organization. The MA organization must, for each MA plan –
>
> (1) Identify payers that are primary to Medicare under Section 1862(b) of the Act and part 411 of this chapter;
>
> (2) Identify the amounts payable by those payers; and
>
> (3) Coordinate its benefits to Medicare enrollees with the benefits of the primary payers, including reporting, on an ongoing basis, information obtained related to requirements in paragraphs (b)(1) and (b)(2) of this section in accordance with CMS instructions. 42 C.F.R. 422.108.

In addition, subsection (f) provides in part:

> The MA organization will exercise the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations in subparts B through D of part 411 of this chapter. 42 C.F.R. 422.108(f).

Subpart B provides in §411.24(b) the following:

> (b) Right to initiate recovery. CMS may initiate recovery as soon as it learns that payment has been made or could be made under workers' compensation, any liability or no fault insurance, or an employer group health plan. 42 C.F.R. 411.24(b).

It follows that since Medicare (and Medicare Advantage plans) can recover even after payment has been made by a primary plan (such as a settlement) that the right of recovery exists regardless of notice. It is well settled that Medicare has a "super lien" vesting them with rights to recovery without pre-settlement notice to parties. The foregoing provision suggests that Medicare Advantage plans have the same rights.

It therefore follows that steps must be undertaken in settlement of workers' compensation claims involving Medicare beneficiaries to identify any such claimants who are covered under a Medicare Advantage plan as opposed to traditional Medicare.

The primary pitfall arises from the fact that the Medicare conditional payments demand does not include payments from Medicare Advantage insurers. Therefore, it is incumbent upon employers and their insurers to identify cases involving Medicare Advantage beneficiaries and identify the Medicare Advantage insurer. This insurer should then be contacted with respect to any conditional payments that it may have made for injury related medical expenses.

The standing of Medicare Advantage plans to pursue recovery under the Medicare Secondary Payer Act has

been litigated in several cases. Early cases suggested that Medicare Advantage plans did not have the same rights of recovery as CMS. More recent cases, however, illustrate a trend toward finding that Medicare Advantage plans have the same rights under the Medicare Secondary Payer Act as CMS. In *In re Avandia Marketing*, 685 F.3d 353 (3d Cir. 2012), the Court of Appeals for the Third Circuit held that a Medicare Advantage plan, Humana, had a private cause of action under the Medicare Secondary Payer Act to recover payments from primary payers. *In re Avandia Marketing*, 685 F.3d at 356-357, 367.

The Court of Appeals for the Seventh Circuit, which has jurisdiction over federal appeals arising in Illinois, has yet to address the issue. If and when a federal appeals court issues a contrary decision to the decision in *Avandia*, then the question may ultimately be accepted for resolution by the U.S. Supreme Court.

The Illinois Workers' Compensation Act does contain a provision prohibiting liens, which provides that no payment, claim, award or decision under the Act "shall be assignable or subject to any lien." 820 ILCS 305/21. Principals of federal preemption, however, would not bar Medicare Advantage plans from asserting a conditional payments lien. The Code of Federal Regulations specifically provides:

> [c]oncerning the Federal preemption of State law, the rules established under this section supersede any State laws, regulations, contract requirements, or other standards that would otherwise apply to MA plans. A State cannot take away an MA organization's right under Federal law and the MSP regulations to bill, or to authorize providers and suppliers to bill, for services for which Medicare is not the primary payer. 42 C.F.R. 422.108(f).

The issue of Medicare Advantage plan's rights under the Medicare Secondary Payer Act will undoubtedly continue to be litigated throughout the country. Medicare Advantage plans such as Humana have become aggressive in their attempts to establish their rights under the Medicare Secondary Payer Act.

Until this issue is either resolved by the U.S. Supreme Court or is addressed by the Seventh Circuit, employers and their insurers must identify claimants/petitioners who are Medicare Advantage beneficiaries and take steps to identify any conditional payments liens that the MA may possess. Thus, any conditional payments lien presented by a Medicare Advantage plan should be addressed and fully resolved in order to protect the parties involved.

Additional issues will arise where conditional payment liens are identified by Medicare Advantage plans. For example, what are the petitioners' and respondents' rights if an Medicare Advantage plan improperly asserts a conditional payments lien containing medical expenses that were not related to the workers' compensation claim? If Medicare Advantage plans have the same standing as Medicare to enforce the Medicare Secondary Payer Act, it would appear to logically follow that the Medicare Advantage plan's interests must also be protected as to future medical expense. Until these issues are fully resolved in the courts, arguably Medicare Set-Asides would need to be used to protect Medicare Advantage plans. Moreover, care should be undertaken to address these issues through the course of settlement negotiations.

The risk associated with not protecting Medicare Advantage plans is illustrated by the case of *Humana Medical Plan, Inc. v. Western Heritage Ins. Co.*, 94 F. Supp. 3d 1285 (S.D. Fla. 2015). There, in the underlying personal injury action, the plaintiff asserted that she had no outstanding Medicare liens. In addition, a conditional payments demand letter from CMS confirmed that CMS had made no Medicare payments on behalf of the plaintiff. The plaintiff, however, was insured by Humana under a Medicare Advantage plan. The insurer for the defendant, Western Heritage, attempted to place Humana's name on the settlement draft. A state court judge ordered the draft to issue without Humana named. Ultimately, Humana sued Western Heritage seeking recovery under the Medicare Secondary Payer Act, 42 U.S.C. § 1395y(b)(2). Western Heritage argued that Humana did not have a private cause of action under the Medicare Secondary Payer Act. The U.S. District Court for the Southern District of Florida disagreed and not only found that Humana had a private cause of action under the Medicare Secondary Payer Act, but entered summary judgment against Western Heritage. The court then proceeded to award double damages.

The downside in not protecting Medicare Advantage plans is apparent from the *Western Heritage* ruling. Accordingly, Medicare Advantage policies involving workers' compensation claimants and petitioners must be identified, conditional payments confirmed, and resolved prior to settlement.

Are Petitioners Required to Submit AMA Impairment Rating Reports Into Evidence In Order to Recover Under The Illinois Workers' Compensation Act?

The use of AMA impairment ratings to establish permanent partial disability was introduced in Illinois as a part of the 2011 workers' compensation reforms. The statute provided in part that "[f]or accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria; (a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing." 820 ILCS 305/8.1b(a). The defense bar has argued the use of the term "shall" in Section 8.1b places an affirmative burden on the claimant to admit an AMA impairment rating report into evidence as a necessary element of their case-in-chief. In the absence of such a report, a claimant would be barred from recovering permanency.

As we reported in our November 10 blast, in *Continental Tire of the Americas, LLC v. Illinois Workers' Compensation Comm'n*, 2015 IL App (5th) 140445WC, the Appellate Court, Workers' Compensation Commission Division, held that the Commission is not required to follow a respondent's AMA impairment rating report even where the claimant fails to place into evidence a contradictory or opposing report. The appellate court explained that the AMA impairment rating was but one factor that the Commission should consider in establishing the claimant's permanent partial disability.

Since an AMA report was submitted by the employer, the court did not squarely address the issue of whether *claimants* are, in fact, obligated to submit an AMA impairment report into evidence under Section 8.1b. 820 ILCS 305/8.1b(a). At one point, the court stated, "[t]he statute does not require the claimant to submit a written physician's report. It only requires that the Commission, in determining the level of the claimant's permanent partial disability, consider a report that complies with subsection (a), regardless of which party submitted it." *Continental Tire*, 2015 IL App (5th) 140445WC, ¶ 17. Yet at another location the decision says that "[s]ection 8.1b(a) requires a licensed physician to prepare a permanent partial disability report setting out the level of the claimant's impairment in writing." *Id.* ¶ 10.

Notwithstanding, during oral arguments, one Justice commented, "If your argument was there was no report at all, you would have an argument" (oral argument recording at 3:57). Even the claimant's counsel appeared to acknowledge during oral arguments that submission of an AMA report is required. When asked why the petitioner would want to put an AMA report into evidence if it had a zero impairment rating, petitioner's counsel responded, "[b]ecause it's required by the statute that it be there" (oral argument recording at 24:51).

It is expected that the appellate court will have an opportunity to further address this issue in 2016. As we are counsel for at least one of those cases, we will keep you advised.

Social Security Administration Proposes Mandatory Reporting of Workers' Compensation Benefits

The Social Security Administration (SSA) has published its proposed 2016 budget, which includes, as an appendix, several legislative proposals currently under consideration, see https://www.socialsecurity.gov/budget/FY16Files/2016BO.pdf, including a proposal that would require states, local governments, and private insurers to report to the Social Security Administration workers' compensation benefits that would affect the offset of social security disability benefits. The proposal states:

> Current law requires SSA to reduce an individual's Disability Insurance (DI) benefit if he or she receives workers' compensation (WC) or public disability benefits (PDB). SSA currently relies upon beneficiaries to report when they receive these benefits. This proposal would improve program integrity by requiring states, local governments, and private insurers that administer WC and PDB to provide this information to SSA. Furthermore, this proposal would provide for the development and implementation of a system to collect such information from states, local governments and insurers.

Id. When social security disability recipients also receive workers' compensation benefits, the Social Security Administration is entitled to offset those benefits pursuant to the Social Security Act 42 U.S.C. §424a. Generally, the Social Security Act requires that the total amount of social security disability and workers' compensation or public disability benefit be reduced by an amount necessary to insure that the sum of the benefits does not exceed 80 percent of the individuals pre-disability average current earnings 42 U.S.C. § 424a(a).

Currently, the Social Security Administration does not have a means to independently determine whether a disability beneficiary is also receiving workers' compensation benefits or governmental disability benefits. The Social Security Administration relies upon the beneficiary to report when they are receiving such benefits. The potential for fraud or underreporting is very apparent.

The proposal would call for the creation of a system for governments and insurers to report the nature and amount of the benefit received by the social security disability beneficiary. The proposal does not address the issue of how the insurers or governmental entities are to determine whether the claimant is, in fact, a social security disability beneficiary.

This proposal is substantially similar in principle to the MMSEA §111 mandatory reporting requirement for reporting benefits and settlements to Medicare. While the goal of reducing fraud is certainly meritorious, the proposal will shift the burden of reporting workers' compensation and public disability benefits from the claimant/beneficiary to government entities and workers' compensation insurers. The burden may be increased if the Social Security Administration requires insurers and public entities to acquire releases from the claimant/beneficiaries prior to disclosure of their workers' compensation or public disability benefit. It is likely that this proposal will receive widespread support.

Although the proposal does not suggest an effective date, it is quite likely that the effective date would be approximately 12-18 months after any such legislative proposal became law.

COMMISSION NEWS

In compliance with Section 14 of the Illinois Workers' Compensation Act, the dockets of all existing downstate arbitrators will be reassigned to another arbitrator effective January 1, 2016. The Commission website will begin to list the name of the new arbitrator shortly and in advance of the January 1, 2016, docket transfer. According to the Commission's webpage, all cases will be transferred on January 1st, including those cases where a decision has been reached on a 19(b). The 19(b) cases will not follow the current arbitrator to their new assignment but will stay in the docket where it was originally assigned.

Brad Peterson

Urbana Office

Brad's practice is divided between workers' compensation, civil litigation and Medicare Secondary Payer Act compliance. For over a decade Brad has had a special interest in Medicare Set-Aside Trusts and the Medicare Secondary Payer Act, and has written and spoken extensively on these issues. Brad was one of the first attorneys in the State of Illinois to publish an article regarding the application of the Medicare Secondary Payer Act to workers' compensation claims: "Medicare, Workers' Compensation and Set-Aside Trusts," *Southern Illinois Law Journal* (2002). He is a member of the National Association of Medicare Set-Aside Professionals. Brad has served a number of terms in the Illinois State Bar Association Assembly, has been a member of the ISBA Bench and Bar Section Council, and has served as its Chair in 2000-2001. Brad is a member of the ISBA Workers' Compensation Section Council where he served as Chairman in 2012-2013 and he is a past editor of the Workers' Compensation Section Newsletter. He currently serves as the contributing editor of the Workers' Compensation Report for the *Illinois Defense Counsel Quarterly*.

HEYL ROYSTER

WORKERS' COMPENSATION GROUP

ILLINOIS WORKERS' COMPENSATION RATES

PEORIA
Craig Young
cyoung@heylroyster.com
(309) 676-0400

CHICAGO
Kevin Luther
kluther@heylroyster.com
(312) 853-8700

EDWARDSVILLE
Toney Tomaso
ttomaso@heylroyster.com
(618) 656-4646

ROCKFORD
Kevin Luther
kluther@heylroyster.com
(815) 963-4454

SPRINGFIELD
Dan Simmons
dsimmons@heylroyster.com
(217) 522-8822

URBANA
Bruce Bonds
bbonds@heylroyster.com
(217) 344-0060

TTD, DEATH, PERM. TOTAL & AMP. RATES

ACCIDENT DATE	MAX. RATE TTD, DEATH, PERM. TOTAL, AMP.	MIN. RATE DEATH, PERM. TOTAL, AMP.
7/15/10 to 1/14/11	1243.00	466.13
1/15/11 to 7/14/11	1243.00	466.13
7/15/11 to 1/14/12	1261.41	473.03
1/15/12 to 7/14/12	1288.96	483.36
7/15/12 to 1/14/13	1295.47	485.80
1/15/13 to 7/14/13	1320.03	495.01
7/15/13 to 1/14/14	1331.20	499.20
1/15/14 to 7/14/14	1336.91	501.34
7/15/14 to 1/14/15	1341.07	502.90
1/15/15 to 7/14/15	1361.79	510.67
7/15/15 to 1/14/16	1379.73	517.40

Death benefits are paid for 25 years or $500,000 whichever is greater.
As of 2/1/06, burial expenses $8,000

MINIMUM TTD & PPD RATES

# of dependents, including spouse	7/15/07-7/14/08	7/15/08-7/14/09	7/15/09-7/14/10	7/15/10-1/14/16
0	200.00	206.67	213.33	220.00
1	230.00	237.67	245.33	253.00
2	260.00	268.67	277.33	286.00
3	290.00	299.67	309.33	319.00
4+	300.00	310.00	320.00	330.00

MAXIMUM PERMANENT PARTIAL DISABILITY RATES

ACCIDENT DATE	MAXIMUM RATE
7/1/08 to 6/30/09	664.72
7/1/09 to 6/30/10	664.72
7/1/10 to 6/30/11	669.64
7/1/11 to 6/30/12	695.78
7/1/12 to 6/30/13	712.55
7/1/13 to 6/30/14	721.66
7/1/14 to 6/30/15	735.37

MAXIMUM 8(D)(1) WAGE DIFFERENTIAL RATE

ACCIDENT DATE	MAXIMUM RATE
1/15/12 to 7/14/12	966.72
7/15/12 to 1/14/13	971.60
1/15/13 to 7/14/13	990.02
7/15/13 to 1/14/14	998.40
1/15/14 to 7/14/14	1002.68
7/15/14 to 1/14/15	1005.80
1/15/15 to 7/14/15	1021.34
7/15/15 to 1/14/16	1034.80

SCHEDULED LOSSES (100%)

	Effective 2/1/06 (and 7/20/05 to 11/15/05)
Person as a whole	500 wks
Arm	253 wks
Amp at shoulder joint	323 wks
Amp above elbow	270 wks
Hand	205 wks
Repetitive carpal tunnel claims	190 wks
Benefits are capped at 15% loss of use of each affected hand absent clear and convincing evidence of greater disability, in which case benefits cannot exceed 30% loss of use of each affected hand.	
Thumb	76 wks
Index	43 wks
Middle	38 wks
Ring	27 wks
Little	22 wks
Leg	215 wks
Amp at hip joint	296 wks
Amp above knee	242 wks
Foot	167 wks
Great toe	38 wks
Other toes	13 wks
Hearing	
Both ears	215 wks
One ear	54 wks
Eye	
Enucleated	173 wks
One eye	162 wks
Disfigurement	162 wks

Workers' Compensation Group

"We've Got the State Covered!"

ILLINOIS ZONE MAP

Zone 4

Dockets Covered:
Kankakee • New Lenox • Ottawa

Contact Attorney:
Kevin J. Luther
kluther@heylroyster.com
815.963.4454

Bruce L. Bonds
bbonds@heylroyster.com
217.344.0060

Zone 3

Dockets Covered:
Bloomington • Rock Island • Peoria

Contact Attorneys:
Bradford B. Ingram
bingram@heylroyster.com
309.676.0400

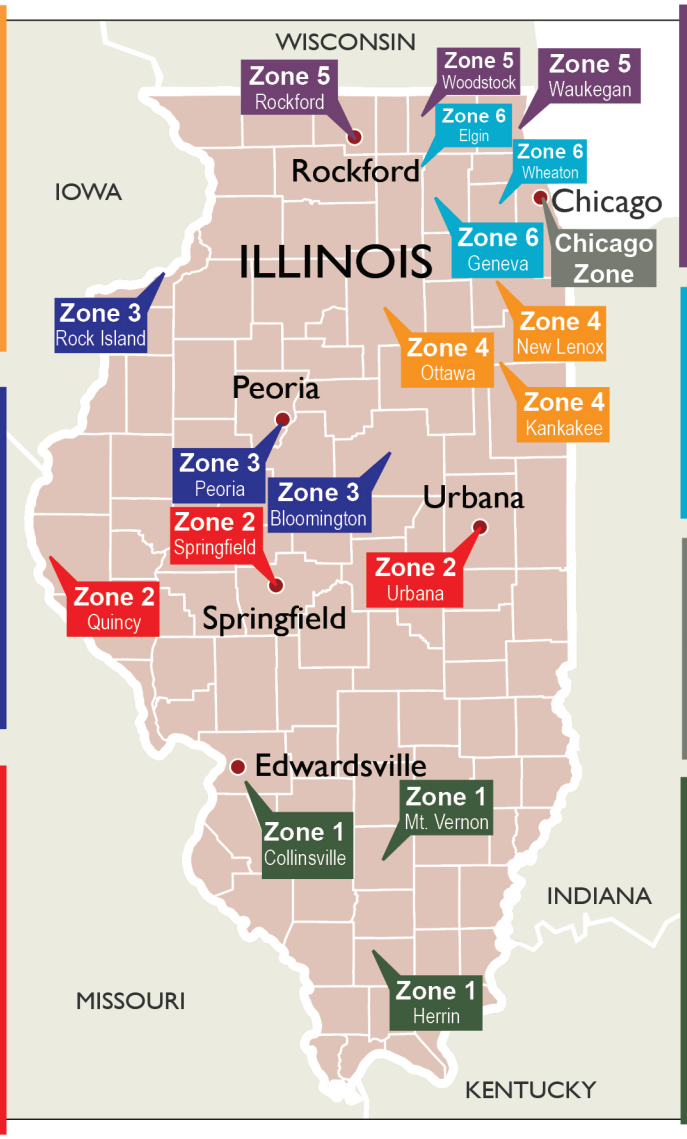
Craig S. Young
cyoung@heylroyster.com
309.676.0400

Zone 2

Dockets Covered:
Quincy • Springfield • Urbana

Contact Attorneys:
Bruce L. Bonds
bbonds@heylroyster.com
217.344.0060

Daniel R. Simmons
dsimmons@heylroyster.com
217.522.8822



Zone 5

Dockets Covered:
Rockford • Waukegan • Woodstock

Contact Attorney:
Kevin J. Luther
kluther@heylroyster.com
815.963.4454

Zone 6

Dockets Covered:
Elgin • Geneva • Wheaton

Contact Attorney:
Kevin J. Luther
kluther@heylroyster.com
815.963.4454

Chicago Zone

Contact Attorney:
Kevin J. Luther
kluther@heylroyster.com
312.971.9807

Zone 1

Dockets Covered:
Collinsville • Herrin • Mt. Vernon

Contact Attorneys:
Bruce L. Bonds
bbonds@heylroyster.com
217.344.0060

Toney J. Tomaso
ttomaso@heylroyster.com
618.656.4646

Statewide Workers' Compensation Contact

Contact Attorney:
Craig S. Young - cyoung@heylroyster.com
309-676-0400

Statewide Appellate

Contact Attorney:
Brad A. Elward - belward@heylroyster.com
309-676-0400

heylroyster.com

Office Locations

Peoria
300 Hamilton Blvd.
PO Box 6199
Peoria, IL 61601
309.676.0400

Chicago
33 N. Dearborn St.
Seventh Floor
Chicago, IL 60602
312.853.8700

Edwardsville
105 W. Vandalia St.
Mark Twain Plaza III
Suite 100
PO Box 467
Edwardsville, IL 62025
618.656.4646

Rockford
120 W. State St.
Second Floor
PO Box 1288
Rockford, IL 61105
815.963.4454

Springfield
3731 Wabash Ave.
PO Box 9678
Springfield, IL 62791
217.522.8822

Urbana
102 E. Main St.
Suite 300
PO Box 129
Urbana, IL 61803
217.344.0060

HEYL ROYSTER

Below is a sampling of our practice groups highlighting a partner who practices in that area – For more information, please visit our website
www.heylroyster.com

Appellate Advocacy
Craig Unrath
cunrath@heylroyster.com

Arson, Fraud and First-Party Property Claims
Dave Perkins
dperkins@heylroyster.com

Business and Commercial Litigation
Tim Bertschy
tbertschy@heylroyster.com

Business and Corporate Organizations
Deb Stegall
dstegall@heylroyster.com

Civil Rights Litigation/Section 1983
Keith Fruehling
kfruehling@heylroyster.com

Class Actions/Mass Tort
Patrick Cloud
pcloud@heylroyster.com

Construction
Mark McClenathan
mmcclenathan@heylroyster.com

Employment & Labor
Brad Ingram
bingram@heylroyster.com

Governmental
John Redlingshafer
jredlingshafer@heylroyster.com

Insurance Coverage
Jana Brady
jbrady@heylroyster.com

Liquor Liability/Dramshop
Nick Bertschy
nbertschy@heylroyster.com

Long Term Care/Nursing Homes
Mike Denning
mdenning@heylroyster.com

Mediation Services/Alternative Dispute Resolution
Brad Ingram
bingram@heylroyster.com

Product Liability
Rex Linder
rlinder@heylroyster.com

Professional Liability
Renee Monfort
rmonfort@heylroyster.com

Railroad Litigation
Steve Heine
sheine@heylroyster.com

Toxic Torts & Asbestos
Lisa LaConte
llaconte@heylroyster.com

Trucking/Motor Carrier Litigation
Matt Hefflefinger
mhefflefinger@heylroyster.com

Workers' Compensation
Craig Young
cyoung@heylroyster.com

Scan this QR Code for more information about our practice groups and attorneys

Peoria
300 Hamilton Boulevard
PO Box 6199
Peoria, IL 61601
309.676.0400

Chicago
33 N. Dearborn Street
Seventh Floor
Chicago, IL 60602
312.853.8700

Edwardsville
105 West Vandalia Street
Mark Twain Plaza III
Suite 100
PO Box 467
Edwardsville, IL 62025
618.656.4646

Rockford
120 West State Street
PNC Bank Building
2nd Floor
PO Box 1288
Rockford, IL 61105
815.963.4454

Springfield
3731 Wabash Ave.
PO Box 9678
Springfield, IL 62791
217.522.8822

Urbana
102 E. Main St.
Suite 300
PO Box 129
Urbana, IL 61803
217.344.0060