

2011
REFORM

CHAMPAIGN • IL



19th WORK INJURY CONFERENCE

Challenges • Debates • Solutions

10.19.2011

PRESENTATIONS



"KEYS TO REFORM"

The Menard Prison Scandal, an Inside Look.

Mr. Jay Tebbe
President & Publisher
Belleville News Democrat

"KEYS TO REFORM"

- ⊙ The BND: Who we are and why watchdog reporting remains a key mission;
- ⊙ Employees hurt of the job deserve benefits;
- ⊙ Workers' Compensation fraud hurts all of Illinois;
- ⊙ Illinois vs. Adjacent States, the impact of causation;
- ⊙ The State's system for handling state employees is poor;
- ⊙ The Mendard Debacle;
- ⊙ Politics hold back real change.



WORK COMP REFORM 101: *IMPACT OF HB 1698*

Mr. Kim Presbrey
Managing Partner
Former President ITLA
Presbrey & Associates, P.C.

A Perfect Storm for Bad Legislation
A Trial Lawyer's Perspective

HOW IT STARTED

Promises were made to Business in March of 2010

- ⊙ At the meeting in January of 2011, Business referred to promises made to them in March of 2010
- ⊙ The only event that occurred at that time was the current Chairman was appointed over the unanimous recommendation of the WC Advisory Committee that Acting Chairman Amy Masters be retained
- ⊙ These promises pre-dated the Oregon Study along with any events or data suggesting that there was any problem with the WC system in IL.

THE OREGON STUDY

- ⊙ This study suggested that IL was the 2nd most expensive workers' compensation system in the US behind Montana.
- ⊙ Within this study, there were 18 caveats as to known issues with the data collection on which the study was based.
- ⊙ This study was clearly a "Come to Oregon" plea by the State of Oregon and their Chamber of Commerce
- ⊙ This study was the justification used for the initial WC hearings chaired by President Cullerton in November of 2010 to review the WC system.
- ⊙ None of the empirical data mandated by the 2006 WC law had been collected or published by the IL Department of Insurance at this time.

THE MENARD CONTROVERSY

- ⊙ Approximately 200 workers at the Menard Correctional Facility contract CTS.
- ⊙ The BND reports this and takes the position that there is an organized evil cabal somehow faking emg's and manufacturing the physical symptoms associated with the condition.
- ⊙ The BND never questions why the Attorney General waited until 200 cases accumulated before they hired an expert to review films of the jobs to see if this was a safety or a conspiracy issue.
- ⊙ The BND never reported that the expert that reviewed the films agreed that the activities of the job caused the CTS.

THE MENARD CONTROVERSY, CONTINUED

- ⊙ The BND never reported that the first 6 cases were extensively tried and found to be compensable based on these reports.
- ⊙ The BND never considered the fact that 200 people having the same medical condition in the same workplace is far beyond the definition of anomaly.
- ⊙ Instead, the BND focused on the arbitrators that heard the cases and a possible further conspiracy with the prosecuting attorney of the cases.

THE ARBITRATORS

- ◎ The allegations regarding one of the arbitrators, if true, require her termination.
- ◎ The allegations regarding the arbitrator seem very circumstantial and not even worthy of publication. Accidents happen, most accidents are not witnessed, and there is no suggestion of any pattern or practice by this arbitrator of filing cases.
- ◎ There is also no proof that the rest of the arbitrators in the state are engaging in any unethical behavior warranting their dismissal.
- ◎ The present arbitrators are ten times as professional as the arbitrators that existed at the WCC when I started practicing in the 70's and no contemporary attorney would disagree with that assessment.



THE MEDICAL FEE SCHEDULE

- ⊙ It came into existence with the 2006 legislation.
- ⊙ It completely removed outliers and introduced UR.
- ⊙ The data concerning cost savings was never gathered from the insurance companies.
- ⊙ Most large employers were already paying far less than the fee schedule.

THE MEDICAL FEE SCHEDULE, CONTINUED

- ⊙ Existing PPO's, attached to insurance companies, were already paying less than the fee schedule.
- ⊙ Neither larger employers nor insurance companies have ever divulged what their actual medical costs are.
- ⊙ The state of Indiana, where all businesses threaten to move, does not have a fee schedule. IL medical business, employing thousands of high paid workers are now considering relocation to IN.

HEARINGS

Legislative Hearings Occurred from November thru December

- ⊙ The house had 3 hearings and the Senate had 3 hearings;
- ⊙ Only 1 minority sat on the 2 panels;
- ⊙ Business presented many anecdotes regarding fraud and the manipulation of the system.
- ⊙ Many of the anecdotes proved to be completely fabricated or at best, half-truths when investigated by the attorneys handling the cases.
- ⊙ It also became clear that CMS was having some real problems with staffing and data collection

HEARINGS, CONTINUED

The Director of the DOI, Mike McRaith became an increasing presence

- ⊙ As the hearings transpired the Chairman became less visible and McRaith became more visible;
- ⊙ It became apparent that McRaith was the only person in the administration whom could provide real data;
- ⊙ It was also apparent that his agenda was to substantially cut the medical fee schedule

LEGISLATIVE PROCESS

Veto Session Attempt at Passing New Legislations

- ⊙ John Bradley, a majority leader, became the drafter, negotiator and chief whipping boy for the negotiation process.
- ⊙ Business, labor and the trial lawyers were in the process.
- ⊙ The medical society was excluded from the process.

LEGISLATIVE PROCESS, CONTINUED

After several days of intense negotiation the bill was not called

- ◎ It was unclear at this point if the Senate or the House was the real push for the bill.
- ◎ Cullerton seemed much more hands on than Madigan, at this point, even though Bradley was taking an extremely active role.

LEGISLATIVE PROCESS, CONTINUED

February to May, 2011

- ⊙ Although the bill was not called, negotiations and meetings continued.
- ⊙ McRaith became ever more active in the process and in the gathering of data to support his decision.
- ⊙ Kwame Raoul became the lead person for the Senate President
- ⊙ The issues of sole causation, AMA Guidelines and utilization review became the principle negotiation points with the medical fee schedule cuts becoming a non-negotiable issue.

LEGISLATIVE PROCESS, CONTINUED

February to May, 2011

- ⊙ The IL Medical Society continued to be denied access to the negotiation process.
- ⊙ Numerous newspaper articles began surfacing all indicting the system and the process used to adjudicate claims.
- ⊙ The Menard Prison became the focal point for a corrupt system without any on the ground investigation or document review of the facts.

LEGISLATIVE PROCESS, CONTINUED

Passage of the Bill

- ◎ At the conclusion of many negotiations, re-drafts and threats, a bill was finally produced that forced the trial lawyers and labor to go neutral
 - a. No substantial benefit cuts besides wage differential and cts*
 - b. No change in the definition of causation*
 - c. AMA Guidelines introduced, but only a factor in assessing disability*
 - d. Depositions of UR doctors allowed*
- ◎ The first attempt at bill passage fails
- ◎ Madigan recalls the bill and secures his votes personally.



WC REFORM: *A STAKEHOLDER'S PERSPECTIVE*

MODERATOR:
Mr. Mike Holt
Attorney
Hennessy & Roach, P.C.

Stakeholder Panel Discussion

LABOR



Mr. Marc Poulos

Executive Director
Indiana, Illinois and Iowa
Foundation for Fair Contracting



Mr. Kevin Gregerson

Program Administrator
Union Construction Workers'
Compensation Program

© Marc Poulos

Q: How do you get Union and Contractor to buy into a program that dramatically changes the way we are used to doing business in the Workers' Compensation arena?

A: *Education, but not just any education. Education from those that have done it before.*

Q: How do we make an impact with just two programs on a pilot basis?

A: *You don't. There should be one pilot that becomes open to all trades like in Minnesota. That way, there is a larger impact.*

© Kevin Gregerson

Q: Work injury medical care reform, PPA's that administer PPP's that are derived from discounted PPO's. Does a different acronym spell quality medical care at a reasonable cost?

Q: Now that weekly wage differential benefits are capped, how do injured workers maintain their pre-injury earning capacity?

Q: How does a Labor-Management partnership create a better Workers' Compensation System?

INSURANCE



Mr. Ron Bensyl
Area Senior Vice President
Arthur J. Gallagher Risk
Management Services

◎ Mr. Ron Bensyl

Q: How do we address the availability, or lack of, adequate networks in rural areas and employer/employee access options?

A: Could preference be given to including physician practices that make use of evidence based treatment protocols that would lead to a more uniformed standard of practice?

Q: Will insurers be able to more effectively manage claims resulting in cost reductions?

A: The medical fee schedule reduction will not obtain the reductions expected to lower rates. This will take a multi-disciplinary approach to ultimately control costs that will lead to rate relief for Illinois employers.

NURSE CASE MANAGER



Mrs. Nancy Davis
RN, CCM, CLCP, MSCC
NurseValue, Inc.

Q: Is HB1698 going to impact the role of case management?

If so, how?

A: The fact that an employee has the ability to opt-out of the PPO at any time, in writing, will mean that even with the larger employers there will be injured workers seeking treatment outside of the PPO that will still need to be managed with case managers. Although Nurse Case Management was not specifically addressed in HB 1698, I believe, the value of case management will not be significantly diminished within the Illinois WC system. The case manager will continue to be able to work within the system and clarify communication between the provider and the employee.

Q: How does the reduction in the medical fee schedule, required use of AMA guidelines and impairment rating, and the strengthening of the Utilization Provision change the landscape in the scope of nurse case management?

A: It will not be a surprise if some of the best doctors/facilities will opt-out of work comp and simply choose not to accept these lower payments, especially if their practice doesn't need to. Discounted prices will usually lead to a higher frequency of visits on discounted medical rates for services rendered and, the best results cost money. Case Managers will be challenged to help assure timely and medically accepted treatment is recommended and rendered.

The need for use of the AMA impairment ratings by Illinois physicians is a first time thing. This will pose a big challenge to treating physicians and one that will require re-education and training. This may discourage some of the best doctors from participating at all in the system. This, combined with the lesser fee schedule, will challenge all parties in obtaining quality and timely care for the injured worker. The case manager can be helpful in assuring the client is getting adequate treatment, but not duplication of services between the providers.

The strengthening of the UR is not really going to impact case management directly, but in good management of the file the expense of a UR could be avoided.

EMPLOYER/BUSINESS



Mrs. Lorianne Bauer
PHR
Branch Manager
Paramount Staffing

© Ms. Lorianne Bauer

Q: How can employers compensate for the fact that they are not able to provide all types of benefits that most employees would like to have? Thus, resulting in frequent work comp claims or exaggerated injuries.

A: Start by providing a thoroughly detailed job description. In light of the 24/7 nature for industrial environments, require a time limit for response from the company and also deliver timely treatment to the injured worker. This may also limit lost time of the providers behalf.

Q: How do we maintain our client relationships when there has been an escalation of treatment without good objective diagnosis and reporting by providers?

A: Regulate treatment of known WC injuries. Make sure that physicians understand not to just generate a prescription, but the importance of recommending OTC treatment. Another suggestion would be to mandate provider training on basic workers' compensation statues.

EMPLOYER/BUSINESS



Mr. Doug Whitley
President & CEO
Illinois Chamber of Commerce

⊙ Mr. Doug Whitley

Q: Once again, Illinois' elected officials have chosen to ignore the "causation" issue as a critical element of the state's workers' compensation system. Do you think this subject will continue to be a "non-starter" and, therefore, remain untouchable?

A: *In order to get elected officials to redress the biggest issues associated with workers' compensation, it is imperative that we build the case by putting more emphasis on the burden workers' compensation has on state and local government budgets. In tough fiscal times governments need to make better use of limited taxpayer dollars. The case must be made that public sector employees have just as big of a stake in the WC system as the public sector employees do. It is also important to demonstrate to legislators how 'bad' WC laws and administration are anti-taxpayer.*

Q: Historically, Illinois' elected officials have only dealt with workers' compensation law changes every four to five years. Do you think it is realistically feasible for the employer community to have any hope that the laws and system will receive additional attention any sooner?

A: *Private sector employers must be vigilant in documenting their stories of disbelief between WC cases in Illinois and comparable situations in other states. The workers' compensation results in Illinois remains an unbalanced business climate issues that Illinois cannot afford to ignore.*

ATTORNEY



Mr. Bruce Warren
Respondent Attorney
Thomas, Mamer & Haughey



Mr. Todd Strong
Petitioner Attorney
Strong Law Offices

◎ Mr. Bruce Warren

Q: How do the new changes effect the respondent attorney?

◎ Mr. Todd Strong

Q: Do the changes made to the IWCA impose a complexity that will aid respondents and insurance carriers in defeating claims handled by less experienced practitioners?

A: *As to the complexity that has been added, less experience attorneys will see drastic reductions in settlement and success. More experienced practitioners will have to work harder to avoid the pitfalls that are now imposed.*

Q: Do misconceptions of the workers' compensation system, advanced by the media, impose a fear factor on both employees and employers that does nothing to promote a safe work environment?

A: *The Workers' Compensation System is viewed as unfair by all parties. There needs to be education or reporting on the fact that our current system is in fact a compromise on everyone's part. A no-fault system with damage caps vs. a at fault system with unlimited damages set by a jury of peers.*

PHYSICIAN (PROVIDER)



Dr. Richard Kube
MD
Prairie Spine & Pain Institute



Dr. Lawrence Li
MD
Orthopedic & Shoulder Center

◎ Dr. Richard Kube

Q: How do we address access to care in down state Illinois?

Q: How do we handle UR time demands and increase use of IR without delaying treatment?

◎ Dr. Lawrence Li

Q: How do I provide care to patients who have an alleged work injury, but have denied claims and who do not have any other insurance?

Q: I need to better understand who the use of the AMA Guides, 6th Edition, will impact and what is the determination of impairment?

PHYSICIAN (PROVIDER)



Mr. Patrick Gallagher
Vice President, Health Policy
Research & Advocacy
Illinois State Medical Society



Ms. Theresa Delvo
Physical Therapist
Midwest Rehabilitation, Inc.

◎ Mr. Patrick Gallagher

Q: How will the consolidation in payment localities and fee schedule reductions improve access to care for injured employees and simultaneously reduce costs for employers?

A: *Need to focus on other aspects of the workers' compensation system, such as prevention rather than crude price reductions.*

Q: Would a fee schedule based on Medicare be fairer and more accurate?

A: *Employers need to offer competitive contracts and develop networks rather than focusing on outdated and irrelevant comparisons to Medicare.*

◎ Ms. Theresa Delvo

Q: Will providers continue to elect to treat work related injuries?

Q: How does the reduction in the fee schedule affect services? FCE's, Work Hardening programs, etc?

A: *We must realize that if we continue with the 30% reduction, there will be changes in providers and available services and, therefore, additional money spent in the end.*



Dr. Charles Bush-Joseph
MD, Managing Partner
Midwest Orthopaedics at Rush



Mr. David Kolb
President & CEO
HFN, Inc.



Mr. Robert Maciorowski
Respondent Attorney
Maciorowski, Sackmann & Ulrich

DEVELOPING THE EMPLOYER PPO NETWORK

DEVELOPING THE EMPLOYER PPO NETWORK

- ⊙ So many unanswered questions that need to be addressed for this new option for employers to direct care. Including:
 - ⊙ What is the certification process to become a PPO Network member?
 - ⊙ If the employer chooses to utilize a physician group that is not involved in a PPO network, will this be authorized? Paid? Approved?
 - ⊙ Will there be different PPO groups?
 - Categorized by Region, Specialty, etc?
 - If yes, who determines these?



INTOXICATION DEFENSE AND WORK COMP FRAUD CHARGES

Mr. Gene Keefe
Equity Partner
Keefe, Campbell &
Associates, LLC

Presentation on Intoxication and WC Fraud
changes in the 2011 Amendments to the Illinois
Workers' Compensation Act

WHAT IS HAPPENING TO OUR ILLINOIS WORKERS' COMPENSATION SYSTEM?

- ⊙ The Menard Correctional Center “Scandal”
- ⊙ The state income tax and toll way hikes
- ⊙ Correcting an anti-jobs and anti-business climate in a tough economy
- ⊙ Maintaining our strengths
 - ⊙ Good schools
 - ⊙ Good infrastructure
 - ⊙ Good health care
 - ⊙ Central location among the states

SECTION 11 OF THE ILLINOIS WORKERS' COMPENSATION ACT

- ⊙ Provides an intoxication defense, however, this was greatly limited

The new section confirms no compensation shall be payable if an employee's intoxication is the proximate cause of the employee's accidental injury at the time of the accident, or if the employee was so intoxicated that the intoxication constituted a departure from the employment.

There is no way to tell if this new Section is going to be a cost-savings; we will have to wait and see what the IWCC does with it

SECTION 11 OF THE ILLINOIS WORKERS' COMPENSATION ACT, CONTINUED

- ⊙ Admissible evidence of the concentration of cannabis or a controlled substance listed in the Illinois Controlled Substances Act shall be construed in any hearing to determine any level of intoxication
- ⊙ The .08 alcoholic standard applies for alcohol pursuant to Illinois law. Concentrations at these levels create a rebuttable presumption of intoxication being the proximate cause of the injury

SECTION 11 OF THE ILLINOIS WORKERS' COMPENSATION ACT, CONTINUED

- ⊙ If the employee refuses to submit to testing of blood, breath or urine, *there shall be a rebuttable presumption that the employee was intoxicated and that the intoxication was a proximate cause of the injury.*
- ⊙ The employee may overcome these rebuttable presumptions by proving by a preponderance of the evidence the intoxication was not the “sole proximate cause” of the injury. The defense was striped of its teeth with this addition – as a “sole proximate cause” is almost a legal nullity; any first year torts student can tell you proximate cause is a tricky issue, as every event leading up to an injury can be a proximate cause of the injury.

SECTION 11 OF THE ILLINOIS WORKERS' COMPENSATION ACT, CONTINUED

- ⊙ Employers should be careful to note the rules must ensure samples are collected and tested in conformance with national, state, legal and regulatory standards for privacy in a manner reasonably calculated to prevent substitutions or interference in such collection. Employees are afforded the opportunity to provide notification of an information which they believe relevant to the tests, including identification of any recently used prescription or non-prescription medication
- ⊙ The sample storage, transportation and place of testing must reasonably preclude the possibility of contamination

CAN YOU FIRE A WORKER FOR LATE REPORTING OF AN ACCIDENT?

- ⊙ Assume some workers will “hide” the event and report late specifically to avoid alcohol and drug testing
- ⊙ You can get hair follicle testing for drugs but not alcohol
- ⊙ Some employers now require accident reporting on a same-day or same-shift basis or they will terminate
- ⊙ Some unions go along with the requirement
- ⊙ Litigation expected one of these days

SECTION 25.5 OF THE ILLINOIS WORKERS' COMPENSATION ACT

- ⦿ Addresses WC fraud and delineates unlawful Acts and penalties for various violations
 - ⦿ Subsection (a)(9) adds intentionally presented bills or statements for services not provided as a violation.
 - ⦿ Any violation of subsection (a) for \$300.00 or less becomes a Class A misdemeanor;
 - ⦿ Any claim or attempt to collect fraudulently in excess of \$10,000.00 is a Class 2 felony;
 - ⦿ Any attempt to collect fraudulently in excess of \$100,000.00 is a Class 1 felony;
 - ⦿ Any person convicted under this section shall pay restitution for any such charges fraudulently collected.
 - ⦿ Subsection (e-5) requires the Fraud and Insurance Non-compliance Unit to develop a computer modeling system which looks at social networking, data mining and other advanced computer processes to prevent fraud and waste.
 - ⦿ Subsection (h) requires the Fraud and Insurance Non-Compliance Unit to issue an annual report to the Chairman of the Commission and the General Assembly outlining the number of allegations of insurance non-compliance and fraud reported, the source of reporting and the number of allegations investigated

We still don't see this as a major change, but we will have to see how State's Attorneys across Illinois handle the newly heightened felony levels

WHERE DO YOU BRING THE CLAIM FOR WC FRAUD?

- ⊙ *Country Insurance & Financial Services v. Roberts* appears to indicate it has to be brought at the WC Commission?
- ⊙ There are numerous WC Commission rulings saying they won't handle WC fraud claims.
- ⊙ The WC Commission can't award damages under the Insurance Fraud Act.
- ⊙ The WC Commission can't award restitution.
- ⊙ The WC Commission doesn't handle WC retaliatory discharge claims – if you apply the same reasoning, they should.

PREVENTION & SAFETY:

BEST PRACTICES

2:45 pm – 3:15 pm

Mr. Brian Bothast
Compliance Assistance
Specialist
OSHA

- ③ Strategies to prevent work related injuries and how to better manage costs.

INTRODUCTION

- ⊙ What does OSHA know about best practices?
 - ⊙ I thought OSHA just set minimum standards?
- ⊙ Effective safety and health programs
- ⊙ Implementation
- ⊙ Questions any time



OSHA's MISSION

Assure so far as possible safe and healthful
working conditions for every working man
and woman in the nation

I2P2:

EFFECTIVE SAFETY & HEALTH PROGRAMS

- ① Management Commitment
- ① Employee Involvement
- ① Worksite Analysis
- ① Hazard Prevention & Controls
- ① Training and Understanding
- ① Continuous Improvement

DO YOU HAVE A TRULY EFFECTIVE SAFETY AND HEALTH PROGRAM?

- ① Do you have clear rules and expectations?
- ① How do you know employees understand the rules and expectations?
- ① Do you have an effective process to discover deviations from expectations?
- ① Do you have an effective enforcement program?

LOOKING FOR HAZARDS

- ⊙ Inspector at Site
 - ⊙ Complaint
 - ⊙ Fatality
 - ⊙ Lists
- ⊙ No Quota

OSHA MUST APPROVE

- ⊙ Exposed employee
- ⊙ Serious hazard
- ⊙ Employer knowledge
- ⊙ Feasible method to abate hazard

SERVICING AND MAINTENANCE

“Exposure to Unexpected Energy”

- ⊙ Constructing, installing, setting up, adjusting, inspecting, and modifying equipment.
- ⊙ Lubrication
- ⊙ Cleaning
- ⊙ Unjamming
- ⊙ Adjustments
- ⊙ Tool changes
- ⊙ Establishes minimum performance requirements

PERIODIC INSPECTION

- ① Conducted annually
- ① Ensure procedures are properly implemented

MACHINE SPECIFIC PROCEDURES

- ⦿ Location
 - ⦿ Switch number one on electrical panel #302
- ⦿ Method
 - ⦿ Apply circuit breaker device and personal lock
- ⦿ Verification
 - ⦿ Push main green start button on equipment, look for lights or movement

RETRAINING

- ① If there changes in job assignments, machines, process, or a new hazard.
- ① Inadequate in the employee's knowledge of the control procedures.
- ① The retraining shall establish employee proficiency.

WHO HERE HAS WORKED ON OR LIVED NEAR ELECTRICAL?

- ⊙ Hazard: arc flash, arc blast & shock
- ⊙ Work performed on or near energized circuits
 - ⊙ Testing, troubleshooting, measuring voltage
- ⊙ Conduct a flash hazard analysis
 - ⊙ Ensure use of proper electrical protective equipment in compliance with NFPA 70e
- ⊙ Establish a flash protection boundary

RESPIRATORY PROTECTION PROGRAM

- ⊙ Program Administrator
- ⊙ Written program – selection process
 - ⊙ Do you know the level of the contaminant?
- ⊙ Medical evaluation
- ⊙ Fit test
- ⊙ Training
- ⊙ Record keeping

A CONFINED SPACE IS...

- ⊙ Large enough and so configured that an employee can bodily enter and perform assigned work
- ⊙ Limited or restricted means of entry or exit
- ⊙ Not designed for continuous human occupancy
 - ⊙ Must meet all three requirements

ROLES FOR ENTRY

- ① Entry supervisor
- ① Entrant
- ① Attendant
- ① Rescue and emergency services

PEOPLE DIE IN CONFINED SPACES BECAUSE ...

- ⊙ Do not recognize the hazards
- ⊙ Do not eliminate the hazards
- ⊙ Overcome by emotions

RECOGNIZE THE HAZARDS

- ⊙ Mechanical
- ⊙ Carbon monoxide
- ⊙ Carbon dioxide
- ⊙ Rotting vegetation
- ⊙ Rust inside of a tank
- ⊙ Sources outside the space
- ⊙ Thermal - steam

THE PERMIT

- ⊙ Space
- ⊙ Purpose
- ⊙ Date and duration
- ⊙ Names of entrants
- ⊙ Names of attendants
- ⊙ Name and signature of entry supervisor
- ⊙ Hazards of the space
- ⊙ Measures to isolate the space
- ⊙ Acceptable entry conditions
- ⊙ Monitoring results with time and initials
- ⊙ Means for summoning rescue and emergency services
- ⊙ Communication procedures
- ⊙ Equipment for entry
- ⊙ Additional permits

RESCUE

- ⊙ Each member shall practice simulated rescue operations every 12 months from representative spaces.
- ⊙ Must be trained in CPR and first aid.
- ⊙ Entrants shall use a full body harness to facilitate rescue.
- ⊙ Evaluation of rescue service.

RESCUE FROM CONFINED SPACES

- ① The preferred time for successful rescue is 4 minutes.
- ① Brain damage or death will result if the victim is without oxygen for longer than 4 minutes.

EVALUATE RESCUER'S ABILITY TO RESPOND IN A TIMELY MANNER

- ⊙ Evaluate rescue service's
 - ⊙ Ability
 - ⊙ Proficiency with rescue-related tasks and equipment
 - ⊙ Function from the particular permit space types of spaces



AMA GUIDELINES

Will the changes in HB 1698 Section 8.1(b), allowing the use of physician impairment rating, be utilized by the IWCC?

Dr. David J. Fletcher
MD, MPH, FACOEM
SafeWorks Illinois

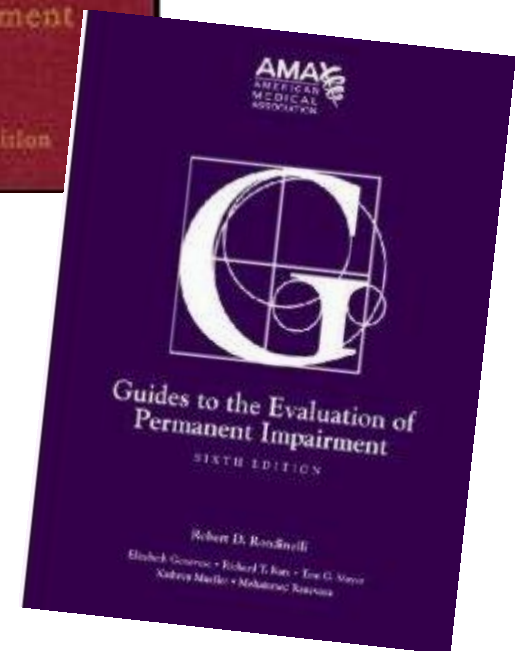
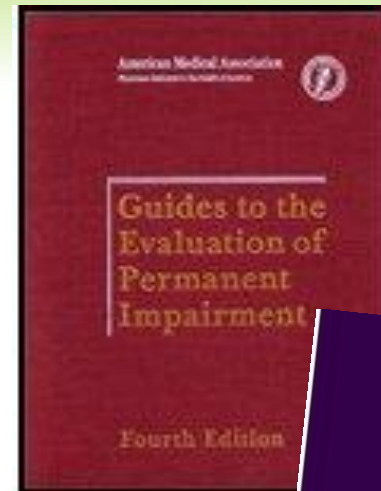
HISTORY OF GUIDES

1956: 1st articles in JAMA regarding physician impairment rating

1993: 4th edition

2000: 5th edition

2008: 6th edition



IMPORTANT TO NOTE:

The concept of the AMA Guidelines, added to the IL WC statute for the first time, is only one factor in assessing disability.

FAQs

- ③ What skill set is necessary to determine and validate a PPI Rating?
- ③ How is credibility established regarding the determination of a PPI Rating and application of the AMA Guidelines?
- ③ At what point are the AMA Guidelines applicable to be utilized? Validated?

RATIONALE FOR TRAINING FOR AMA GUIDES

- ⊙ Until 2011, the State of Illinois WC System did not consider physician rating of *permanent partial impairment* (PPI) until the passage of HB 1698 on May 31, 2011.
- ⊙ Previously, it was the exclusive purview of arbitrators to determine a *permanent partial disability* (PPD) award for an injured worker.

RATIONALE FOR TRAINING FOR AMA GUIDES, CONTINUED

- ◎ HB 1698 Section 8.1 (b) delineates the determination of PPD.

For all accidents occurring on or after September 1, 2011, permanent partial disability shall be established by a licensed physician reporting on the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that shall include, but not be limited to, lost range of motion, loss of strength, any atrophy or tissue mass reduction or any other measurement that may establish the nature and extent of impairment. The most current edition of the American Medical Association's Guide to the Evaluation of Permanent Impairment shall be used.

RATIONALE FOR TRAINING FOR AMA GUIDES, CONTINUED

- ⊙ HB 1698 did not state that the percentage impairment rating would be the disability rating that the arbitrators would use.

HB 1698 Section 8.1 (b) did state that:

In determining PPD value, the Commission shall base its determination on the following factors: 1) the reported level of impairment pursuant to the above Section, 2) the occupation of the employee, 3) the age of the employee at the time of injury, 4) the employee's future earning capacity, 5) evidence of disability corroborated by the treating medical records. Of note: no single enumerating factor shall be the sole determining factor for disability.

IMPACT OF HB 1698 8.1(B)

- ⊙ For now, this provision will not be a significant change to the Illinois WC law.
- ⊙ Treating doctors and IME evaluators can start using the most current AMA Guidelines, but the Illinois Workers' Compensation Commission (IWCC) may accept or reject with the PPI ratings as they will.

KEY CONCEPTS

- ③ AMA Guidelines 6th edition defines a new international standard for impairment assessment and applies a well-designed methodology to each chapter.
- ③ The goal is to provide an impairment rating guide that is authoritative, fair and equitable to all parties.
- ③ Editorial process used an evidence-based foundation when possible and a modified Delphi panel approach to consensus building.
- ③ Impairment Ratings are performed only after the status of “Maximum Medical Improvement” (MMI) is determined

IMPAIRMENT VS. DISABILITY

- ⊙ AMA Guides rate *impairment*, not disability; objective
- ⊙ Disability relates to legal ramifications of impairment to compensate for impairment, decided by an adjudicator of the legal system at hand.
- ⊙ Even with clear-cut impairment, it cannot be fully measured for disability without taking into account the following: whole person, age, past earning ability, education and location of their home.
- ⊙ One individual can be impaired significantly and have no disability, while another person can be quite disabled with only limited impairment.

IMPAIRMENT

- ⊙ Defined as: an alteration of an individual's health status; a deviation from normal in a body part or organ system and its functioning.
- ⊙ As defined by the World Health Organization (WHO): any loss or abnormality of psychological, physiological or anatomical structure or function.
- ⊙ The Social Security Administration (SSA) states, that a physical or mental impairment "must be established by medical evidence consisting of signs, symptoms and laboratory findings, not only by the individual's statement of symptoms.

DISABILITY

- ⊙ Defined as: an alteration of an individual's capacity to meet personal, social or occupational demands because of an impairment.
- ⊙ As defined by the WHO: an activity limitation that creates a difficulty in the performance, accomplishment or completion of an activity in the manner or within the range considered normal for a human-being.
- ⊙ The SSA defines disability as, the inability to engage in any substantial, gainful activity by reason of any medically determinable physical or mental impairment(s), expected to be continuous for no less than 12 months or result in death.



KEY PRINCIPLES FOR DISABILITY DETERMINATION

- ⊙ Impairment assessment, necessary first step
- ⊙ Disability Determination required information:
 - I. Age
 - II. Individual's Education
 - III. Skills
 - IV. Job History
- ⊙ Environmental requirements:
 - I. Adaptability
 - II. Modifications

FUNDAMENTAL PRINCIPLES OF THE GUIDES

- ① Guides are based on objective criteria. Physician must use all clinical knowledge, skill and abilities in determining whether the provided information is consistent and concordant with the pathology being evaluated

PPI DETERMINATION

- ◎ Involves four basic points of consideration:
 1. What is the problem (diagnosis):
Diagnosed-Based Impairment Rating (DBI)
 2. What symptoms and resulting functional difficulty does the patient report?
 3. What are the physical findings pertaining to the problem?
 4. What are the results of clinical studies?

WHO IS AUTHORIZED?

- ⊙ Who is authorized to determine a PPI rating?
 - ⊙ Physicians, Chiropractors, etc.
 - ⊙ There is no certification required.

CHANGES WITHIN THE 6TH EDITION

- ◎ The new methodology applies terminology and adopts an analytical frameworks based on the **World Health Organization's International Classification of Functioning (ICF), Disability and Health.**
- ◎ Five impairment classes permit the rating of the patient from no impairment to most severe.
- ◎ Diagnosed-based grids developed for each organ system.
 - ◎ Grids arrange diagnosis into five classes of impairment severity.
- ◎ Functionality based history, physical findings and accepted clinical test results, where applicable, are integrated and then provides a impairment value rating that is transparent, clearly stated and reproducible.

TABLE 17-4 Lumbar Spine Regional Grid: Spine Impairments

Lumbar Spine Regional Grid					
CLASS	CLASS 0	CLASS 1	CLASS 2	CLASS 3	CLASS 4
IMPAIRMENT RATING (WPI %)	0	1%–9%	10%–14%	15%–24%	25%–33%
SOFT TISSUE AND NON-SPECIFIC CONDITIONS					
Non-specific chronic, or chronic recurrent low back pain (also known as: chronic sprain/strain, symptomatic degenerative disc disease, facet joint pain, SI joint dysfunction, etc)	0 Documented history of sprain/strain-type injury, now resolved, or occasional complaints of back pain with no objective findings on examination	1 2 3 3 Documented history of sprain/strain type injury with continued complaints of axial and/or non-verifiable radicular complaints and similar findings on multiple occasions (see Sec. 17.2, General Considerations)			
MOTION SEGMENT LESIONS					
Intervertebral disk herniation and/or AOMSI ^a <i>Note:</i> AOMSI includes instability (specifically as defined in the <i>Guides</i>), arthrodesis, failed arthrodesis, dynamic stabilization or arthroplasty, or combinations of those in multiple-level conditions	0 Imaging findings of intervertebral disk herniation without a history of clinically correlating radicular symptoms	5 6 7 8 9 Intervertebral disk herniation(s) or documented AOMSI, at a single level or multiple levels with medically documented findings; with or without surgery <i>and</i> for disk herniation(s) with documented resolved radiculopathy or nonverifiable radicular complaints at clinically appropriate level(s), present at the time of examination ^a	10 11 12 13 14 Intervertebral disk herniation or AOMSI at a single level with medically documented findings; with or without surgery <i>and</i> with documented residual radiculopathy at the clinically appropriate level present at the time of examination (see <i>Physical Examination adjustment grid in Table 17-7 to grade radiculopathy</i>)	15 17 19 21 23 Intervertebral disk herniations or AOMSI at multiple levels, with medically documented findings; with or without surgery <i>and</i> with documented residual radiculopathy at a single clinically appropriate level present at the time of examination (see <i>Table 17-7 to grade radiculopathy</i>)	25 27 29 31 33 Intervertebral disk herniations and/or AOMSI, at multiple levels, with medically documented findings; with or without surgery <i>and</i> with documented signs of residual bilateral or multiple-level radiculopathy at the clinically appropriate levels present at the time of examination (see <i>Table 17-7 to grade radiculopathy</i>)
Pseudarthrosis <i>Note: Only applies after spinal surgery intended for fusion</i> with resultant documented motion (not necessarily AOMSI by definition provided in footnote) with consistent radiographic findings or hardware failure; with or without surgery to repair	0	5 6 7 8 9 Pseudarthrosis (post surgery) at a single level or multiple levels with medically documented findings <i>and</i> with documented resolved radiculopathy or non-verifiable radicular complaints at the clinically appropriate level(s) present at the time of examination	10 11 12 13 14 Pseudarthrosis (post surgery) at a single level with medically documented findings may have documented signs of radiculopathy at the clinically appropriate level present at the time of examination (see <i>Table 17-7 to grade radiculopathy</i>)	15 17 19 21 23 Pseudarthrosis (post surgery) at a multiple levels with medically documented findings may have documented radiculopathy at a single clinically appropriate level present at the time of examination (see <i>Table 17-7 to grade radiculopathy</i>)	25 27 29 31 33 Pseudarthrosis (post surgery) at a multiple levels with medically documented findings may have documented signs of bilateral or multiple level radiculopathy at the clinically appropriate levels present at the time of examination (see <i>Table 17-7 to grade radiculopathy</i>)
^a Or AOMSI in the absence of radiculopathy, or with documented resolved radiculopathy or nonverifiable radicular complaints at the clinically appropriate levels present at the time of examination.					

CHANGES WITHIN THE 6TH EDITION, CONTINUED

- ◎ Features of the new edition include:
 - I. A standardized approach across organ systems and chapters
 - II. The most contemporary, evidence-based concepts and terminology of disablement from the ICF.
 - III. The latest scientific research and evolving medical opinions provided by nationally and internationally recognized experts.

CHANGES WITHIN THE 6TH EDITION, CONTINUED

- IV. Methodology helps physicians calculate impairment ratings through a grid construct, consistent scoring.
- V. A more comprehensive and expanded diagnostic approach;
- VI. Precise documentation of functional outcomes, physical findings and clinical test results;
- VII. Improved physician inter-rater reliability.

FIGURE 17-7

Spine and Pelvis Impairment Evaluation Record Example (Based on Example 17-2)

Name: <i>John Smith</i>	Exam Date: 11/04/07
ID Number: 356-92-XXXX	Sex: F (M) Side: (R) L
Diagnosis:	Birth Date: 12/07/1971
	Injury Date:

Grid	Diagnosis / Criteria	Class Diagnosis (CDX)	Grade Modifier Adjustments	Net Adjustment Value and Assigned Grade Modifier	Whole Person Impairment																															
Cervical (C)	<i>Cervical disk herniation with resolved right-sided C6 radiculopathy</i>	0 1 2 3 4	<table border="1"> <tr><td>GMFH</td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>n/a</td></tr> <tr><td>GMPE</td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>n/a</td></tr> <tr><td>GMCS</td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>n/a</td></tr> </table> <p>Net Adjustment = (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX)</p>	GMFH	0	1	2	3	4	n/a	GMPE	0	1	2	3	4	n/a	GMCS	0	1	2	3	4	n/a	<p>Adjusted Grade = Net Adjustment applied to Default Value C</p> <table border="1"> <tr><td>≤-2</td><td>-1</td><td>0</td><td>+1</td><td>≥2</td></tr> <tr><td>A</td><td>B</td><td>C</td><td>D</td><td>E</td></tr> </table>	≤-2	-1	0	+1	≥2	A	B	C	D	E	6%
GMFH	0	1	2	3	4	n/a																														
GMPE	0	1	2	3	4	n/a																														
GMCS	0	1	2	3	4	n/a																														
≤-2	-1	0	+1	≥2																																
A	B	C	D	E																																
Thoracic (T)		0 1 2 3 4	<table border="1"> <tr><td>GMFH</td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>n/a</td></tr> <tr><td>GMPE</td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>n/a</td></tr> <tr><td>GMCS</td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>n/a</td></tr> </table>	GMFH	0	1	2	3	4	n/a	GMPE	0	1	2	3	4	n/a	GMCS	0	1	2	3	4	n/a	<p>Adjusted Grade</p> <table border="1"> <tr><td>≤-2</td><td>-1</td><td>0</td><td>+1</td><td>≥2</td></tr> <tr><td>A</td><td>B</td><td>C</td><td>D</td><td>E</td></tr> </table>	≤-2	-1	0	+1	≥2	A	B	C	D	E	
GMFH	0	1	2	3	4	n/a																														
GMPE	0	1	2	3	4	n/a																														
GMCS	0	1	2	3	4	n/a																														
≤-2	-1	0	+1	≥2																																
A	B	C	D	E																																
Lumbar (L)		0 1 2 3 4	<table border="1"> <tr><td>GMFH</td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>n/a</td></tr> <tr><td>GMPE</td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>n/a</td></tr> <tr><td>GMCS</td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>n/a</td></tr> </table>	GMFH	0	1	2	3	4	n/a	GMPE	0	1	2	3	4	n/a	GMCS	0	1	2	3	4	n/a	<p>Adjusted Grade</p> <table border="1"> <tr><td>≤-2</td><td>-1</td><td>0</td><td>+1</td><td>≥2</td></tr> <tr><td>A</td><td>B</td><td>C</td><td>D</td><td>E</td></tr> </table>	≤-2	-1	0	+1	≥2	A	B	C	D	E	
GMFH	0	1	2	3	4	n/a																														
GMPE	0	1	2	3	4	n/a																														
GMCS	0	1	2	3	4	n/a																														
≤-2	-1	0	+1	≥2																																
A	B	C	D	E																																
Pelvis (P)		0 1 2 3 4	<table border="1"> <tr><td>GMFH</td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>n/a</td></tr> <tr><td>GMPE</td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>n/a</td></tr> <tr><td>GMCS</td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>n/a</td></tr> </table>	GMFH	0	1	2	3	4	n/a	GMPE	0	1	2	3	4	n/a	GMCS	0	1	2	3	4	n/a	<p>Adjusted Grade</p> <table border="1"> <tr><td>≤-2</td><td>-1</td><td>0</td><td>+1</td><td>≥2</td></tr> <tr><td>A</td><td>B</td><td>C</td><td>D</td><td>E</td></tr> </table>	≤-2	-1	0	+1	≥2	A	B	C	D	E	
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GMPE	0	1	2	3	4	n/a																														
GMCS	0	1	2	3	4	n/a																														
≤-2	-1	0	+1	≥2																																
A	B	C	D	E																																

Signed: *Dr. Know*

Date: 11/04/07

Whole Person Impairment: 6%



FIVE AXIOMS OF 6TH EDITION

1. Adopt methodology of WHO's International Classification of Functioning, Disability and Health (ICF).
2. More diagnosed-based, diagnoses are evidence based;
3. Priority for simplicity and ease;
4. AMA Guides must stress conceptual and methodological congruity within and between organ system ratings
5. Provide rating percentages that consider clinical history and examination studies, which are consensus based.

HOW WIDELY ACCEPTED ARE THE GUIDES?

- ◎ Not only IL recognized, but recognized nationally. The Guides, in 90% of states and territories, are either recommended or mandated for use by Workers' Comp law.
- ◎ Use of the Guides:
 - ◎ USA Federal System:
 1. Federal Employees Compensation Act
 2. Longshore and Harbor Workers' Compensation Act
 3. Federal Employees compensation laws



FUNCTIONAL ASSESSMENT TOOLS:

- ◎ Two key tools to help determine level of function that is important in the modifiers:
 1. DASH (Upper Extremity Function)
 2. The Pain Disability Questionnaire (PDQ):
 - i. The PDQ is a psychometric evaluation study of a new measure of functional status.

HOW TO PERFORM A PPI RATING

- ⊙ Impairment class is determined by a “key factor” diagnosis/specific criteria that is adjusted by grade modifiers
- ⊙ “Non-Key Factors” include:
 - Functional History (FH)
 - Physical Findings (PF)
 - Relevant Clinical Studies (CS)



SAMPLE CASE STUDY #1

Intervertebral Disk Herniation at a Single Level

Subject: 44 year-old man.

History: The patient sustained a blow to the posterior aspect of his neck from a machine support that slipped. Studies revealed a C7-T1 disk herniation. He was managed conservatively, and in spite of persistent symptoms, refused surgery. He was evaluated for impairment one year after his injury.

SAMPLE CASE STUDY #1, CONTINUED

Intervertebral Disk Herniation at a Single Level

Current Symptoms: The patient reports neck pain with radiation to the ulnar aspect of the hand and numbness of the ring and little fingers. He is unable to use his dominant left hand for ADLs without considerable pain in the neck, left upper back, and ulnar side of the left upper limb, with minimal activity.

Functional Assessment: The PDQ score is 120, consistent with severe disability

SAMPLE CASE STUDY #1, CONTINUED

Intervertebral Disk Herniation at a Single Level

Physical Exam: Decreased range of motion in the neck, positive cervical compression with severe radiating pain to the left arm in a C8 distribution. He has decreased finger flexion strength (3/5), and decreased sensation in ring and little fingers.

Clinical Tests: MRI: left posterolateral disk herniation C7-T1.
EMG: left C8 fibrillation potentials

Diagnosis: Cervical disk herniation with C8 radiculopathy

SAMPLE CASE STUDY #1, CONTINUED

Intervertebral Disk Herniation at a Single Level

Impairment Rating: Regional Impairment: Diagnosis is consistent with “intervertebral disk herniation and/or AOMSI at a single level with medically documented findings; with or without surgery and with documented radiculopathy at the clinically appropriate level present at the time of examination” and therefore, assigned to class 2. Adjustment grids: Functional History: Grade modifier 3 based on symptoms with minimal activity and PDQ score. Physical Examination: Grade modifier 2 based on sensory and motor findings. Clinical Studies: Grade modifier 2. Net adjustment is +1, resulting in class 2, grade D. Impairment is 12% WPI.



SAMPLE CASE STUDY #2

Carpal Tunnel Syndrome

Subject: 55 year-old woman.

History: Insidious onset of right-side symptoms consistent with carpal tunnel syndrome. Diagnosis confirmed electrodiagnostically and underwent carpal tunnel release two years ago. Symptoms stable for over a year. Determined administratively to be work-related.

Current Symptoms: complaints of significant intermittent problems with numbness and discomfort; however, able to perform all activities of daily living, despite symptoms.

SAMPLE CASE STUDY #2, CONTINUED

Carpal Tunnel Syndrome

Functional Assessment: *QuickDASH* score is 14.

Physical Exam: Normal, including sensory examination (2 point and monofilament testing), focal muscle testing and range of motion. Well-healed scar.

Clinical Studies: Electrodiagnostic studies pre-operatively revealed mild sensory and motor conduction delays of the right median nerve.

Diagnosis: Carpal tunnel syndrome, s/p carpal tunnel release

SAMPLE CASE STUDY #2, CONTINUED

Carpal Tunnel Syndrome

Impairment Rating: The diagnosis of carpal tunnel syndrome was confirmed electrodiagnostically and the patient is at maximal medical improvement. Rating is based on Table 15-23, Entrapment/Compression Neuropathy. Testing findings are grade modifier 1 (conduction delay), history is grade modifier 2 (significant intermittent symptoms), and physical findings are grade modifier 1 (normal). The grade modifiers total 4 (1+2+1) and average 1.33. Therefore, grade modifier 1 is selected with a default of 2% UEI; however, the *QuickDASH* is 14 in the normal range, therefore the lowest UEI for that grade modifier is selected, i.e. 1% UEI which is equivalent to 1% hand impairment or 1% WPI.



UTILIZATION REVIEW AND PRACTICE TREATMENT GUIDELINES

Dr. Richard Kube
MD
Prairie Spine & Pain Institute

UTILIZATION REVIEW

- ⊙ New responsibilities Doctor's now have;
- ⊙ Usage of guidelines, merits and shortcomings;
- ⊙ The costs that Utilization Review (UR) brings to the system.



Q & A: *SOLUTIONS AND CLOSING REMARKS*

Dr. David J. Fletcher
MD, MPH, FACOEM
SafeWorks Illinois