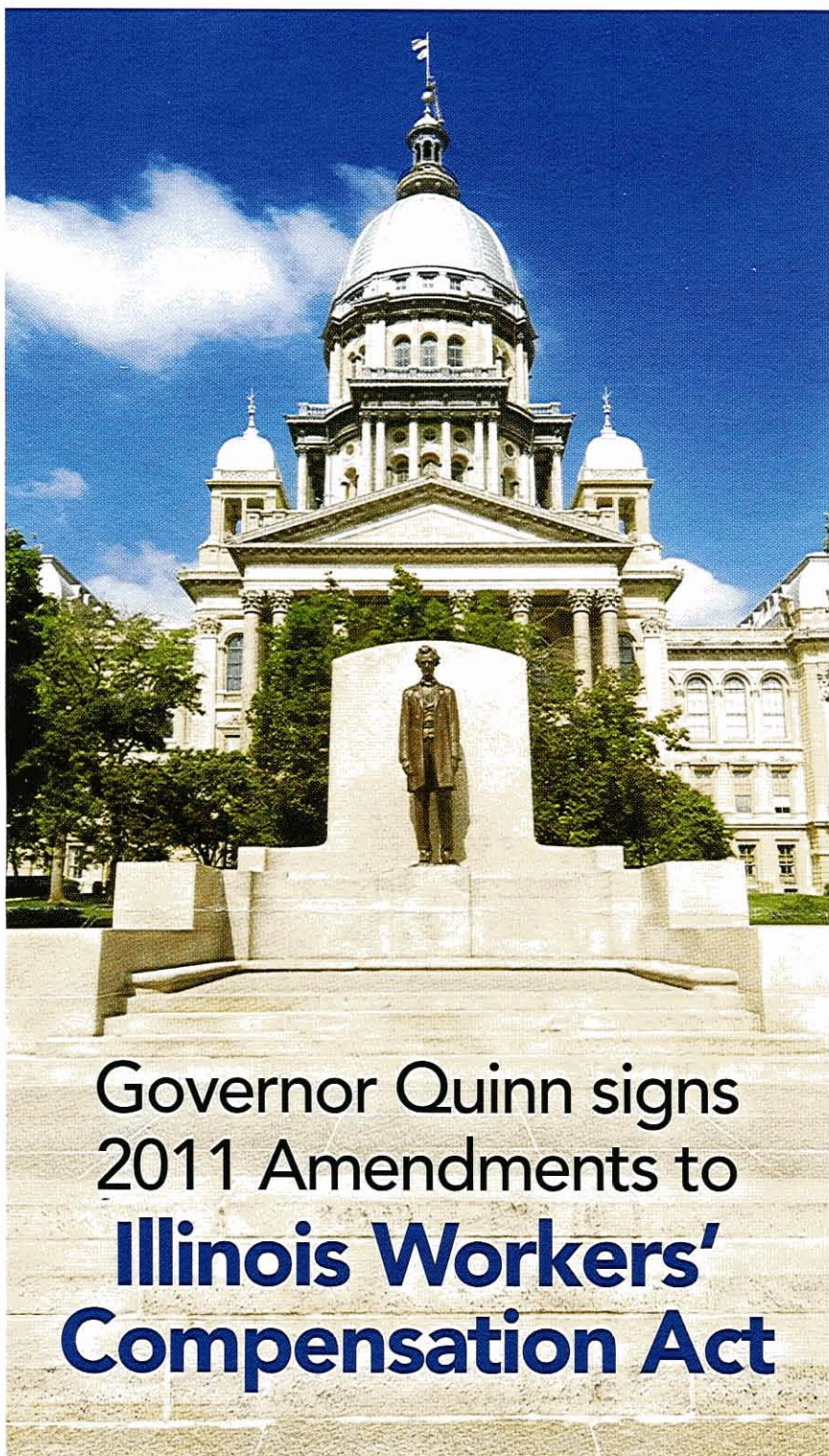


# IPRF ISSUES

Risk & Safety Tips from the ILLINOIS PUBLIC RISK FUND

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## Governor Quinn signs 2011 Amendments to **Illinois Workers' Compensation Act**

On May 31, 2011 the Illinois General Assembly passed Amendments to the Illinois Workers' Compensation Act. Governor Quinn signed this bill June 28, 2011. The amendments make a "down payment" towards meaningful reform, but the Illinois workers' compensation system will remain high cost and out-of-line with other Midwestern states.

### **SUMMARY OF AMENDMENTS TO ILLINOIS WORKERS' COMPENSATION ACT**

#### **The Preferred Provider Program**

This program authorizes employers to establish a preferred provider program for medical treatment. The plan must provide coverage by specialty and to treat common injuries experienced by injured workers in the geographic area where the employees reside. If the employee chooses, in writing, to treat outside of the employer's preferred provider network, the preferred provider network will count as one of the employee's two chains of choices. If the employer does not have a preferred provider network then petitioner would retain the current two chains of referral. If the employee seeks treatment outside of the provider network before giving notice to the employer of his injury any such non-emergency treatment will be counted as petitioner's first choice. The Commission may order treatment outside of the provider network on a case by case basis if the medical provider network does not contain a physician who can provide the required treatment and if the employee has complied with any pre-authorization requirements of the preferred provider network. The Commission may authorize petitioner to seek treatment at employee's expense outside of the network upon a finding that the employee's second choice of provider within the employer's network is improper or inadequate.

#### **Burden of Proof Defined**

The new paragraph provides "To obtain compensation under this Act, an employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of employment."

#### **Medical Fee Schedule – Amendments and Reductions**

Prior to February 1, 2006, Illinois never had a fee schedule for medical bills. The Fee Schedule enacted February 1, 2006 was enacted with the reported intent that it was going to be a cost savings tool for employers. That was simply false. The medical fee schedule did not result in significantly lower costs. Workers' compensation medical costs have remained extraordinarily high. The new statute imposes a significantly more restricted fee schedule. Additional authority and directions are given to the Commission with respect to the fee schedule. The Act provides:

"The Commission shall establish and maintain fee schedules for procedures, treatments, products, services, emergency room, ambulatory surgical treatment centers, accredited ambulatory surgical treatment facilities, prescriptions filled and dispensed outside of a licensed pharmacy, dental services, and professional services."

Further effective, January 1, 2012, instead of analyzing non-hospital fees based on geozip, the Fee Schedule is based on non-hospital services into just four regions:

1. Cook County;
2. DuPage, Kane, Lake and Will Counties;
3. Bond, Calhoun, Clinton, Jersey, Macoupin, Madison, Monroe, Montgomery, Randolph, St. Clair and Washington Counties; and
4. All other counties of the State.

**With respect to hospital fees, the State is broken down into 14 regions.**

**With respect to any fees that are scheduled, the maximum allowable payment is reduced to 70% of the Fee Schedule amount.**

The reimbursement rate for any unscheduled fees, which is currently set at 76% is reduced by 30% down to 53.2%. Implants shall be reimbursed at 25% above the net manufacturer's invoice price, less rebates, plus reasonable shipping charges. Additionally, prescriptions are limited to a fee schedule that shall not exceed the Average Wholesale Price (AWP) plus a dispensing fee of \$4.18.

#### **Additional Medical Fee Changes**

Medical bills are now required to be paid within 30 days instead of 60 days so long as the claim contains substantially all the required data elements necessary to adjudicate the bills.

The employer is now required to provide written notification within 30 days if a bill is being denied or payment is being delayed because of insufficient information.

Medical providers can charge interest if a bill is not paid within 30 days at a rate of 1% per month. It provides any required interest payments be made within 30 days after payment.

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## Current Ranking (By Cost) of States with Fee Schedule

1. Alaska .....	215 percent
<b>2. Illinois .....</b>	<b>150 percent</b>
3. Delaware.....	131 percent
4. Idaho .....	121 percent
5. Nevada .....	119 percent

6. Oregon .....	101 percent
7. Montana.....	98 percent
8. Nebraska.....	91 percent
9. Connecticut .....	89 percent
10. Arizona .....	84 percent

*Even with a 30 percent reduction, Illinois will still have the 2nd highest fee schedule in the United States at 150 percent over Medicare.*

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### Intoxication and Drug Use – Rebuttable Presumption Defense

For the first time imposed a statutory framework for disputing and denying drug and alcohol cases has been imposed.

The new paragraph in the statute states “No compensation shall be payable if the employee’s intoxication is the proximate cause of the employee’s accidental injury or at the time the employee incurred the accidental injury, the employee was so intoxicated that the intoxication constituted a departure from the employment.”

Admissible evidence on this issue includes evidence of the concentration of either alcohol, cannabis or other drugs in an employee’s blood, breath or urine at the time of the accidental injury. The statute states that if at the time of the accidental injuries, the employer can prove an alcohol level of 0.08%, or if there is evidence of impairment as a result of the use of cannabis or other drugs, then “there shall be a rebuttable presumption that the employee was intoxicated and that the intoxication was the proximate cause of the employee’s injury.”

The statute further provides that the employee can overcome the rebuttable presumption by presenting admissible evidence that the intoxication was not the sole proximate cause or the proximate cause of the accidental injuries.

### Medical Payment Changes

This is the medical provision which obligates the employer to pay for reasonable and necessary medical treatment limited to the Fee Schedule. The amendment limits the medical provider fees “even if a health care provider sells, transfers or otherwise assigns an account receivable for procedures, treatments or services covered under this Act.”

### TPD Formula Changed

This statute was amended to create temporary partial disability as of February 1, 2006. Oddly, the temporary partial disability calculation is contained in the medical provision of the Act. The new temporary partial disability calculation “is equal to two-thirds of the difference between the average amount that the employee would be able to earn in the full performance of his or her duties in the occupation which he or she was engaged at the time of the accident and the gross amount which he or she is earning in the modified job.”

### Electronic Claims Processing

Electronic Claims are entitled and it requires that the Department of Insurance adopt rules to: “Ensure that all health care providers and facilities submit medical bills for payment on standardized forms; Require acceptance by employers and insurers of electronic claims for payment of medical services; Ensure confidentiality of medical information submitted on electronic claims for payment of medical services.”

This provision is to be effective January 1, 2012 and employers are required to accept electronic claims on or before June 30, 2012.

### Utilization Review – Amendments and Enforcement

When the statute was amended February 1, 2006, for the first time it included utilization review provisions. The statute defined utilization review and gave employers the right to use utilization review but it did not impose any requirement that the Commission actually use utilization review reports in rendering their decisions. In fact, since February 1, 2006, there are very few Commission decisions which actually deny medical treatment based on utilization review reports.

This new statute modifies the utilization review provisions in an effort to bolster the importance and effectiveness of utilization review.

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

Written notice of utilization review decisions are to be provided to the medical provider and the employee. Medical bills can only be denied on the grounds that the extent and scope of medical treatment is excessive and unnecessary.

Most importantly, the statute further provides “When a payment for medical services has been denied or not authorized by an 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 is reasonably required to cure or relieve the effects of his or her injury.”

The statute further provides that the medical professional responsible for the utilization review in the final stage has to be available for either an interview or deposition in this State. The interview may be via telephone, video conference or other electronic means. If the professional is available for a video deposition, the employer must bear the burden of the cost.

Clearly, the statute bolsters the use of utilization review. However, the change in the statute does not mandate the Commission to adopt a utilization review finding. The statute is changed and now provides “An admissible utilization review shall (instead of will) 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.”

### Fraud penalties - Defined

Greater penalties are amended for fraud. The penalties are as follows: If the value of the fraud is \$300.00 or less, the violation is a Class A misdemeanor. If the violation is greater than \$300.00 but less than \$10,000.00, it is a Class 3 felony. If it is more than \$10,000.00 but less than \$100,000.00, it is a Class 2 felony. If it is more than \$100,000.00, it is a Class 1 felony. In addition to criminal penalties, anyone convicted of fraud is responsible for restitution, including court costs and attorney’s fees.

### Wage Differential Limitations Placed

The calculation of wage differential remains the same but a cap is imposed on the length of time that an individual can receive wage differential benefits. The new Act provides “for accidental injuries that occur on or after September 1, 2011, an award for wage differential shall be effective only until the employee reaches the age of 67 or five years from the date the award becomes final, whichever is later.”

### Carpal Tunnel Cases – New limitations Reduction in the Value of a Hand for Carpal Tunnel Cases

The number of weeks of PPD for the loss of use of the hand is reduced from 205 weeks back down to 190 weeks (the same as pre-2/1/06), but only for carpal tunnel syndrome cases caused by repetitive or cumulative trauma.

The new act further states that if a claim involving the hand injury is for carpal tunnel syndrome as a result of repetitive trauma or cumulative trauma, the permanent partial disability award “shall not exceed 15% loss of use of the hand, except for cause shown by clear and convincing evidence and in which case the award shall not exceed 30% loss of use of the hand.”

### IPRF is ready for the new Illinois Workers’ Comp Reform

A significant benefit for IPRF members is the ability to now **DIRECT** care in Illinois.

*“...an employee of an employer utilizing a preferred provider program shall only be allowed to select a participating network provider from the network.”*

**IPRF PPO Partners comply with the new changes in the law and are ready for Employer Enrollment today!**

**IPRF PPO Partners have the Largest Coordinated Occupational Health Network in Illinois (COP®)**

- COP® Networks enhance and emphasize the Return to Work initiative
- 24 Hour In System Coverage

**IPRF PPO Partners have the Largest Workers’ Comp Network in Illinois**

- Over 100 hospitals contracted with IPRF below the Illinois State Fee Schedule
- Over 22,000 providers below the Illinois State Fee Schedule. IPRF Partners are licensed PPO Networks and accept electronic claim submission.

### AMA Guidelines

AMA Guidelines introduces to Illinois for the first time the most recent edition (6th) of the *AMA Guidelines* to help determine permanent impairment under the Workers’ Compensation Act. Although the Commission will have the final say in determining the permanent partial disability value based not only upon a licensed physician’s “rating exam” in accordance with the *AMA Guides*, but also considering the claimants treating medical records, age, occupation, and future earnings capacity. As a matter of Illinois law, physician ratings of permanent partial disability or permanent impairment have been excludable from the evidence submitted in workers’ compensation proceedings on grounds that such “ratings” invade the province of the Commission. Now such ratings, commonplace in other states, will be admissible as a matter of law provided that they are based upon the 6th Edition of the *AMA Guides*. The qualifications of every IME physician should be reviewed to assure appropriate knowledge, experience, and training with the *AMA Guides*. In practice, few Illinois physicians are familiar with the *AMA Guides* (especially the 6th Edition published in 2008), and fewer still have received specific training in performing evaluations using the *AMA Guides*.

### Other Changes Affecting Illinois Employers

- Requires Employee Leasing Companies to provide the Commission with proof that their client companies are listed as additional named insureds on their policies.
- Allows for employer non-compliance fines for lack of insurance coverage of \$500-\$2500.
- The Workers’ Compensation Advisory Board is terminated as of effective date with new Board to be appointed within 30 days.
- Department of Insurance reporting requirements that require insurers to report specific items to DOI.
- Claims by Workers’ Compensation Employees sent to be heard by Independent Arbitrator.