STATE OF ILLINOIS

OFFICE OF THE AUDITOR GENERAL

MANAGEMENT AUDIT OF THE

WORKERS' COMPENSATION PROGRAM

AS IT APPLIES TO STATE EMPLOYEES

APRIL 2012

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WILLIAM G. HOLLAND

To the Legislative Audit Commission, the Speaker and Minority Leader of the House of Representatives, the President and Minority Leader of the Senate, the members of the General Assembly, and the Governor:

This is our report of the Management Audit of the Workers' Compensation Program as it applies to State employees.

The audit was conducted pursuant to House Resolution Number 131, which was adopted March 10, 2011. This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

The audit report is transmitted in conformance with Section 3-14 of the Illinois State Auditing Act.

WILLIAM G. HOLLAND
Auditor General

Springfield, Illinois
April 2012

STATE OF ILLINOIS
OFFICE OF THE
AUDITOR GENERAL
William G. Holland, Auditor General

SUMMARY REPORT DIGEST

WORKERS' COMPENSATION PROGRAM AS IT APPLIES TO STATE EMPLOYEES

MANAGEMENT AUDIT
Release Date: April 2012

SYNOPSIS

The Workers' Compensation Program as it applies to State employees involves three State agencies: the Department of Central Management Services (CMS), the Illinois Workers' Compensation Commission, and the Illinois Attorney General. According to data received from CMS, for the four-year period January 1, 2007, through December 31, 2010, State employees **filed a total of 26,101 workers' compensation claims**. As of July 2011, over **$295 million was paid** in workers' compensation for State employees on claims filed during the four-year period.

Our review of the workers' compensation program found that **CMS**:

- Data was incomplete, inaccurate, and inconsistent.
- Adjusted claims and made decisions regarding compensability without appropriate forms being submitted.
- Did not have caseload standards and could not always provide Adjuster caseloads.
- Needed to establish clearer policies regarding settlement contracts and approval limits.
- Negotiated settlement contract terms directly with the injured employee's legal counsel.
- Did not have formal policies for conflicts of interest for Adjusters or other employees who process workers' compensation claims.

Our review of the workers' compensation program found that the **Workers' Compensation Commission**:

- Data was incomplete, inaccurate, and inconsistent.
- Did not conduct annual reviews to evaluate Arbitrator performance.
- Did not have guidelines for Arbitrators regarding awards. We reviewed awards and found that many were inconsistent for the same type of injury to the same body part.
- Review Board responsible for conducting investigations of complaints against Arbitrators and Commissioners did not meet for 3 ½ years (February 11, 2008-September 9, 2011).
- Did not have a formal policy or specific procedures to identify fraud.

Our review of the workers' compensation program found that the **Attorney General**:

- Did not have specific policies or procedures to identify or control fraud for workers' compensation cases referred to them.

Throughout this audit we identified numerous shortcomings in both the structure and operations of the workers' compensation program as it applies to State employees. These problems have led to a program that is ill designed to protect the State's best interests as it relates to processing and adjudicating workers' compensation claims for State employees. Because of the extensive problems that permeate the workers' compensation program as it applies to State employees, **the General Assembly may wish to consider further changes to the structure and operations of the Workers' Compensation Program as it applies to State employees**.

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FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

BACKGROUND

Workers' compensation is a system of benefits provided by law to most workers who have job-related injuries or diseases. Employers, including the State of Illinois, provide workers' compensation benefits either by purchasing insurance policies or by paying for the benefits themselves (known as self-insurance). The State of Illinois covers its employees through self-insurance.

Three State agencies have responsibilities for processing, reviewing, determining compensation, and paying workers' compensation claims filed by State workers.

- **The Department of Central Management Services (CMS)** is statutorily responsible for administering the workers' compensation program for State of Illinois agencies, boards, commissions, and universities (20 ILCS 405/405-411).
- **The Illinois Workers' Compensation Commission (Commission)** acts as an administrative court system to resolve disputes between injured workers and their employers regarding workers' compensation claims. Although for private sector employers/employees the decisions of the Workers' Compensation Commission may be appealed through the courts, decisions are final for cases involving employees of the State of Illinois. Therefore, **for claims involving State employees the Workers' Compensation Commission is the court of last resort for settling disputes.**
- As the attorney for the State, **the Attorney General (AG)** represents the State of Illinois at proceedings in front of the Workers' Compensation Commission for claims filed by State employees. The AG also prepares, reviews, and approves settlement contracts for injured State employees. (pages 13-20)

CMS and the Illinois Workers' Compensation Commission need to address several data issues regarding workers' compensation claims and cases.

DATA ISSUES

CMS and the Illinois Workers' Compensation Commission need to address several data issues regarding workers' compensation claims and cases. At our request, both CMS and the Commission provided data regarding claims and cases filed for the four-year period 2007-2010. However, after reviewing the data and testing case files, we determined that several limitations existed in the data provided. Both agencies' workers' compensation information systems contained data that was incomplete, inaccurate, and inconsistent. (pages 20-21)

ANALYSIS OF CLAIMS FILED 2007-2010

For the period January 1, 2007 through December 31, 2010, State employees filed a total of 26,101 workers' compensation claims.

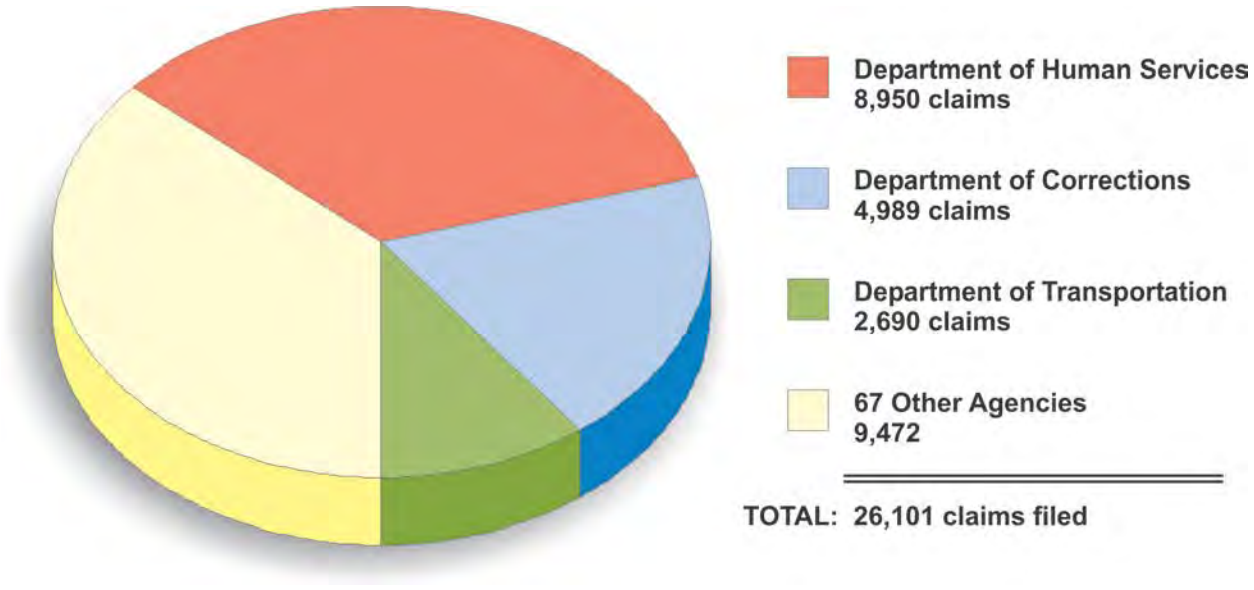
According to data received from CMS, for the period January 1, 2007, through December 31, 2010, **State employees filed a total of 26,101 workers' compensation claims**. Two types of injuries accounted for three-quarters of all injuries (sprains and contusions). For 13,412 (51%) claims, the primary injury involved a sprain. Contusions accounted for another 6,235 (24%) claims.

Number of Claims Filed by Agency

DHS and Corrections comprised over half of all claims.

Three agencies accounted for 16,629 (64%) of the total claims filed during 2007-2010 (DHS, Corrections, and IDOT). Together, **DHS and Corrections comprised over half of all claims (53%)** filed, at 8,950 and 4,989 claims filed, respectively (See Digest Exhibit 1). Certain facilities and employing units drive the large number of claims that were filed by these two agencies. At DHS, for instance, employees at Chester Mental Health Center filed 1,180 claims during the four-year period, giving that facility the highest number of claims for any facility or employing unit in State government during that timeframe. Overall, six of the top 10 employing units for workers' compensation claims filed during 2007-2010 were DHS mental health or developmental centers.

Digest Exhibit 1
WORKERS' COMPENSATION CLAIMS FILED BY AGENCY
January 1, 2007 through December 31, 2010



Source: OAG analysis of CMS workers' compensation claims data for claims filed 2007-2010.

Of Corrections' facilities, Menard Correctional Center had the most claims with 869 claims filed during the four-year period. Stateville Correctional Center ranked second of Corrections'

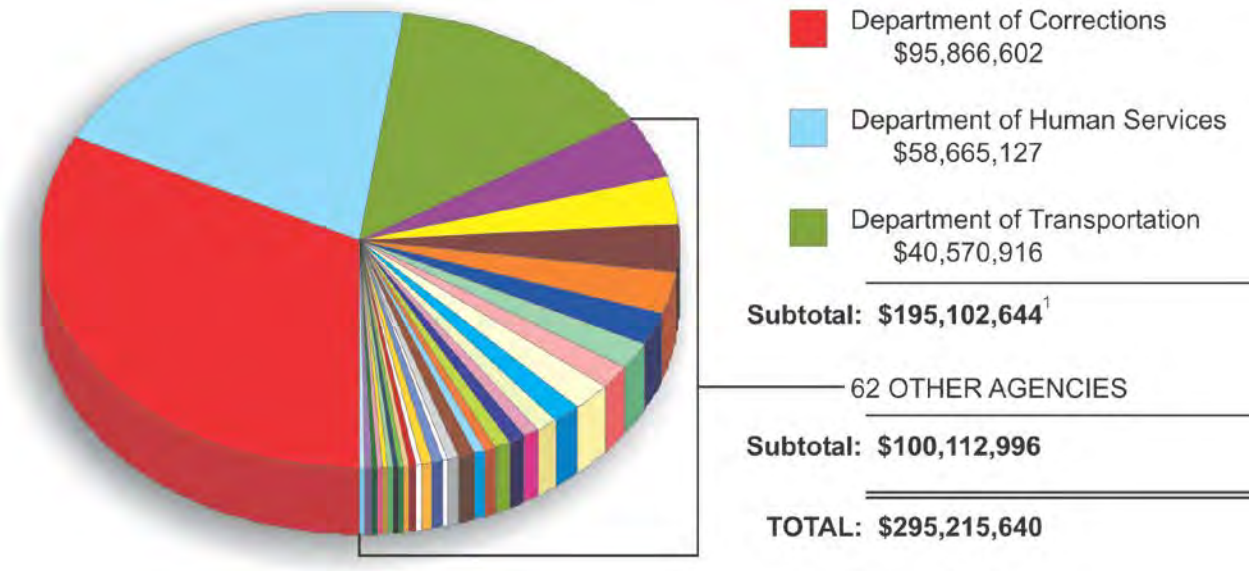
facilities with 668 claims filed during the same period.

Dollar Value of Claims Filed by Agency

Over $295 million was paid in workers' compensation for State employees on claims filed during the four-year period 2007-2010, according to CMS data.

Over $295 million was paid in workers' compensation for State employees on claims filed during the four-year period 2007-2010, according to CMS data. The largest single category of the State's payments - $103.1 million or 35 percent of all State payments - were made directly to medical providers for medical treatment of injured workers or to reimburse employees for medical costs. Settlements paid to State employees or their attorneys accounted for about one third (32%) of the State's payments for workers' compensation, or $95.6 million. Approximately 25 percent or $74.7 million was for Temporary Total Disability amounts paid to employees to provide income while they were off work. Awards from decisions made by Arbitrators at the Illinois Workers' Compensation Commission accounted for about six percent of the payments at $17.7 million.

Digest Exhibit 2
WORKERS' COMPENSATION PAYMENTS BY AGENCY
For Claims Filed 2007-2010
As Of July 2011



Note: [1]Total does not add due to rounding.

Source: OAG analysis of CMS workers' compensation claims payment data for claims filed 2007-2010.

Almost $96 million or about one third of the $295 million in workers' compensation claims paid during the four-year period was for Corrections' employees.

Although overall DHS employees filed more claims during the audit period, claims filed by Corrections' employees accounted for the highest dollar value of State payments. Almost **$96 million or about one third of the $295 million in workers' compensation claims paid during the four-year period was for Corrections' employees**. As of July 2011, Menard Correctional Center workers' compensation claims filed for the past four years have resulted in over $30 million in payments. DHS claims accounted for $58.7 million of the

The average cost per claim for DHS employees as of July 2011 was $6,555. By comparison, the average cost per claim for Corrections employees as of July 2011 was $19,216.

$295 million in State payments for workers' compensation claims filed during 2007-2010. Even though employees at DHS facilities filed nearly twice as many workers' compensation claims as employees at the Department of Corrections, the total payments related to those claims were only about half as much. The average cost per claim for DHS employees as of July 2011 was $6,555. By comparison, the average cost per claim for Corrections employees as of July 2011 was $19,216. (pages 24-39)

CLAIMS REPORTING

We identified several problems regarding notification and injury reporting. Documenting supervisory notification of an injury by the employee is critical when filing a claim because by law the employee must notify the employer within 45 days of the accident or injury. Although there is a form for supervisors to complete, supervisor notification can also be verbal and is not always documented. The CMS 900-3 (Supervisor's Report of Injury or Illness) contains information regarding how (oral or in writing) and when (date and time) the supervisor was informed by the employee of the accident or injury. However, this form was missing or incomplete in 19 percent of the cases we reviewed.

We identified 1,318 claims (5%) that took longer than the 45 day requirement from the date of injury to the date reported in CMS' system. Of the 109 claim files we reviewed that involved settlements and awards, 26 (24%) took more than 45 days from the date of the injury to the date the injury was reported according to CMS data. Only 4 of these 26 claims were initially denied for compensability according to CMS responses.

For repetitive trauma cases such as Carpal Tunnel Syndrome, determining an accident date is problematic because these claims are filed only after the injury is diagnosed or manifests itself.

For repetitive trauma cases such as **Carpal Tunnel Syndrome**, determining an accident date is problematic because these claims are filed only after the injury is diagnosed or manifests itself. In our file testing, we found examples of Carpal Tunnel Syndrome claims in which the date of the accident was listed as years prior to the date reported. We also found instances in which the employee was no longer employed with the State when the claim was filed or was on leave for an unrelated workers' compensation claim when they filed another workers' compensation claim for repetitive trauma. (pages 47-50)

CLAIMS ADJUDICATION AT CMS

CMS was adjusting claims and making decisions regarding compensability without appropriate forms being submitted.

CMS needs to improve its process for adjusting claims for State employee workers' compensation. We reviewed 109 claims files at CMS (68 settlements and 41 awards) and found a significant amount of missing or incomplete forms. We also found:

- CMS was adjusting claims and making decisions regarding compensability without appropriate forms being submitted, and forms that were submitted were not always

complete.

- Determinations of compensability by adjusters were not reviewed by supervisors.
- Cases where no formal request for TTD was made by employees, but employees were receiving TTD benefits.
- CMS adjusters did not verify Average Weekly Wage information submitted by agency workers' compensation coordinators and did not have access to payroll information.
- Medical bills were not always properly approved or dated.

Adjustor Caseloads

CMS does not have caseload standards and could not always provide Adjuster caseloads.

We found that CMS did not have caseload standards and could not always provide Adjuster caseloads. As of May 2011, there were eight CMS staff to adjust workers' compensation claims and two claims supervisors. From our review of disposition codes in CMS' data, we identified 12,613 claims that were open as of July 2011. If these claims were distributed equally among adjusters, each Adjuster would be responsible for 1,577 claims. If the two claims supervisors also assumed a caseload, the caseload would be 1,261 cases each. According to workers' compensation industry sources the typical adjuster caseload is 175 to 250 active claims per adjuster. It should be noted, however, that a number of the 12,613 claims open as of July 2011 may be inactive and merely being held open by CMS until the expiration of the statute of limitations period. CMS was unable to estimate the number of inactive cases in its system for the auditors. (pages 50-61)

WORKERS' COMPENSATION COMMISSION

Establishing a case with the Workers' Compensation Commission is a separate process from filing a claim with CMS. Simply because an employee is injured on the job does not mean there will be a case filed with the Commission related to the injury claim.

We found that improvements need to be made in the process for establishing a case with the Commission.

We found that improvements need to be made in the process for establishing a case with the Commission. We reviewed case files and found Applications for Adjustment of Claim were not always being filed with the Commission. An Application for Adjustment is a key document for the Commission because it is used to establish a case file, assign a case number, and establish the city in which the accident occurred so that a call site and Arbitrator can be assigned. Of the 109 settlements and awards sampled, 13 (12%) did not contain an Application for Adjustment in the file at the Commission. There were also three case files in our sample that could not be located.

Cases More Than Three Years Old

Commission rules provide that cases that were filed three years ago or more must proceed to arbitration unless the parties show they have good cause to wait. These are known as "red-line" cases. Because of data accuracy issues, the

status call and red-line reports were not accurate. The Commission has even posted a request on its website for assistance from parties in removing settled cases from the call lists. According to Commission data (received in August 2011), as of June 1, 2011, 2,515 cases were more than three years old according to the date of the Application for Adjustment but had not been closed out. However, because of the inconsistency of employer name in the Commission's system, it was not possible to determine how many of these were cases filed by State employees. Of the 109 cases we sampled that received a settlement or award, 15 (14%) were more than three years old and may have warranted dismissal. These cases were 36 to 164 days past the three year mark.

Data that we received from the Workers' Compensation Commission has severe limitations because the data has missing, inaccurate, and/or inconsistent information.

Data Issues

Data that we received from the Workers' Compensation Commission has severe limitations because the data has missing, inaccurate, and/or inconsistent information. Although we were able to analyze the overall caseloads for Arbitrators, we were unable to determine with any accuracy the number of cases involving a State employee assigned to each Arbitrator by employing unit (i.e. State agency) or by type of injury.

Lack of Performance Reviews

The Workers' Compensation Act requires annual performance reviews for Arbitrators. However, in our review of the personnel files for 31 Arbitrators assigned to call sites as of April 2011, we found that there were **no annual reviews being conducted to evaluate Arbitrator performance**. The personnel files did not contain any other information to indicate that reviews of Arbitrators' performance had been conducted. (pages 63-78)

There were no annual reviews being conducted to evaluate Arbitrator performance.

SETTLEMENTS AND AWARDS PROCESS

There are significant differences between resolving a workers' compensation claim by reaching a settlement or by receiving an award through a trial with a Commission Arbitrator. A **settlement** is a contract negotiated between an injured employee and the employer in order to resolve any dispute regarding the benefits due to the injured employee under the Workers' Compensation Act or Occupational Diseases Act. If an employer and injured employee cannot reach an agreement or choose not to, either party may petition for a trial with an Arbitrator at the Commission and a trial will be held. If an Arbitrator's decision rules in favor of the injured employee, this is termed an **award**.

CMS provided auditors with a listing of all claims filed for the four-year period January 1, 2007, to December 31, 2010. Of the 26,101 workers' compensation claims filed during the four-year period, **3,621 (14%) received a settlement** as of July 2011. According to our analysis of CMS' data, these **3,621 settlements involved 3,299 individuals who received a**

total of $107,362,741. Of the 26,101 workers' compensation claims filed during the four-year period, **611 (2%) received an award** as of July 2011. According to our analysis of CMS' data, these **611 awards involved 567 individuals who received a total of $17,806,709**.

We reviewed the settlement process and found that:

CMS needs to establish clearer policies regarding settlement contracts and approval limits for Risk Management employees.

- CMS needs to establish clearer policies regarding settlement contracts and approval limits for Risk Management employees.

CMS Risk Management Supervisors were negotiating, and in some cases finalizing, settlement contract terms directly with the injured employee's legal counsel.

- CMS Risk Management Supervisors were negotiating, and in some cases finalizing, settlement contract terms directly with the injured employee's legal counsel.
- CMS' files did not always contain support for all injuries compensated as part of the settlement. Although most CMS files generally contained medical support for the injuries listed in the settlement contract, we identified settlement contracts that did not contain medical evidence.
- Settlement files at the Commission also did not always contain medical evidence. In these instances, the evidentiary basis for the Arbitrator's approval of the settlement contract is not apparent.

The Commission's Application for Adjustment does not contain a specific question regarding whether the employer is the State of Illinois.

- The Commission's Application for Adjustment does not contain a specific question regarding whether the employer is the State of Illinois. Although the Commission's information system contains a data field used to identify State employees, the field is not always accurate.

We reviewed the awards process and found that:

- All 41 award files we reviewed contained an award decision.
- For the award files reviewed that did not involve an expedited hearing, the time from the trial to the date the decision was filed ranged from 13 to 83 days. The decisions in five cases were filed more than 60 days after the trial. Our sample of 41 award decisions included nine 19(b) (expedited) cases. For the 19(b) cases, the decision was filed between 7 to 66 days after the trial date. Of these nine cases, 7 decisions were filed more than 25 days after the trial date. Three of these 7 decisions were filed more than 60 days after the trial date.

The Commission does not have guidelines for Arbitrators regarding awards.

- The Commission does not have guidelines for Arbitrators regarding awards. We reviewed awards and found that many are inconsistent for the same type of injury to the same body part. These inconsistencies involved the percent loss of use as well as the manner of determining loss. For instance, for Carpal Tunnel

Syndrome claims, the amount awarded for cases we reviewed ranged from as little as 5 percent loss of a hand to as much as permanent total disability for life. Repetitive motion injury awards varied with some Arbitrators awarding the same percentage loss amount for either hand while others awarded more for loss of the dominant hand. (pages 79-101)

POSSIBLE CONFLICTS OF INTEREST

Although the Illinois Workers' Compensation Commission has promulgated rules regarding conflicts of interest for Commissioners and Arbitrators, we identified several relationships that may have posed a conflict for the Arbitrator.

The Commission's Review Board did not meet for 3 ½ years (February 11, 2008-September 9, 2011).

The **Commission's Review Board** is responsible for conducting investigations of complaints against Arbitrators and Commissioners. The Board is required to meet quarterly and to call a meeting within 15 days of any complaints received. The Board did not meet for 3 ½ years (February 11, 2008-September 9, 2011). During this timeframe, we found several allegations regarding Arbitrators and Commissioners alleging fraud, unethical practices, and favoritism. In addition, on February 15, 2011, the Commission placed two Arbitrators on administrative leave while they were being investigated.

The Department of Central Management Services has no formal policies for conflicts of interest for Adjusters or other employees who process workers' compensation claims. CMS provided two e-mails from 2004 and 2006 as documentation of its conflict of interest policies. However, all Adjusters employed by CMS during the audit period were not included in the e-mail. (pages 103-115)

FRAUD IDENTIFICATION POLICIES

The Workers' Compensation Commission does not have a formal policy or specific procedures to identify fraud.

We found the Workers' Compensation Commission does not have a formal policy or specific procedures to identify fraud and does not conduct statistical reviews or analyses to identify fraud or trends that might warrant further review or investigation. According to a Commission official, the Workers' Compensation Commission monitors complaints and allegations, and all fraud allegations are referred to the Department of Insurance (DOI) Fraud Unit for follow-up. However, we found the Commission did not refer any cases to the DOI Fraud Unit during the four-year period subject to our audit.

CMS has policies that require Risk Management Division employees to act on any reports of workers' compensation disability benefit abuse and to assist law enforcement officials in efforts toward prosecuting abuses. Although CMS has established policy guidance for identifying possible fraud, as well as procedures for reporting cases for investigation, we found that CMS does not conduct statistical analyses to identify trends and patterns in claim reporting that might be

indicators of fraudulent activity. According to CMS officials, the agency's computer system's data integrity problems and a shortage of staff made it difficult to conduct statistical reviews of the data to analyze and identify fraudulent trends.

The Office of the Attorney General does not have specific policies or procedures to identify or control fraud for workers' compensation cases referred to them.

We found the Office of the Attorney General does not have specific policies or procedures to identify or control fraud for workers' compensation cases referred to them. Attorney General officials stated that they are limited in identifying trends or fraud through data analysis because they only have a small number of the total workers' compensation cases (i.e., those cases in which a settlement contract is negotiated and/or approved by the Attorney General's Office, or which are taken to the Commission and the Attorney General represents the State at trial). Therefore, any analysis that could be conducted would be limited. Attorney General officials also stated that their focus is on assembling a defense in order to set beneficial precedent and prevent fraudulent trends from occurring.

Department of Insurance Fraud Unit

Public Act 94-277, codified at 820 ILCS 305/25.5 and effective July 20, 2005, created a Workers' Compensation Fraud Unit within the Illinois Department of Insurance (formerly the Division of Insurance at DFPR). The Unit's sole purpose is to examine reports of workers' compensation fraud and noncompliance with insurance requirements by employers. On October 17, 2011, we inquired with the Department of Insurance (DOI) about the number of workers' compensation referrals, investigations, and convictions for State employee workers' compensation claims the DOI Fraud Unit had been involved in. DOI officials responded that "we cannot search our records by 'state employee' because none of the captured information in the system specified the target's place of employment in a searchable field. As such we will have to search our records manually in order to get the numbers." DOI responded to our inquiry more than four months later, on February 27, 2012, by saying that there had been a total of eight investigations of State employee workers' compensation claims resulting in no convictions during the four-year time period subject to our audit.

The DOI Fraud Unit has not procured or implemented the required system utilizing analytics such as predictive modeling, data mining, social network analysis, and scoring algorithms for the detection and prevention of fraud, waste, and abuse.

Public Act 097-018, effective June 28, 2011, imposed additional requirements on DOI for the purpose of identifying and detecting workers' compensation fraud. The Fraud Unit at the Department of Insurance is required to procure and implement a system utilizing analytics such as predictive modeling, data mining, social network analysis, and scoring algorithms for the detection and prevention of fraud, waste, and abuse. The Act states that this system must be implemented on or before January 1, 2012. As of February 28, 2012, the DOI Fraud Unit had not procured or implemented the required system. (pages 115-122)

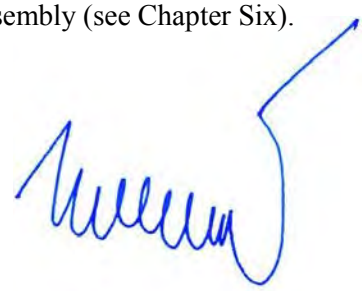
REPORT CONCLUSIONS

Throughout this audit we identified numerous shortcomings in both the structure and operations of the workers' compensation program as it applies to State employees. These problems have led to a program that is ill designed to protect the State's best interests as it relates to processing and adjudicating workers' compensation claims for State employees. Because of the extensive problems that permeate the workers' compensation program as it applies to State employees, **the General Assembly may wish to consider further changes to the structure and operations of the Workers' Compensation Program as it applies to State employees**. (pages 123-125)

RECOMMENDATIONS

The audit report contains a total of 22 recommendations. Some recommendations include more than one agency. The report contains 12 recommendations to the Department of Central Management Services, 10 to the Illinois Workers' Compensation Commission, 3 to the Attorney General, and 1 to the Department of Insurance. Agencies generally agreed with the recommendations. Appendix E to the audit report contains the agency responses.

The audit report also contains a Matter for Consideration by the General Assembly (see Chapter Six).



WILLIAM G. HOLLAND
Auditor General

WGH:MSP

AUDITORS ASSIGNED: This Management Audit was performed by the Office of the Auditor General's staff.

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GLOSSARY OF TERMS

Arbitrator
The Illinois Workers' Compensation Commission (IWCC) employee who serves as the first-level hearing officer on a case.

Adjuster
Employee at the Department of Central Management Services who determines the compensability of a workers' compensation claim.

Application for Adjustment of Claim
Form filed to establish a case with the Illinois Workers' Compensation Commission.

Award
The resulting decision of a disputed claim by an Arbitrator at the Illinois Workers' Compensation Commission in favor of the injured employee.

Average Weekly Wage (AWW)
The calculation of an employee's gross (pre-tax) wages, on which benefits are based.

Benefit
All payments associated with a claim such as those for medical treatment, TTD, PTD, etc..

Claims Rate
The number of claims per 100 employees.

Commissioner
The Illinois Workers' Compensation Commission officer who serves as the review-level hearing officer on a case.

Death Benefit
A benefit of $8,000, paid to the survivor or the person paying for the burial of a fatally-injured worker, plus survivor benefits.

Fee Schedule
A list of fees, rules, instructions, and guidelines regarding the payment for most treatments that are covered under the Workers' Compensation Act.

Illinois Workers' Compensation Commission
The State agency that resolves disputes between injured workers and their employers regarding workers' compensation.

Independent Medical Exam (IME)
A medical exam of the employee, requested by the employer.

Maximum Medical Improvement (MMI)
The point at which an employee has finished healing from an injury and has become medically stationary.

Medical Benefit
Employer-paid medical care that is reasonably necessary to cure or relieve the employee from the effects of the injury.

Permanent Partial Disability (PPD)
The complete or partial ***loss*** of a part of the body; or the complete or partial ***loss of use*** of a part of the body; or the partial loss of use of the body as a whole.

Permanent Total Disability (PTD)
The permanent and complete loss of use of both hands, both arms, both feet, both legs, both eyes, or any two such parts, such as one leg and one arm; or a complete disability that renders the employee permanently unable to do any kind of work for which there is a reasonably stable employment market.

Petitioner
The injured employee filing the Application for Adjustment of Claim with the Commission.

Pro Se
A claimant who does not have an attorney.

Respondent
Employer that is listed in the Application for Adjustment of Claim filed with the Commission.

Schedule of Injuries
The value of certain body parts expressed as a number of weeks of compensation for each part.

Settlement
A contract between the employee and the employer to close a claim in exchange for an agreed-upon amount of money that is approved by the Commission.

Subrogation
The act of recovering funds from a third party that may be responsible for the injury or accident.

Temporary Partial Disability (TPD)
Benefit paid for the period in which an injured employee is still healing and is working light duty, on a part-time or full-time basis.

Temporary Total Disability (TTD)
Benefit paid for the period in which an injured worker is either temporarily unable to return to any work, as indicated by his or her doctor, or is released to do light-duty work, but whose employer is unable to accommodate him or her.

Wage Differential
The difference in wages that an employee earns as a result of his or her on the job injury at a new job and the amount he or she would be earning in the pre-injury occupation(s).

Chapter One

INTRODUCTION AND BACKGROUND

REPORT CONCLUSIONS

Workers' compensation is a system of benefits provided by law to most workers who have job-related injuries or diseases. Each year there are approximately 200,000 employee reported work related injuries in Illinois. Employers, including the State of Illinois, provide workers' compensation benefits either by purchasing insurance policies or by paying for the benefits themselves (known as self-insurance). The State of Illinois covers its employees through self-insurance.

There are three State agencies with responsibilities for processing, reviewing, determining compensation, and paying workers' compensation claims filed by State workers. These agencies include the Department of Central Management Services (CMS), the Illinois Workers' Compensation Commission (Commission), and the Attorney General's Office (AG). **CMS is statutorily responsible for administering the workers' compensation program for State of Illinois agencies, boards, commissions, and universities** (20 ILCS 405/405-411).

The Illinois Workers' Compensation Commission acts as an administrative court system to resolve disputes between injured workers and their employers regarding workers' compensation claims. Although for private sector employers/employees the decisions of the Illinois Workers' Compensation Commission may be appealed through the courts, decisions are final for cases involving employees of the State of Illinois. Therefore, **for claims involving State employees the Illinois Workers' Compensation Commission is the court of last resort for settling disputes.**

The Attorney General's Office becomes involved in a workers' compensation claim when an injured State employee seeks a settlement or an award. **As the attorney for the State, the AG represents the State of Illinois at proceedings in front of the Illinois Workers' Compensation Commission** for claims filed by State employees. The AG also prepares, reviews, and approves settlement contracts for injured State employees.

Data Issues

CMS and the Illinois Workers' Compensation Commission need to address several data issues regarding workers' compensation claims and cases. At our request, both CMS and the Commission provided data regarding claims and cases filed for the four-year period 2007-2010. However, after reviewing the data and testing case files, we determined that several limitations existed in the data provided. **Both agencies' workers' compensation information systems contained data that was incomplete, inaccurate, and inconsistent.**

For instance, CMS has established status codes that show where the claim is in the claims process. However, determining the disposition of claims was complicated by the fact that CMS status codes are not always specific regarding the current status of the claim and codes are out of date in some instances. According to data received from CMS, as of July 2011, of the 26,101 claims filed during the four-year period 2007-2010, 12,613 (48%) claims remained open because the State was paying for medical costs, Temporary Total Disability, or the claim was pending further information. Since CMS does not close cases until the statute of limitations runs out for filing an Application for Adjustment of Claim with the Commission (three years from the date of the accident, where no compensation has been paid, or two years after the last payment of compensation to the employee), this number includes cases which may be inactive.

The number and amount of payments made for workers' compensation claims over the past four years is complicated by the fact that CMS is approximately 16 months behind in paying some workers' compensation claims. According to CMS officials, although TTD (Temporary Total Disability) payments are made without delay, payments for medical expenses, settlements, and awards are delayed due to a lack of funds. As of May 11, 2011, CMS was paying workers' compensation expenses from December 2009. All workers' compensation settlements are currently deferred 180 days with no interest. As of May 18, 2011, CMS officials estimated that the State is approximately $61.5 million behind in payments ($50 million for medical and an additional $11.5 million for settlements).

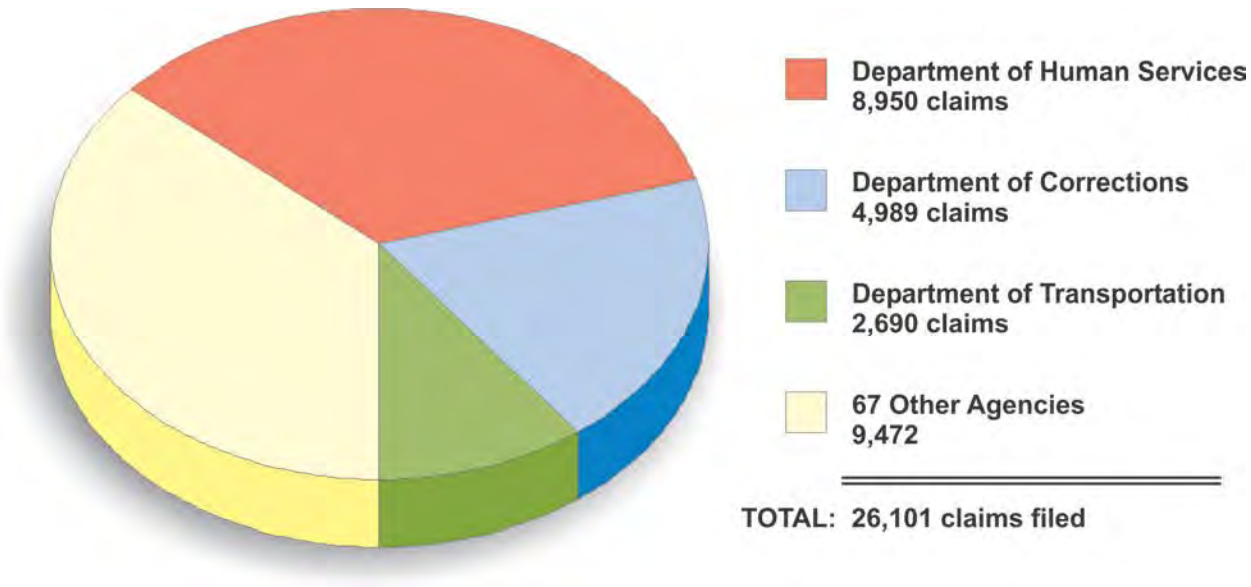
Analysis of Claims Filed 2007-2010

According to data received from CMS, for the period January 1, 2007, through December 31, 2010, State employees filed a total of 26,101 workers' compensation claims. Two types of injuries accounted for three-quarters of all injuries (sprains and contusions). For 13,412 (51%) claims, the primary injury involved a sprain. Contusions accounted for another 6,235 (24%) claims.

Number of Claims Filed by Agency: Three agencies accounted for 16,629 (64%) of the total claims filed during 2007-2010 (Department of Human Services (DHS), Department of Corrections (Corrections), and Illinois Department of Transportation (IDOT)). Together, **DHS and Corrections comprised over half of all claims (53%) filed, at 8,950 and 4,989 claims filed, respectively**. Certain facilities and employing units drive the large number of claims that were filed by these two agencies. At DHS, for instance, employees at Chester Mental Health Center filed 1,180 claims during the four-year period, giving that facility the highest number of claims for any facility or employing unit in State government during that timeframe. Chester MHC was followed closely by two other DHS facilities: Shapiro Developmental Center employees filed 1,052 claims and Murray Developmental Center employees filed 954 claims during the four-year period. Overall, six of the top 10 employing units for workers' compensation claims filed during 2007-2010 were DHS mental health or developmental centers.

Of Corrections' facilities, Menard Correctional Center had the most claims with 869 claims filed during the four-year period. Stateville Correctional Center ranked second of DOC facilities with 668 claims filed during the same period.

WORKERS' COMPENSATION CLAIMS FILED BY AGENCY
January 1, 2007 through December 31, 2010

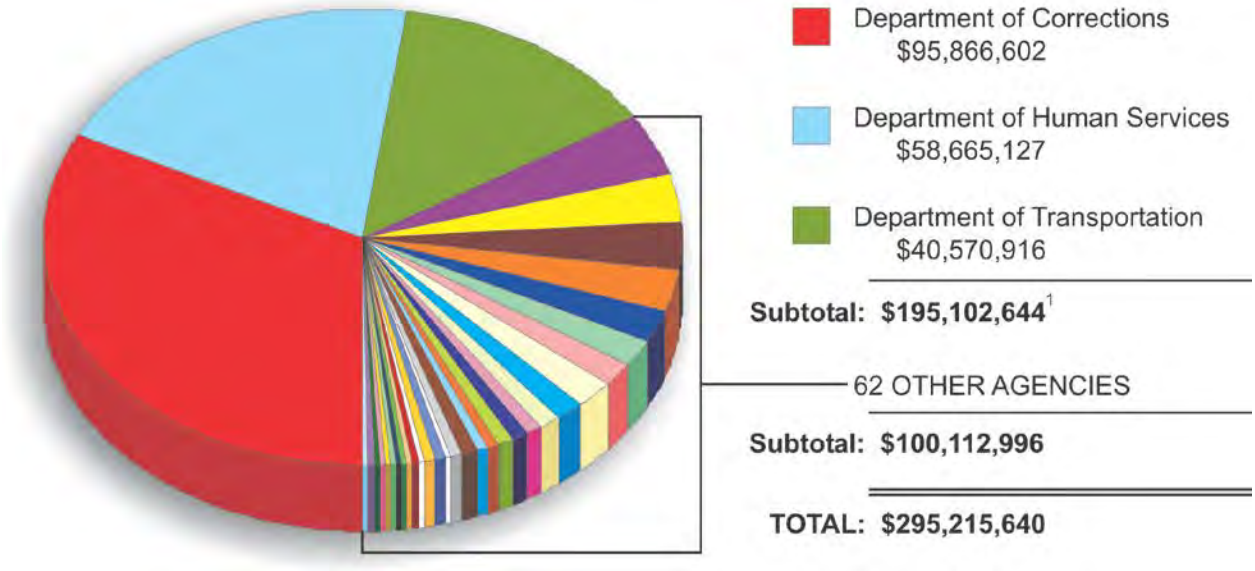


Source: OAG analysis of CMS workers' compensation claims data for claims filed 2007-2010.

Dollar Value of Claims Filed by Agency: **Over $295 million was paid in workers' compensation for State employees on claims filed during the four-year period 2007-2010, according to CMS data.** The largest single category of the State's payments - $103.1 million or 35 percent of all State payments - were made directly to medical providers for medical treatment of injured workers or to reimburse employees for medical costs. Settlements paid to State employees or their attorneys accounted for about one third (32%) of the State's payments for workers' compensation, or $95.6 million. Approximately 25 percent or $74.7 million was for Temporary Total Disability amounts paid to employees to provide income while they were off work. Awards from decisions made by Arbitrators at the Illinois Workers' Compensation Commission accounted for about six percent of the payments at $17.7 million.

Although overall DHS employees filed more claims during the audit period, claims filed by Corrections' employees accounted for the highest dollar value of State payments. **Almost $96 million or about one third of the $295 million in workers' compensation claims paid during the four-year period was for Corrections' employees.** As of July 2011, **Menard Correctional Center workers' compensation claims filed for the past four years have resulted in over $30 million in payments**. DHS claims accounted for $58.7 million of the $295 million in State payments for workers' compensation claims filed during 2007-2010. Even though employees at DHS facilities filed nearly twice as many workers' compensation claims as employees at the Department of Corrections, the total payments related to those claims were only about half as much. **The average cost per claim for DHS employees as of July 2011 was $6,555. By comparison, the average cost per claim for Corrections employees as of July 2011 was $19,216.**

WORKERS' COMPENSATION PAYMENTS BY AGENCY
For Claims Filed 2007-2010
As Of July 2011



Note: [1]Total does not add due to rounding.

Source: OAG analysis of CMS workers' compensation claims payment data for claims filed 2007-2010.

Workers' compensation claims at the Illinois State Toll Highway Authority (ISTHA) and the University of Illinois (U of I) are not subject to the same process as claims filed by employees at all other State agencies. Therefore, we compared claims filed by State employees through CMS to the rate of claims filed for the Illinois State Toll Highway Authority and the University of Illinois. We also reviewed statistics available from the U.S. Department of Labor Bureau of Labor Statistics. We found that the number of claims filed per 100 employees at the ISTHA was consistent with the number of claims filed by IDOT employees. The rate of claims filed by employees of the U of I was also within the range of those filed by employees of other universities that are subject to CMS procedures. In contrast, however, we found that the rate of claims filed for certain State facilities exceeded rates for private industries, including for relatively dangerous jobs in construction and mining.

We also analyzed State employee claims filed for the four-year period 2007 through 2010 by the county of residence. The annual average number of claims filed by State employees for all counties was 7 claims per 100 State employees residing in that county. However, for **nine counties in the State the annual rate was more than twice the average, ranging from 15 claims per 100 employees in both Clinton County and Adams County to 29 claims per 100 employees in Randolph County.** Chester Mental Health Center and Menard Correctional Center are both located in Randolph County.

Workers' Compensation Act Amendments

Significant changes were made to the Workers' Compensation Act by Public Act 97-018, which was effective June 28, 2011. Amendatory provisions included changes to Commission

operations, fraud requirements, and the Medical Fees and Schedules. The Act also created the State Workers' Compensation Program Advisory Board located within CMS. The Board was created to review, assess, and provide recommendations to improve the State workers' compensation program and to ensure that the State manages the program in the interests of injured workers and taxpayers. By law, the Board was to submit a report outlining workers' compensation best practices by September 30, 2011. However, the Board did not hold its first meeting until January 12, 2012, and the required report has not yet been issued.

Claims Reporting Issues

Missing Documentation: We identified several problems regarding notification and injury reporting. In addition to inaccurate injury dates in CMS' system, there are few requirements for documenting when notification of injury is given by State employees to their employer. Documenting supervisory notification of an injury by the employee is critical when filing a claim because by law the employee must notify the employer within 45 days of the accident or injury. Although there is a form for supervisors to complete, supervisor notification can also be verbal and is not always documented. The CMS 900-3 (Supervisor's Report of Injury or Illness) contains information regarding how (oral or in writing) and when (date and time) the supervisor was informed by the employee of the accident or injury. However, this form was missing or incomplete in 19 percent of the cases we reviewed.

Untimely Filings: We identified 1,318 claims (5%) that took longer than the 45 day requirement from the date of injury to the date reported in CMS' system. Of the 109 claim files we reviewed that involved settlements and awards, 26 (24%) took more than 45 days from the date of the injury to the date the injury was reported according to CMS data. Only 4 of these 26 claims were initially denied for compensability according to CMS responses.

Date of Accident Issues: **For repetitive trauma cases such as Carpal Tunnel Syndrome, determining an accident date is problematic because these claims are filed only after the injury is diagnosed or manifests itself.** In our file testing, we found examples of Carpal Tunnel Syndrome claims in which the date of the accident was listed as years prior to the date reported. We also found instances in which the employee was no longer employed with the State when the claim was filed or was on leave for an unrelated workers' compensation claim when they filed another workers' compensation claim for repetitive trauma.

Claims Adjudication at CMS

CMS needs to improve its process for adjusting claims for State employee workers' compensation. We reviewed 109 claims files at CMS (68 settlements and 41 awards) and found a significant amount of missing or incomplete forms. We also found:

- **CMS was adjusting claims and making decisions regarding compensability without appropriate forms being submitted, and forms that were submitted were not always complete.**
- Determinations of compensability by Adjusters were not reviewed by supervisors.
- Cases where no formal request for TTD was made by employees, but employees were receiving TTD benefits.

- CMS Adjusters did not verify Average Weekly Wage information submitted by agency workers' compensation coordinators and did not have access to payroll information.
- Medical bills were not always properly approved or dated.

Subrogation: CMS reviews each new claim file to determine whether there is a third party that may be responsible for some of the costs associated with the injury or incident. This process is called subrogation. According to information provided by CMS, for FY10 subrogation resulted in the recovery of $1.3 million. However, we determined that timely pursuit of subrogation is an issue. For one case we reviewed, the amount was not recovered for over three and a half years after the settlement date. For subrogation, there is a two year statute of limitations on commencing a proceeding against the third party. However, the State cannot commence a proceeding against a third party until three months prior to the time such action would be barred because the injured individual is allowed to file first. If subrogation is not pursued in a timely manner, the State may miss opportunities to reduce its costs by recovering funds from third parties since the passage of time makes identifying responsible third parties and collecting from them less likely.

Verification of Recipient Eligibility: Some employees and their beneficiaries receive monthly benefits for Permanent Total Disability, wage differentials, or because of deaths. CMS sends an annual affidavit but does not conduct periodic matches to determine if these employees or their beneficiaries are still eligible to receive benefits. According to CMS officials, matches are performed with Group Insurance data, but some employees are not members of Group Insurance, and it is difficult to get relevant information from other State agencies. CMS officials provided emails that showed they have been trying to gain access to Illinois Department of Employment Security (IDES) information since December 2006. Public Act 097-0621, effective November 18, 2011, allows CMS Risk Management to access information in the possession of IDES that may be necessary or useful for the purpose of determining whether a recipient of a disability benefit or a State employee receiving workers' compensation benefits is gainfully employed.

Adjustor Caseloads: **We found that CMS does not have caseload standards and could not always provide Adjuster caseloads.** As of May 2011, there were eight CMS staff to adjust workers' compensation claims and two claims supervisors. From our review of disposition codes in CMS' data, we identified 12,613 claims that were open as of July 2011. If these claims were distributed equally among Adjusters, each Adjuster would be responsible for 1,577 claims. If the two claims supervisors also assumed a caseload, the caseload would be 1,261 cases each. According to workers' compensation industry sources the typical adjuster caseload is 175 to 250 active claims per adjuster. The more cases an adjuster handles the less time that adjusters can spend on each case. If adjusters have too many cases to handle, this can drive less-than-desirable outcomes, including medical and indemnity expenses being paid out longer than necessary. It should be noted, however, that a number of the 12,613 claims open as of July 2011 may be inactive and merely being held open by CMS until the expiration of the statute of limitations period. CMS was unable to estimate the number of inactive cases in its system for the auditors.

Illinois Workers' Compensation Commission and Arbitrator Caseloads

Establishing a case with the Illinois Workers' Compensation Commission is a separate process from filing a claim with CMS. Simply because an employee is injured on the job does not mean there will be a case filed with the Commission related to the injury claim. Many employees simply seek medical treatment and are back on the job quickly without filing with the Commission. In these cases, if there was a claim filed with CMS, CMS would have made a determination of whether the costs of medical treatment should be paid to the medical provider by the workers' compensation program. However, the injured employee would not have received any form of monetary settlement or award. We were unable to determine the number of claims filed with CMS that were subsequently filed with the Commission because the workers' compensation information systems at each agency used different tracking numbers.

Missing Documentation: **We found that improvements need to be made in the process for establishing a case with the Commission**. We reviewed case files and found Applications for Adjustment of Claim were not always being filed with the Commission. An Application for Adjustment is a key document for the Commission because it is used to establish a case file, assign a case number, and establish the city in which the accident occurred so that a call site and Arbitrator can be assigned. **Of the 109 settlements and awards sampled, 13 (12%) did not contain an Application for Adjustment in the file at the Commission. There were also three case files in our sample that could not be located.**

Cases More Than Three Years Old: Commission rules provide that cases that were filed three years ago or more must proceed to arbitration unless the parties show they have good cause to wait. These are known as "red-line" cases. Because of data accuracy issues, the status call and red-line reports were not accurate. The Commission has even posted a request on its website for assistance from parties in removing settled cases from the call lists. According to Commission data (received in August 2011), as of June 1, 2011, 2,515 cases were more than three years old, according to the date of the Application for Adjustment, but had not been closed out. However, because of the inconsistency of employer names in the Commission's system, it was not possible to determine how many of these were cases filed by State employees. Of the 109 cases we sampled that received a settlement or award, 15 (14%) were more than three years old and may have warranted dismissal. These cases were 36 to 164 days past the three year mark.

Data Issues: **Data that we received from the Workers' Compensation Commission has severe limitations because the data has missing, inaccurate, and/or inconsistent information.** Although we were able to analyze the overall caseloads for Arbitrators, we were unable to determine with any accuracy the number of cases involving a State employee assigned to each Arbitrator by employing unit (i.e. State agency) or by type of injury.

Lack of Performance Reviews: The Workers' Compensation Act requires annual performance reviews for Arbitrators. However, in our review of the personnel files for 31 Arbitrators assigned to call sites as of April 2011, we found that there were **no annual reviews being conducted to evaluate Arbitrator performance**. The personnel files did not contain any other information to indicate that reviews of Arbitrators' performance had been conducted.

Settlements and Awards Process

There are significant differences between resolving a workers' compensation claim by reaching a settlement or by receiving an award through a trial with a Commission Arbitrator. A **settlement** is a contract negotiated between an injured employee and the employer in order to resolve any dispute regarding the benefits due to the injured employee under the Workers' Compensation Act or Occupational Diseases Act. If an employer and injured employee cannot reach an agreement or choose not to, either party may petition for a trial with an Arbitrator at the Commission and a trial will be held. If an Arbitrator's decision rules in favor of the injured employee, this is termed an **award**.

CMS provided auditors with a listing of all claims filed for the four-year period January 1, 2007 to December 31, 2010. Of the 26,101 workers' compensation claims filed during the four-year period, **3,621 (14%) received a settlement** as of July 2011. According to our analysis of CMS' data, these **3,621 settlements involved 3,299 individuals who received a total of $107,362,741**. Of the 26,101 workers' compensation claims filed during the four-year period, **611 (2%) received an award** as of July 2011. According to our analysis of CMS' data, these **611 awards involved 567 individuals who received a total of $17,806,709**.

Settlements Process

Settlements are those claims that are resolved through a settlement contract, signed by the injured employee, CMS and the AG. Settlement contracts are reviewed and approved by a Commission Arbitrator. We reviewed the settlement process and found that **CMS needs to establish clearer policies regarding settlement contracts and approval limits for Risk Management employees.** For instance, we found job title descriptions and the policies in CMS' Risk Management Policy Manual contained conflicting amounts above which settlements must be approved by the Manager of the Risk Management Division and the CMS Director. Also, because the lump sum payments to employees do not always contain all agreed payments, the actual amount of some settlements is understated for purposes of determining the approval limit, thereby allowing approval limits to be circumvented.

CMS Risk Management Supervisors were negotiating, and in some cases finalizing, settlement contract terms directly with the injured employee's legal counsel. According to CMS Risk Management policies, upon determination of a proper and appropriate settlement amount by the Unit Supervisor, the Office of the Attorney General is provided with settlement authority not to exceed that specified amount. The Office of the Attorney General, not CMS Risk Management, is responsible for negotiating a settlement with the employee's attorney.

CMS' files did not always contain support for all injuries compensated as part of the settlement. Although most CMS files generally contained medical support for the injuries listed in the settlement contract, we identified settlement contracts that did not contain medical evidence. Settlement files at the Commission also did not always contain medical evidence. In these instances, the evidentiary basis for the Arbitrator's approval of the settlement contract is not apparent.

The Commission's Application for Adjustment does not contain a specific question regarding whether the employer is the State of Illinois. Although the Commission's information system contains a data field used to identify State employees, the field is not always accurate. CMS is not notified directly that an employee has filed a case with the Commission. Therefore, unless the workers' compensation coordinator at the agency or the AG notifies CMS, CMS may be unaware of the case. If the Commission were to provide CMS with access to its workers' compensation information systems it would allow CMS to more easily identify cases that have been filed with the Commission and would assist in record keeping and identifying trends in workers' compensation claims filed by State employees.

Because of the decentralized nature of the workers' compensation program for State employees, communication among the various entities involved is critical. Each workers' compensation case for a State employee may have up to four separate files with different entities (i.e., the employing unit, CMS, the Commission, and the AG).

Awards Process

In those instances where a claim is not resolved through the settlement process, an employee may take the case to the Commission and a trial before a Commission Arbitrator is held. An award decision is required to be written for each case for which a trial is held. The award decision is then signed by the Arbitrator and sent to the Commission. All 41 award files we reviewed contained an award decision. According to Commission officials trial dates are tracked based on self-reporting by the Arbitrators, but independently of the mainframe. **However, because the Commission does not track the trial date in its primary information system, it cannot ensure that Arbitrators are submitting decisions in a timely manner.** The Commission's internal policy requires certain Arbitrator decisions to be filed within 60 days of the trial. For 19(b) (expedited) awards, however, the Commission's rules require the Arbitrator's decision to be filed with the Commission within 25 days after proofs are closed (50 Ill. Adm. Code 7020.80 b)(3)(B)).

We reviewed award decisions to determine the trial date and the date that the Arbitrator's decision was filed. For the award files reviewed that did not involve an expedited hearing, the time from the trial to the date the decision was filed ranged from 13 to 83 days. The decisions in five cases were filed more than 60 days after the trial. Our sample of 41 award decisions included nine 19(b) (expedited) cases. For the 19(b) cases, the decision was filed between 7 to 66 days after the trial date. Of these nine cases, 7 decisions were filed more than 25 days after the trial date. Three of these 7 decisions were filed more than 60 days after the trial date.

Award files generally contained medical information to support the decision. However, we found two cases with no medical information in the file. Since Commission files do not contain trial transcripts, we could not determine who testified, what was discussed at the trial, or how certain elements of the decision were supported. According to Commission officials, it is common practice throughout all trial courts in Illinois not to order a transcript before issuing a ruling. The Arbitrator attended the trial and heard the testimony first hand so there usually is no need to review transcripts. Commission officials stated that requiring a transcript for every case

would be unnecessary, burdensome, and slow down the decision process. Transcripts are ordered only when an Arbitrator's decision is appealed to the Commission.

The Commission does not have guidelines for Arbitrators regarding awards. We reviewed awards and found that many are inconsistent for the same type of injury to the same body part. These inconsistencies involved the percent loss of use as well as the manner of determining loss. For instance, for Carpal Tunnel Syndrome claims, the amount awarded for cases we reviewed ranged from as little as 5 percent loss of a hand to as much as permanent total disability for life. **Repetitive motion injury awards varied with some Arbitrators awarding the same percentage loss amount for either hand while others awarded more for loss of the dominant hand.**

Possible Conflicts of Interest

Commission: Although the Illinois Workers' Compensation Commission has promulgated rules regarding conflicts of interest for Commissioners and Arbitrators, we identified several relationships that may have posed a conflict for the Arbitrator. Public Act 97-018, effective June 28, 2011, requires Arbitrators and Commissioners to follow the Canons of the Code of Judicial Conduct as adopted by the Supreme Court of Illinois for hearing and non-hearing conduct. In our review we identified several relationships that involve Arbitrators including:

- An Arbitrator whose spouse is a high ranking public employee union official hearing workers' compensation cases involving State employees;
- An Arbitrator hearing cases in which the injured employee was represented by an attorney that he had previously been a partner with in a law practice; and
- An Arbitrator hearing testimony from a doctor who had also performed surgery on the Arbitrator for his own workers' compensation claim/case.

Another situation that poses a possible conflict of interest for Arbitrators is one in which the Arbitrator has a workers' compensation case pending with CMS. Six different Arbitrators filed cases with CMS during the four-year period that we reviewed. If these Arbitrators are hearing cases involving State employees, this creates a possible conflict because the respondent in these cases is CMS which is represented by the Attorney General's Office, the same entities that are adjudicating the Arbitrator's own claim.

The Commission's Review Board is responsible for conducting investigations of complaints against Arbitrators and Commissioners. The Board is required to meet quarterly and to call a meeting within 15 days of any complaints received. **The Board did not meet for 3 ½ years (February 11, 2008-September 9, 2011).** During this timeframe, we found several allegations regarding Arbitrators and Commissioners alleging fraud, unethical practices, and favoritism. In addition, on February 15, 2011, the Commission placed two Arbitrators on administrative leave while they were being investigated.

CMS: The Department of Central Management Services has no formal policies for conflicts of interest for Adjusters or other employees who process workers' compensation claims. CMS provided two e-mails from 2004 and 2006 as documentation of its conflict of interest

policies. However, all Adjusters employed by CMS during the audit period were not included in the e-mail.

Attorney General's Office: The Attorney General's Office has established policies regarding conflicts of interest for Assistant Attorneys General. Additionally, Attorney General officials stated that the Assistant Attorneys General are bound by the rules of professional conduct and are subject to discipline by the Attorney Registration and Disciplinary Commission (ARDC) if they do not follow them.

Fraud Identification Policies

Commission: We found the **Illinois Workers' Compensation Commission does not have a formal policy or specific procedures to identify fraud and does not conduct statistical reviews or analyses to identify fraud or trends that might warrant further review or investigation.** According to a Commission official, the Workers' Compensation Commission monitors complaints and allegations, and all fraud allegations are referred to the Department of Insurance Fraud Unit for follow-up. However, we found **the Commission did not refer any cases to the DOI fraud unit during the four-year period subject to our audit.**

CMS: CMS has policies that require Risk Management Division employees to act on any reports of workers' compensation disability benefit abuse and to assist law enforcement officials in efforts toward prosecuting abuses. Although CMS has established policy guidance for identifying possible fraud, as well as procedures for reporting cases for investigation, we found that **CMS does not conduct statistical analyses to identify trends and patterns in claim reporting that might be indicators of fraudulent activity**. According to CMS officials, the agency's computer system's data integrity problems and a shortage of staff made it difficult to conduct statistical reviews of the data to analyze and identify fraudulent trends.

Attorney General's Office: We found the Office of the Attorney General does not have specific policies or procedures to identify or control fraud for Workers' Compensation cases referred to them. Attorney General officials stated that they are limited in identifying trends or fraud through data analysis because they only have a small number of the total workers' compensation cases (i.e., those cases in which a settlement contract is negotiated and/or approved by the Attorney General's Office, or which are taken to the Commission and the Attorney General represents the State at trial). Therefore, any analysis that could be conducted would be limited. Attorney General officials also stated that their focus is on assembling a defense in order to set beneficial precedent and prevent fraudulent trends from occurring.

Department of Insurance: Public Act 94-277, codified at 820 ILCS 305/25.5 and effective July 20, 2005, created a Workers' Compensation Fraud Unit within the Illinois Department of Insurance (formerly the Division of Insurance at DFPR). The Unit's sole purpose is to examine reports of workers' compensation fraud and noncompliance with insurance requirements by employers. **On October 17, 2011, we inquired with the Department of Insurance (DOI) about the number of workers' compensation referrals, investigations, and convictions for State employee workers' compensation claims the DOI Fraud Unit had been involved in.** DOI officials responded that "we cannot search our records by 'state

employee' because none of the captured information in the system specified the target's place of employment in a searchable field. As such we will have to search our records manually in order to get the numbers." **DOI responded to our inquiry more than four months later, on February 27, 2012, by saying that there had been a total of eight investigations of State employee workers' compensation claims resulting in no convictions during the four-year time period subject to our audit.**

Public Act 097-0018, effective June 28, 2011, imposed additional requirements on DOI for the purpose of identifying and detecting workers' compensation fraud. The Fraud Unit at the Department of Insurance is required to procure and implement a system utilizing analytics such as predictive modeling, data mining, social network analysis, and scoring algorithms for the detection and prevention of fraud, waste, and abuse. The Act states that this system must be implemented **on or before January 1, 2012**. **As of February 28, 2012, the DOI Fraud Unit had not procured or implemented the required system.**

INTRODUCTION

On March 10, 2011, the Illinois House of Representatives adopted House Resolution No. 131 directing the Auditor General to conduct a management audit of the workers' compensation program as it applies to State employees (see Appendix A). Specifically, the resolution directs that the audit include:

(1) The roles of the Department of Central Management Services, the Attorney General's Office, and the Illinois Workers' Compensation Commission in processing, reviewing, determining, and paying on workers' compensation claims filed by State workers;
(2) The number of claims filed by State workers during the last 4 years, including a classification of the types of alleged injuries, employing unit, disposition, and claims payments;
(3) A review of the settlement contract process and, in particular, documentation supporting any decisions on these claims;
(4) An analysis of any fraud identification and control policies and procedures governing the workers' compensation program;
(5) Whether the processing of State employee workers' compensation claims complies with applicable State law and regulations;
(6) An analysis of arbitrator caseloads over the 4-year period, including the number of cases closed, a classification of the types of alleged injuries involved in those cases, the employing unit involved in the claims, and claim dispositions and payments;
(7) A review of conflict of interest policies applicable to arbitrators, commissioners, and other principals involved in the workers' compensation program, including any procedures for handling workers' compensation claims filed by arbitrators, commissioners, and other principals involved in the workers' compensation program; and
(8) A comparison of claims history by State workers to claims filed by all other workers covered under the workers' compensation program.

BACKGROUND

Workers' compensation is a system of benefits provided by law to most workers who have job-related injuries or diseases. Each year there are approximately 200,000 employee reported work related injuries in Illinois. State law requires almost every working resident of Illinois to be covered by workers' compensation insurance. Employers, including the State of Illinois, provide workers' compensation benefits either by purchasing insurance policies or by paying for the benefits themselves (known as self-insurance). The State of Illinois covers its employees through self-insurance.

Illinois has a no-fault system of compensation in which employees who are injured at work may obtain payment for lost wages, medical costs, and occupational rehabilitation expenses without regard to their personal negligence or fault. In exchange, employees give up their right to sue their employers directly for negligence or other damages. Employers also benefit by being insulated from the possibility of paying large tort verdicts to injured employees in civil actions. In exchange for that protection, the employer surrenders many of the common-law defenses that otherwise would be available in civil litigation.

ILLINOIS WORKERS' COMPENSATION LAWS

The Illinois workers' compensation program is governed primarily by two acts: the Workers' Compensation Act (820 ILCS 305) and the Workers' Occupational Diseases Act (820 ILCS 310). In 2005, Public Act 94-277 made changes to the State's workers' compensation system. These changes included creating a workers' compensation medical fee schedule, officially creating the Illinois Workers' Compensation Commission (previously the Industrial Commission), and establishing a Medical Fee Advisory Board. Some of these changes were made to address problems of fraud and non-compliance in the Illinois workers' compensation system. Public Act 94-277 also criminalizes workers' compensation fraud and outlined eight specific fraudulent acts involving employees as well as employers. The Act also established the Workers' Compensation Fraud Unit at the Department of Insurance (previously the Division of Insurance at the Department of Financial and Professional Regulation (DFPR)) for the sole purpose of examining reports of workers' compensation fraud and noncompliance.

The Workers' Compensation Act

The Workers' Compensation Act (820 ILCS 305) sets requirements for employees, employers, insurers, medical service providers, and attorneys regarding workers' compensation claims and settlements. The Act:

- Outlines requirements for Commissioners and Arbitrators with the Illinois Workers' Compensation Commission.

- Establishes requirements for both employers and employees for reporting work-related injuries. An employee must notify his or her employer ***within 45 days of the accident***, with the exception of exposure to radiological materials which has a 90 day limit (820 ILCS 305/6 (c)). Additionally, the ***employer must file an accident report***

with the Illinois Workers' Compensation Commission if an accident results in an employee missing more than three scheduled work days. The employer must report this to the Commission between the 15th and the 25th of ***every month***, with the exception of accidents resulting in the death of an employee, which must be filed within two days (820 ILCS 305/6 (b)).

- Outlines requirements for establishing a case with the Commission. ***Employees must file with the Commission within three years of the date of the accident, where no compensation has been paid, or within two years after the last payment of compensation to the employee.*** There is an exception for exposure to hazardous material, in which case the employee must file a claim with the Commission within 25 years after the last day the employee worked in such an environment (820 ILCS 305/6 (d)).

Types of Benefits

The Illinois Workers' Compensation Act includes specific benefit categories. These categories of compensation include:

a) **Medical care** that is reasonably required to cure or relieve the employee of the effects of the injury;
b) **Temporary Total Disability (TTD)** benefits while the employee is off work recovering from the injury;
c) **Temporary Partial Disability (TPD)** benefits while the employee is recovering from the injury but working on light duty;
d) **Vocational Rehabilitation/Maintenance** benefits are provided to an injured worker who is participating in an approved vocational rehabilitation program;
e) **Permanent Partial Disability (PPD)** benefits for an employee who sustains a permanent disability or disfigurement, but can work;
f) **Permanent Total Disability (PTD)** benefits for an employee who is rendered permanently unable to work; and
g) **Death** benefits for surviving family members.

Although private sector employers/employees may appeal the decisions of the Illinois Workers' Compensation Commission through the courts, those decisions are final for cases involving employees of the State of Illinois. Therefore, **for State employees, the Illinois Workers' Compensation Commission is the court of last resort for settling disputes.** In all other cases, either party may appeal to the Circuit Court, the Appellate Court, and in some cases, to the Illinois Supreme Court (820 ILCS 305/19 (f)(1)(2)).

Significant changes were made to the Act in 2011. Public Act 97-018, effective June 28, 2011, terminated all Arbitrators at the Commission, changed the medical fees schedule, capped awards for Carpal Tunnel Syndrome to 15 percent loss of use, and created a Workers' Compensation Program Advisory Board, among other provisions. A more detailed discussion of these changes is presented later in this chapter.

AGENCY ROLES IN THE WORKERS' COMPENSATION PROGRAM

There are three State agencies with responsibilities for processing, reviewing, determining compensation, and paying workers' compensation claims filed by State workers. These agencies include the Department of Central Management Services (CMS), the Illinois Workers' Compensation Commission (Commission), and the Attorney General's Office (AG). Exhibit 1-1 is an overview of these agencies' general roles in the process as it applies to State employees.

CMS is statutorily responsible for administering the workers' compensation program for State of Illinois agencies, boards, commissions, and universities (20 ILCS 405/405-411). CMS does not process workers' compensation claims for the University of Illinois and the Illinois State Toll Highway Authority. CMS acts as the insurance company for the State by adjusting and paying claims filed by State employees. Information regarding claims is provided to CMS through a network of workers' compensation coordinators located at the various State agencies/facilities throughout Illinois.

Exhibit 1-1
OVERVIEW OF AGENCY ROLES IN WORKERS' COMPENSATION PROGRAM

- The **Department of Central Management Services (CMS)** is statutorily responsible for administering the workers' compensation program for State of Illinois agencies, boards, commissions, and universities. CMS acts as the State's "insurance company" by processing claims filed by State workers and determining their compensability.
- The **Illinois Workers' Compensation Commission (Commission)** acts as an administrative court system to resolve disputes between workers and their employers regarding workers' compensation claims.
- The **Illinois Attorney General's (AG)** Workers' Compensation Bureau defends the State of Illinois in workers' compensation claims filed by State employees.

Source: OAG analysis of program data.

The Illinois Workers' Compensation Commission acts as an administrative court system to resolve disputes between injured workers and their employers regarding workers' compensation claims. Arbitrators with the Commission approve settlement contracts for workers' compensation claims for all workers including State employees and decide awards if there is a trial. These Arbitrators are located at call sites around the State. If the Arbitrator's ruling is appealed, a panel of three Commissioners makes the final decision regarding the case.

The Illinois Attorney General's Office represents the State of Illinois in workers' compensation cases filed with the Commission by State employees. Exhibit 1-2 shows an overview of the principal parties involved in the workers' compensation process for State employees.

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

The Department of Central Management Services has the statutory responsibility for administering the workers' compensation program for State of Illinois agencies, boards, commissions, and universities. However CMS does not process claims for the University of Illinois or the Illinois State Toll Highway Authority. The benefits administered by CMS include payment of bills for medical treatment, rehabilitation services, temporary disability income payments, and, in some cases, a settlement to compensate for any permanent loss that the employee may have as a result of the injury or disease.

Prior to September 2004, large State agencies such as the Department of Human Services (DHS), Department of Corrections (Corrections), Illinois Department of Transportation (IDOT), and State Police performed the workers' compensation claims function in-house for their agencies. Effective July 30, 2004, Public Act 93-839 consolidated the workers' compensation function within CMS. As a result, in September 2004, these functions were merged into CMS. According to information received from CMS officials through the Office of Finance and Management, there was originally a headcount of 35 positions at all agencies related to the workers' compensation function. However, only 27 of these positions were brought over to CMS when workers' compensation was consolidated.

Exhibit 1-2
STATE EMPLOYEE WORKERS' COMPENSATION CLAIMS PRINCIPALS

- Approximately 6,500 State Employee Claims Annually
- 215 Workers' Compensation Coordinators at State Agencies/Facilities
- 8 CMS Adjusters (20 Total Employees in Risk Management)
- 18 Assistant Attorneys General (25 Total Employees in the Workers' Compensation Bureau)
- 31 Arbitrators At Workers' Compensation Commission (179 total employees)[1]
- 9 Commissioners & 1 Chairman

Note: [1] Commission Arbitrators handle approximately 50,000 cases annually, including State and non-State workers.

Source: OAG analysis of CMS, AG, and Commission data.

Workers' compensation claims are processed by the Workers' Compensation Claims Section at CMS which is located in the Risk Management Division of the Bureau of Benefits. As of May 2011, there were 20 CMS staff processing workers' compensation claims, including preparing claims, adjusting claims, and approving medical bills and payments. Eight of the 20 CMS staff are Claims Adjusters. In addition to the CMS staff, there were seven vendor/contractual staff from *CareSys* and *Coventry* who are located on site to manage and review medical cases. *CareSys* is the intake vendor hired by CMS to take the initial calls from injured State employees. *Coventry* is responsible for reviewing medical bills.

State Agency Workers' Compensation Coordinators

Each State agency has a workers' compensation coordinator. Some agencies, such as DHS or Corrections, have a coordinator at each facility. CMS officials provided auditors with a list of all workers' compensation coordinators and their related agencies. As of April 2011, there were 215 workers' compensation coordinators serving agencies and facilities around the State.

The agency workers' compensation coordinator provides the injured employee with a packet of information to complete for each workers' compensation claim. This packet includes forms such as the Employee's First Notice of Injury (CMS 900-1), the Supervisor's Report (CMS 900-3), Information Release Authorization (CMS 900-5), and Witness Report Form (CMS 900-6). These forms are also available online. The Employee's First Notice of Injury must be completed within 24 hours or as soon as the employee is physically capable. When completed, the agency workers' compensation coordinator forwards the information to CMS' Bureau of Benefits Risk Management Division.

ILLINOIS WORKERS' COMPENSATION COMMISSION

The primary mission of the Illinois Workers' Compensation Commission is to provide a no-fault system of benefits paid by employers to workers who experience job-related injuries or diseases. The Commission operates as the court system in Illinois for workers' compensation claims filed by employees in both the private and public sectors. In addition to settling disputes regarding workers' compensation claims, the Commission also receives statutorily required reports of injuries from employers. The Commission performs four main functions:

- Resolving disputes between employers and employees;
- Ensuring compliance with the Workers' Compensation Act and the Workers' Occupational Diseases Act;
- Administering the self-insurance program by evaluating and approving eligible employers that wish to insure themselves for their workers' compensation liabilities; and
- Collecting statistics by compiling information on work-related injuries and diseases.

The Commission's operations are funded by the Illinois Workers' Compensation Commission Operations Fund. This fund was created in 2003 to pay the administrative costs of the agency through an independent source of funds. Each year, employers pay a 1.01 percent surcharge on workers' compensation insurance premiums, while self-insured employers pay an assessment of .0075 percent of payroll (820 ILCS 305/4d).

At the end of FY10, the Illinois Workers' Compensation Commission consisted of the Chairman, nine Commissioners, 163 employees, plus six employees in the separately funded Self-Insurance Division, for a total of 179 people. The Commission's expenditures for operations in FY10 were $19.9 million. The nine Commissioners and the Chairman are appointed by the Governor. As of April 2011, the Commission had 31 Arbitrators to hear cases and approve settlement agreements.

Commissioners

Commissioners serve a term of four years beginning the 3rd Monday in January of staggered odd-numbered years and until a successor is appointed and qualified. Commissioners must:

- Be licensed to practice law in the State of Illinois; or
- Have served as an Arbitrator at the Illinois Workers' Compensation Commission for at least 3 years; or
- Have at least 4 years of professional labor relations experience.

There are a total of 10 Commissioners appointed by the Governor, one of which is the Chairperson.

- Three represent employers operating under the Act (Business);
- Three represent employees covered by the Act (Labor); and
- Four not identified with employers or employees (Public) (one to be designated as chairperson).

As of January 2011, 7 of the 10 Commissioners were serving on expired terms. One Commissioner had been serving on an expired term for more than four years.

Arbitrators and Commissioner Appointments

In October 2011, the Governor appointed 29 Arbitrators and 7 Commissioners to the Illinois Workers' Compensation Commission. Of the 29 newly appointed Arbitrators, 21 were Arbitrators previously with the Commission. Five of the 29 Arbitrators are not attorneys. Of the 7 newly appointed Commissioners, 5 were previously Commissioners with the Commission.

The Commission also has several associated advisory and review boards. These advisory boards include:

- The **Workers' Compensation Advisory Board** aids the Commission in formulating policies, discussing problems, setting expenditure priorities, and establishing administrative goals. Prior to making appointments to the Commission, the Governor is required to request that the Workers' Compensation Advisory Board make recommendations as to candidates to consider for appointment. The Workers' Compensation Advisory Board makes recommendations to the Governor regarding Commission appointments. The Board met four times in 2009 and four times in 2010.

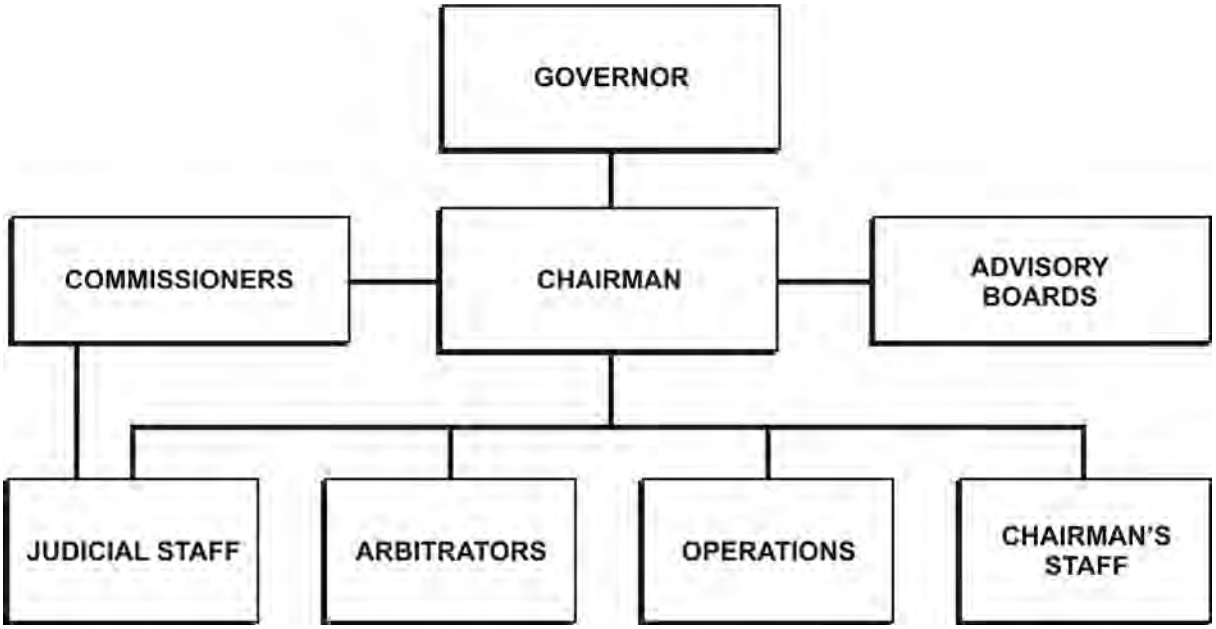
- The **Workers' Compensation Medical Fee Advisory Board** advises the Commission on the establishment of fees for medical services and accessibility of medical treatment. The Board met five times in 2009 and four times 2010.

- The **Self-Insurers Advisory Board** provides for continuation of workers' compensation and occupational disease benefits due and unpaid or interrupted due to

inability of an insolvent self-insurer. This Board met five times in 2009 and four times in 2010.

- The **Workers' Compensation Commission Review Board** compiles, audits, and retains complaints registered against Commissioners and Arbitrators. The Board met February 11, 2008, but did not meet again until September 9, 2011 (3 ½ years).

Exhibit 1-3
ILLINOIS WORKERS' COMPENSATION COMMISSION ORGANIZATIONAL CHART



Source: OAG analysis of IWCC organizational charts.

ILLINOIS ATTORNEY GENERAL

The Attorney General's Office (AG) becomes involved in a workers' compensation claim when an injured State employee seeks a settlement or an award. As the attorney for the State, the AG represents the State of Illinois at proceedings in front of the Illinois Workers' Compensation Commission for claims filed by State employees. The AG also prepares, reviews, and approves settlement contracts for injured State employees. The AG does this through two Workers' Compensation Bureaus - one located in Chicago and the other for Springfield and Regional, both of which are part of the Government Representation Division. The Workers' Compensation Bureaus also provides advice to State agencies on the Workers' Compensation Act.

The Workers' Compensation Bureau for Springfield and Regional as of June 30, 2011, had 13 employees. This included one Bureau Chief, one Assistant Bureau Chief, seven Assistant Attorneys General, one lead worker, one office assistant, and two legal secretaries. The Workers' Compensation Bureau in Chicago had 12 employees. This included one Bureau Chief,

one Assistant Bureau Chief, seven Assistant Attorneys General, one lead worker, and two paralegals. The two Workers' Compensation Bureaus handle cases based on the hearing location.

STATE EMPLOYEE WORKERS' COMPENSATION CLAIMS FILED

CMS and the Illinois Workers' Compensation Commission need to address several data issues regarding workers' compensation claims and cases. At our request, both CMS and the Illinois Workers Compensation Commission provided data regarding claims and cases filed for the four-year period 2007-2010. However, after reviewing the data and testing case files, we determined that several limitations existed in the data provided.

CMS Data Issues

According to data received from CMS, for the period January 1, 2007, through December 31, 2010, State employees filed a total of 26,101 workers' compensation claims. However, during fieldwork testing we determined that the data contained:

- Inaccurate claim filed dates;
- Inaccurate accident dates;
- Incomplete/inaccurate information regarding job titles;
- Incomplete/inconsistent data regarding injury type; and
- Outdated status codes for determining claim disposition.

In addition to the inaccurate and incomplete data listed above, we identified other shortcomings in the data provided. These included:

- Incorrect Adjuster listed in CMS' system;
- No information regarding opposing counsel when the employee had representation; and
- No information regarding the Assistant Attorney General assigned to the case.

Payment data provided by CMS did not reflect refunds in the payment amounts. For one claim we tested, the original award was appealed after CMS issued a check to the claimant. Although the claimant returned the check, the data provided by CMS only showed the payment and not the refund. CMS officials responded that, although the refund was in their system, the 25 year old computer system could not back the refund out of payment totals.

During testing we also determined that the settlement and award amounts in data provided by CMS did not always reflect the total settlement or award amount, rather only the amount paid to date on that settlement or award. We asked whether there was a field for total settlement or award. CMS officials responded that no field is available. However, CMS officials also pointed out that for many awards the claimant will be paid until his/her death. Therefore, the final total amount is not always known.

Illinois Workers' Compensation Commission Data Issues

The Illinois Workers' Compensation Commission provided a download of 218,376 records which represented the entire population of cases filed by all injured employees - both State workers and non-State workers - with the Commission for the four-year period 2007-2010. However, because the data field in the Commission's information system used to identify State employees is not always accurate and because of the inconsistent methods used to record the employer name for each claim, **it was not possible to determine the number of cases and claims attributable to State employees with any accuracy**. For instance, we found at least 16 different listings in the data that would most likely represent an employee who worked at Chester Mental Health Center (e.g., Chester Mental Health Ctr, Chester Medical Ctr, etc…). Some employer listings simply say "State of Illinois" without denoting the specific employing agency or facility.

In addition to inconsistent and incomplete listing of employers, other data issues included vague injuries, invalid social security numbers, and no Arbitrator assigned to the case.

- In 95,725 cases (44%), the injury description was either ***"Injury"*** or ***"To Be Shown."***
- In 14,322 cases (7%), the social security number for the employee was not valid; and
- In 9,794 cases (4%), the Arbitrator assigned to the case is listed as ***"not assigned."***

Contributing to the data issues at the Commission is that data is taken from application forms completed by injured employees or their attorneys. This form is called an Application for Adjustment of Claim. In our review of files, we identified applications that were incomplete or only listed a general statement for items like the injury type listed as **"to be determined"** or ***"to be shown"*** or ***"serious and permanent."*** Since the data in the Commission's information system is taken from these forms, the Commission should require them to be completed accurately; otherwise its ability to aggregate and analyze data is greatly diminished. This problem could be addressed, at least in part, by the use of web based filing with required fields and menus that limit options to ensure consistency.

Consistent and accurate data is critical to tracking cases and conducting analysis of workers' compensation claims filed by State employees. Better quality data is needed from CMS and the Commission to accurately identify trends in workers' compensation claims and to flag cases of suspected fraud or abuse.

Injury Reporting

Employers are required to notify the Commission of all injuries which cause an employee to lose more than three scheduled work days. These reports are made by filing a Form IC-45 (Employer's First Report of Injury) and a Form IC-85 (Employer's Supplementary or Final Report of Injury) with the Commission. Employers can also send accident information electronically. According to Commission officials, about half of the reports received are electronic while the other half is paper. The Commission's Chicago office receives the electronic accident reports and uploads them into the Commission's computer system. CMS' Bureau of Communication and Computer Services sends a file to the Commission on the 8th and 21st of each month reporting injuries to State employees.

All paper IC-45 accident reports are sent to the Commission's Springfield Office where they are either entered into an Excel spreadsheet or sent to the Peoria and Rockford offices to be entered into Excel spreadsheets. For the paper accidents reports (IC-45s), Commission employees only enter the name and address of the injured employee so that a workers' compensation handbook can be sent to the employee. The IC-85 (Employer's Supplementary or Final Report of Injury) forms are also sent to the Springfield Office but, according to Commission officials, are not entered into the system. Therefore, ***for paper accident reports, the Commission does not have readily available electronic data to report aggregate injury statistics, such as*** the type of injury, employer, and any other pertinent information that is included on the IC-45 and the IC-85.

After the accident reports are loaded or input into the system, the Commission sends information regarding the handbook to the injured employees. During our initial review of the process, the Commission was sending addresses to a vendor (Advance Presort). The vendor would then send out the handbooks to the injured employees. Advance Presort's contract was terminated in June 2011 and since then handbook distribution has been handled internally. The Commission now sends injured employees a card identifying the website where the handbook is located and only provides a hardcopy of the handbook if requested.

The Workers' Compensation Act requires the Commission to compile and distribute to interested persons aggregate statistics taken from the reports filed (820 ILCS 305/6 (b)). The Commission cannot comply with this section of the Act without inputting the information from paper injury reports. Paper reports could be eliminated through a web based reporting system, thereby ensuring more consistent and complete electronic injury data.

WORKERS' COMPENSATION DATA	
RECOMMENDATION 1	***The Department of Central Management Services and the Illinois Workers' Compensation Commission should take steps to improve the quality of the data contained in their workers' compensation information systems. CMS and the Commission should also consider implementing and/or enhancing web based reporting systems.***
DEPARTMENT RESPONSE	Agreed. The mainframe data system currently in place is antiquated, and contains data transferred from agency pre-consolidation files and files predating the creation of the database system. As time allows, staff work through data accuracy issues, updating status codes and working towards improved programming and reporting capabilities. CMS plans to discuss options for improved computer systems and web-based reporting systems, and the associated funding, with the Illinois Workers' Compensation Commission, the Attorney General's office, and sister agencies. Currently, headcount, technology and resource limitations hamper the ability for short-term improvements in this area.

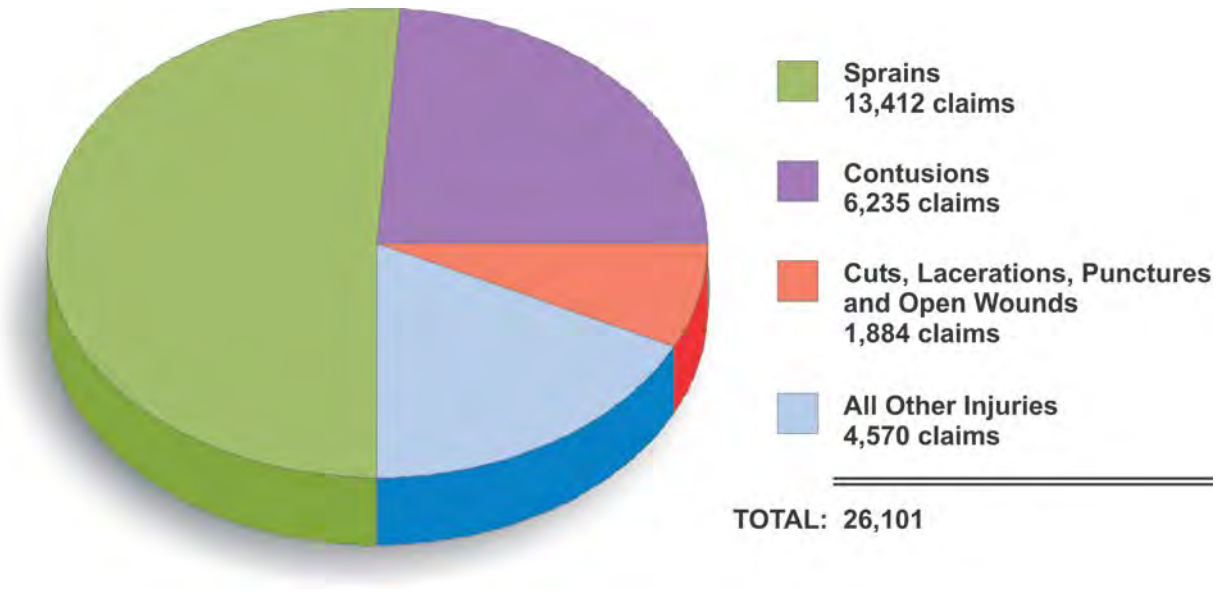
COMMISSION RESPONSE	The Commission agrees with this recommendation. The Commission currently relies on a 30-year-old case management mainframe system, which requires case information to be manually entered into this system. The Commission is beginning the process of documenting its workflow and stabilizing this mainframe system so that the Commission can move towards procuring a more modern case management system focused on more accurate means of storing case information, such as the scanning of documents. However, both procuring and implementing a new case management system will take a significant amount of time, financial investment, and may require external resources. A potential source of funding for implementing a new case management system is the fund for capital or system improvements at the Commission created pursuant to a settlement in Illinois State Chamber of Commerce v. Filan. The Commission has also taken steps towards investigating ways to implement a web-based accident reporting system, either through updating its own current EDI reporting system or by utilizing the staff and technological capabilities of the University of Illinois-Chicago through an intergovernmental agreement. Commission staff will continue to research web-based EDI updates this Spring through the use of the resources of the International Association of Industrial Accident Boards and Commissions (IAIABC), which supports an EDI Committee dedicated to assisting jurisdictions with their electronic reporting efforts. However, mandating the electronic submission of accident report data by employers may possibly require a change to the Workers' Compensation Act.

Types of Alleged Injury

According to data received from CMS, of the 26,101 claims filed for the four-year period (January 1, 2007 through December 31, 2010), two types of injuries accounted for about three-quarters of all injuries (sprains and contusions). As is shown in Exhibit 1-4, in 13,412 (51%) claims the primary injury involved a sprain of some type. Contusions accounted for another 6,235 (24%) claims.

Other primary types of injuries reported in the claims during the four-year period included 1,884 cuts, lacerations, punctures, or open wounds, 761 claims for carpal tunnel, 524 fractures, 494 scratches or abrasions, 266 burns, and 233 insect stings. Although 761 claims listed the injury as carpal tunnel, this does not accurately reflect the number of repetitive motion injuries. During our testing we identified cases in which the injury was listed as "strain/sprain" that were actually repetitive motion claims like Carpal Tunnel Syndrome. It should also be noted that the initial injury descriptions, such as a sprain or strain, may change upon further examination. For a full list of claims by alleged type of injury see Appendix D.

Exhibit 1-4
WORKERS' COMPENSATION CLAIMS FILED BY TYPE OF INJURY
January 1, 2007 through December 31, 2010

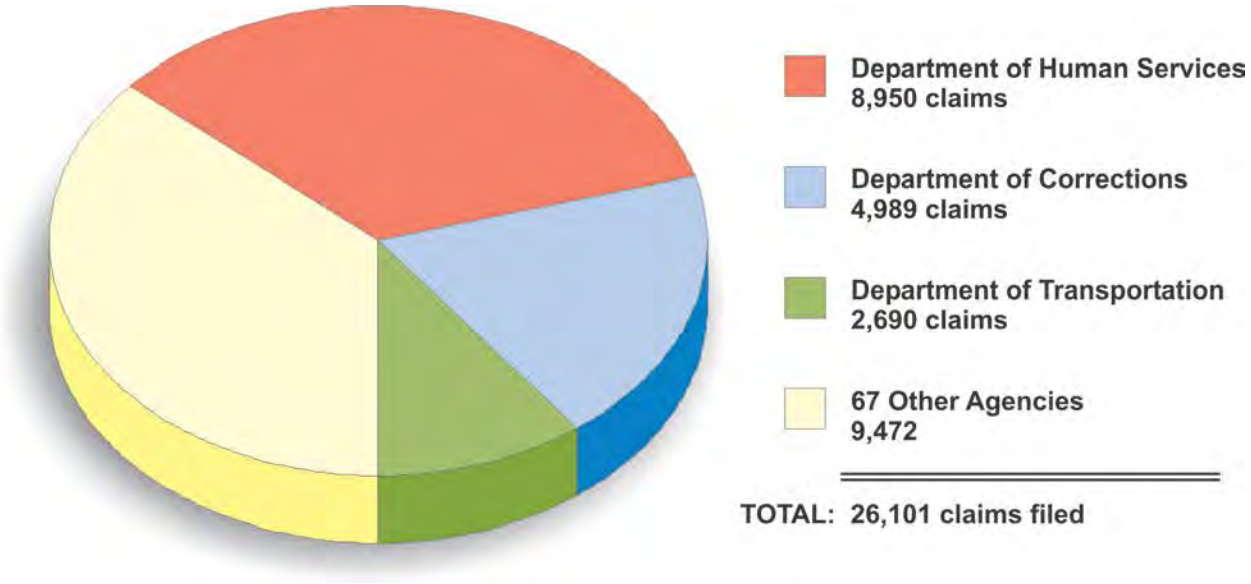


Source: OAG analysis of CMS workers' compensation claims data 2007-2010.

Claims by Employing Unit

As is shown in Exhibit 1-5, three agencies accounted for 16,629 (64%) of the total claims filed during 2007-2010 (DHS, Corrections, and IDOT). Together, DHS and Corrections comprised over half of all claims (53%) filed, at 8,950 and 4,989 claims filed, respectively. Certain facilities and employing units drive the large number of claims that were filed by these two agencies. At DHS, for instance, employees at Chester Mental Health Center, which is a forensic mental health center, filed 1,180 claims during the four-year period, giving that facility the highest number of claims for any facility or employing unit in State government during that timeframe. Chester MHC was followed closely by two other DHS facilities. Shapiro Developmental Center employees filed 1,052 claims and Murray Developmental Center employees filed 954 claims during the four-year period. Overall, based solely on the number of claims filed per employing unit, 6 of the top 10 employing units for workers' compensation claims filed during 2007-2010 were DHS mental health or developmental centers. However, as can be seen in Exhibit 1-6, looking at the number of claims filed as a percentage of workers at each employing unit yields slightly different results.

Exhibit 1-5
WORKERS' COMPENSATION CLAIMS FILED BY AGENCY
January 1, 2007 through December 31, 2010



Source: OAG analysis of CMS workers' compensation claims data 2007-2010.

Of Corrections facilities, Menard Correctional Center had the most claims with 869 claims filed during the four-year period. Stateville Correctional Center ranked second of Corrections facilities with 668 claims filed during the same period. A listing of claims filed for the four-year period by agency and unit is included in this report as Appendix C.

Exhibit 1-6
TOP TEN EMPLOYING UNITS WITH WORKERS' COMPENSATION CLAIMS FILED
2007-2010

Agency/Facility	Total Claims Four-Year Period	Average Annual Claims	Employees[1]	Average Annual Claims Rate
DHS - Mabley DC	584	146	149	98%
DHS - Chester MHC	1,180	295	483	61%
DHS - Jacksonville MH & DC	797	199	408	49%
DHS - Murray DC	954	239	544	44%
Corrections - Menard CC	869	217	738	29%
DHS - Shapiro DC	1,052	263	1,060	25%
DHS - Ludeman DC	600	150	613	24%
IDOT - District 1 (Schaumburg)	827	207	1,119	18%
Corrections - Stateville CC	668	167	1,009	17%
State Police - State Troopers	700	175	1,926	9%

Note: [1]Employees is the average number of FY09 employees from OAG Compliance Examinations.
Source: OAG analysis of CMS claims data and OAG Compliance Examination information.

Claims by Job Title

Certain job titles at the agencies with a high amount of claims seem to be more prone to injuries apparently because of the nature of the position. These include job titles that involve direct care staff such as Mental Health Technician, Correctional Officer, and Security Therapy Aide (see Exhibit 1-7). It also includes labor jobs such as Highway Maintainer.

To get a true picture of the magnitude of claims for jobs that have a series associated with them (e.g., Mental Health Tech I, II, III, etc…), the entire series needs to be added together. For instance, the total claims for the Mental Health Tech series was 4,170. The Security Therapy Aide series had a total of 1,176 claims.

Exhibit 1-7
TOP JOB TITLES WITH WORKERS' COMPENSATION CLAIMS FILED
2007-2010

Title	Primary Agency	Number of Claims
Correctional Officer	Corrections	2,987
Mental Health Tech II	DHS	2,679
New Title[1]	Multiple	1,986
Highway Maintainer	IDOT	1,956
Security Therapy Aide I	DHS	1,037
Support Service Worker II	DHS/DVA	743
Police Officer I	Multiple	615
Mental Health Tech III	DHS	594
Mental Health Tech I	DHS	540
Building Service Worker	Multiple	526
Veteran Nurse Assistant	DVA	521

Note: [1]For 1,986 claims the title was "New Title" because CMS' tables and codes do not include the description for non-code employees.

Source: OAG analysis of CMS claims data.

Although the Correctional Officer title does not have an associated series, it does have levels such as Trainee, Lieutenant, and Sergeant. When all of these levels are totaled there were 3,442 claims made by correctional officers for the four-year period 2007-2010.

Although claims data provided by CMS included a job title for most workers, as can be seen in Exhibit 1-7 "New Title" was listed for 1,986 claims filed. According to CMS officials, on June 1, 1989, there was an initial load of 1,782 titles and job codes. Of those, 257 were added with the "New Title" description. Officials believe the titles classified as "New Title" were those that were not included under the Personnel Code. For workers' compensations injuries, when a call is received by CMS' vendor (*CareSys*) from an individual/employee, the employee gives his/her working title. In some cases, the injured employee may not be using their formal personnel/union title. If that particular working title cannot be located in the vendor's system, the vendor inputs "99999" as a default – new job code. According to CMS officials, they are in the process of cleaning up the titles listed as "New Title" in the system.

Disposition of Claims

As is discussed previously in this chapter, CMS status codes are out of date. House Resolution 131 asks us to report on the disposition of the claims filed during the last four years. CMS has established status codes that show where the claim is in the claims process. However, ***determining the disposition of claims was complicated by the fact that CMS status codes are not always specific regarding the current status of the claim and in some instances codes are out of date.***

Exhibit 1-8
DISPOSITION OF CLAIMS FILED
2007-2010
As of July 2011

Status	Claims
Open	12,613
Closed	11,494
Non-Compensable (Still Open)	932
Awards	650
Settlement Deferred or Pending	404
Other	8
Total	**26,101**

Source: OAG analysis of CMS claims data.

CMS changes these codes as the claims move through the process of determining compensability and eventually closure. Therefore, the data we obtained from CMS shows the disposition of claims at a point in time (July 2011).

According to data received from CMS as of July 2011, of the 26,101 claims filed during the four-year period 2007-2010:

- 12,613 (48%) claims remained open because the State was paying for medical costs, Temporary Total Disability, or the claim was pending further information. Since CMS does not close cases until the statute of limitations runs out for filing an Application for Adjustment with the Commission, this number includes cases which may be inactive.

- 11,494 claims were closed for various reasons, including 4,052 that were closed by Settlement Contract.

- 404 claims had a settlement deferred or pending.

- 650 claims involved an award from an Arbitrator.

- 932 claims were non-compensable but will not be closed until the statutory limitations runs out.

- 8 claims were categorized as "other," including cases in which a death benefit was payable to a widow or dependent or installments had ceased due to death (see Exhibit 1-8).

STATE EMPLOYEE WORKERS' COMPENSATION PAYMENTS

Over $295 million was paid in workers' compensation for State employees on claims filed during the four-year period 2007-2010, according to CMS data (see Exhibit 1-9). However, the number and amount of payments made for workers' compensation claims over the past four years is complicated by the fact that CMS and the State are approximately 16 months behind for certain types of workers' compensation payments. According to CMS officials, although TTD (Temporary Total Disability) payments are made without delay, payments for medical expenses, settlements, and awards are delayed due to a lack of funds.

Exhibit 1-9
WORKERS' COMPENSATION PAYMENTS
For Claims Filed 2007-2010
As of July 2011

Year Filed	Number of People	Number of Claims	Amount Paid
2007	4,848	5,441	$99,482,302
2008	4,914	5,459	$97,586,714
2009	4,422	4,880	$73,894,579
2010	1,656	1,720	$24,252,044
Totals	**15,840**	**17,500**	**$295,215,640**

Note: Amount paid represents payment made for the 26,101 claims filed during the four-year period 2007-2010. Totals may not add due to rounding.

Source: OAG analysis of workers' compensation claims payment data from CMS for claims filed in 2007-2010.

Funding Issues

Although the claims payment data received from CMS shows that over $295 million has been paid out for the four-year period, the total is not representative of the aggregate cost of these claims. According to CMS officials, as of May 11, 2011, CMS was paying workers' compensation expenses from December 2009. All workers' compensation settlements are currently deferred 180 days with no interest. The settlements are not sent to the State Comptroller until there are funds in the Workers' Compensation Revolving Fund to pay the claim. As of May 18, 2011, CMS officials estimated that the State was approximately $61.5 million behind in payments ($50 million for medical and an addition $11.5 million for settlements).

CMS officials explained that the reason for the delay in payments is primarily due to the Fund being a revolving fund that receives its payments from other agencies. Although a certain amount of funds is appropriated to the revolving fund, State agencies may not be transferring the same amount of funds into the Workers' Compensation Revolving Fund. Because of this situation, in reality CMS receives less money than what has been appropriated for this purpose. In addition, the appropriation has remained flat while other costs have been rising. These rising costs include medical expenses and Temporary Total Disability (TTD) payment increases because of wage increases for employees. The shortage of available funds results in some claimants remaining on TTD for a longer period of time because settlement amounts cannot be paid immediately. This, in turn, costs the State additional funds. Settlement contracts are currently on a 180 day deferral. Claimants who resign or cannot return to work remain on TTD during the deferral period while awaiting payment for their settlements. Therefore, if an

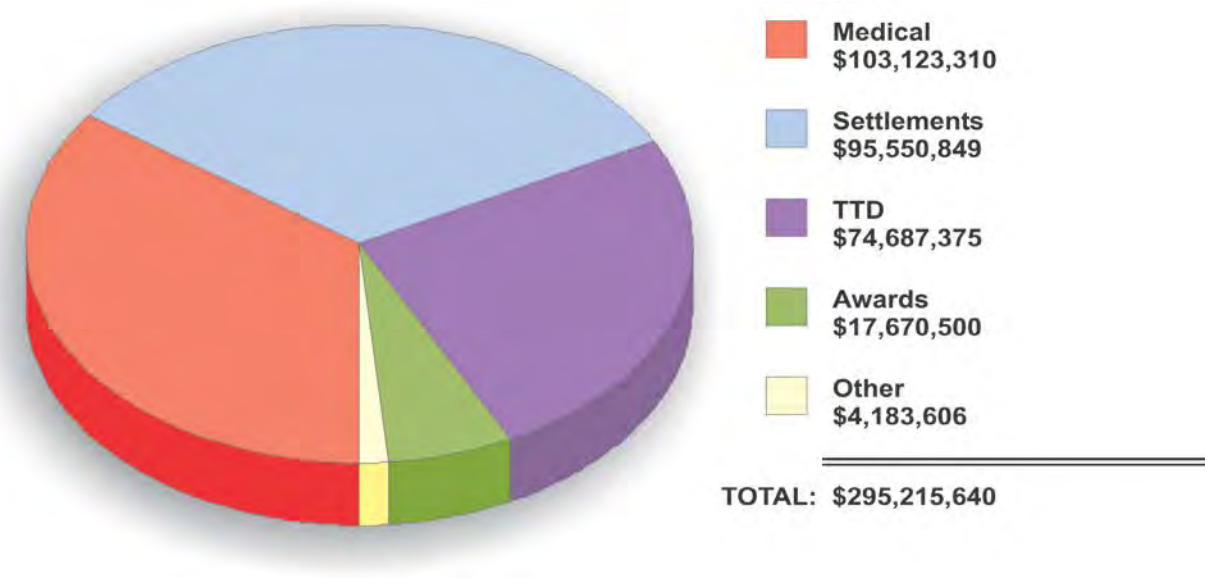
employee's TTD rate was $1,000 per week, with a deferral of 180 days; it would cost the State an additional $26,000.

The fiscal year 2010 CMS financial statements show that the Workers' Compensation Revolving Fund had $537 million in long-term obligations of which $144 million was for fiscal year 2010. CMS's appropriation for fiscal year 2011 was $128 million, of which $6.4 million was for administrative costs and $121.5 million was for the payment of workers' compensation claims.

Payments by Type

Exhibit 1-10 shows that the single largest category of the State's payments for workers' compensation ($103.1 million or 35 percent) were made directly to medical providers for medical treatment of injured workers or to reimburse employees for medical costs. Settlements paid to State employees or their attorneys accounted for about one third (32%) of the State's payments for workers' compensation, or $95.6 million. Approximately 25 percent or $74.7 million was for Temporary Total Disability amounts paid to employees to provide income while they are off work. Awards from decisions made by Arbitrators at the Illinois Workers' Compensation Commission accounted for about 6 percent of the payments, at $17.7 million.

Exhibit 1-10
WORKERS' COMPENSATION PAYMENTS BY TYPE OF PAYMENT
For Claims Filed 2007-2010
As of July 2011



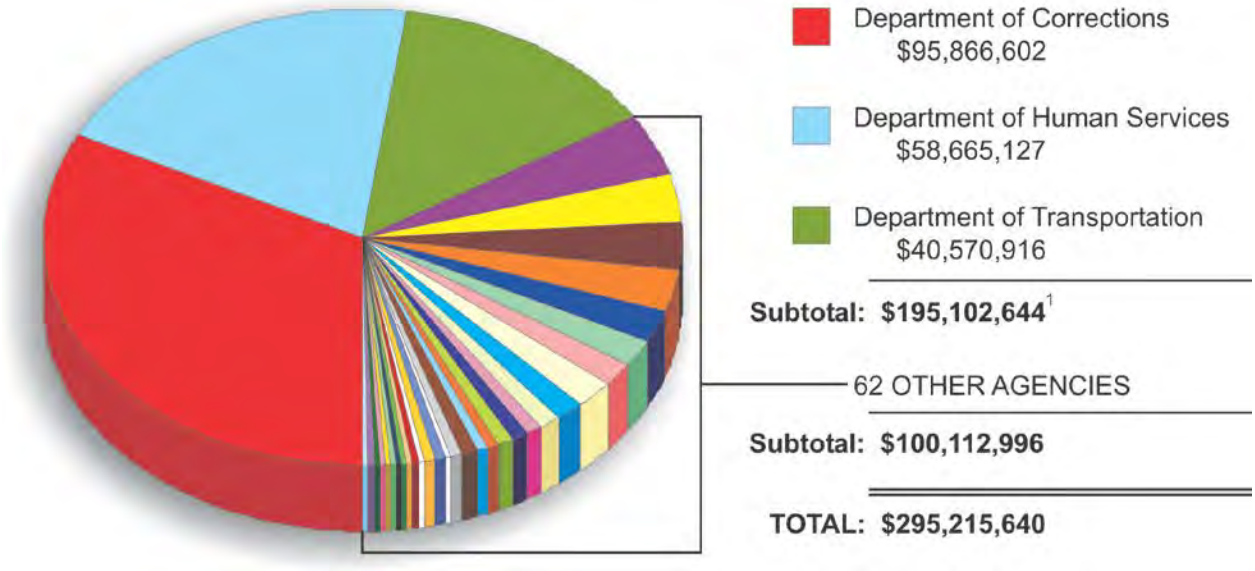
Note: Other includes payments for independent medical examinations, death benefits, pensions, rehabilitation counseling, and claims management expenses.

Source: OAG analysis of CMS workers' compensation payment data.

Payments by Agency and Employing Unit

As is shown in Exhibit 1-11, three agencies accounted for $195 million (66%) of the total payments for claims filed during 2007-2010 (DHS, Corrections, and IDOT). Together, Corrections and DHS comprised over half (52%) of all payments for these claims filed, at $96 million and $59 million, respectively. As with the number of claims, certain facilities and employing units drive the amount of payments related to the claims that were filed by these two agencies.

Exhibit 1-11
WORKERS' COMPENSATION PAYMENTS BY AGENCY
For Claims Filed 2007-2010
As Of July 2011



Note: [1]Total does not add due to rounding.

Source: OAG analysis of CMS workers' compensation payment data.

Exhibit 1-12
DEPARTMENT OF CORRECTIONS
WORKERS' COMPENSATION
CLAIMS PAYMENTS
For Claims Filed
January 1, 2007 – December 31, 2010
As of July 21, 2011

Facility or Division	Total Claims	Total Payments	Average Cost per Claim
Menard CC	869	$30,188,176	$34,739
Pinckneyville CC	300	$8,138,288	$27,128
Stateville CC	668	$6,409,791	$9,595
Shawnee CC	147	$4,107,152	$27,940
Pontiac CC	231	$3,376,451	$14,617
Field Operations	178	$3,353,615	$18,841
Tamms CC	141	$3,191,568	$22,635
Hill CC	161	$3,062,305	$19,021
Big Muddy River CC	140	$2,777,849	$19,842
Dixon CC	267	$2,696,441	$10,099
Vienna CC	94	$2,585,758	$27,508
Lawrence CC	183	$2,417,596	$13,211
Dwight CC	153	$2,407,054	$15,732
Western CC	126	$2,349,065	$18,643
Danville CC	91	$1,956,472	$21,500
Centralia CC	127	$1,809,682	$14,249
Vandalia CC	112	$1,765,216	$15,761
Corr. Industries	43	$1,393,502	$32,407
Lincoln CC	65	$1,341,462	$20,638
Southwestern CC	60	$1,295,379	$21,590
Illinois River CC	88	$1,283,853	$14,589
Logan CC	102	$1,064,581	$10,437
East Moline CC	81	$1,057,149	$13,051
Graham CC	63	$1,043,460	$16,563
Decatur CC	51	$950,954	$18,646
Jacksonville CC	64	$857,263	$13,395
Sheridan CC	130	$741,166	$5,701
Taylorville CC	30	$590,373	$19,679
School District	62	$558,609	$9,010
Gen. Office Adult	45	$535,301	$11,896
Robinson CC	49	$229,250	$4,679
Thomson CC	48	$160,347	$3,341
Training Academy	12	$112,572	$9,381
Gen. Office Juvenile	2	$46,383	$23,192
Kankakee MSU	5	$10,749	$2,150
Transitional Centers	1	$1,769	$1,769
Grand Total	**4,989**	**$95,866,602**	**$19,216**

Note: Totals may not add due to rounding.

Source: OAG analysis of CMS payment data for claims filed January 1, 2007 – December 31, 2010.

Payments for Correctional Employees

The Department of Corrections accounted for about one-third of the $295 million in workers' compensation payments for claims filed during the four-year period. Almost $96 million in workers' compensation payments were for employees of the Department of Corrections (see Exhibit 1-12). **The average cost per claim for Corrections employees as of July 2011 was $19,216.**

Upon review of workers' compensation claims filed over the past four years and their associated payments, one correctional center stands out from the others. Menard Correctional Center workers' compensation claims have resulted in over $30 million in payments for workers compensation claims filed during the four-year period. Menard Correctional Center claims account for nearly one-third of all payments for Corrections employees. Also, because the payment data we received from CMS is a snapshot as of July 2011, these amounts do not include additional costs for ongoing medical or possible settlements and awards for claims that have not yet been settled. The average cost per claim for Menard Correctional Center employees as of July 2011 was $34,739.

The next closest correctional center to Menard in terms of total payments was Pinckneyville with about $8 million in payments.

Exhibit 1-13
DEPARTMENT OF HUMAN SERVICES
WORKERS' COMPENSATION
CLAIMS PAYMENTS
For Claims Filed
January 1, 2007 – December 31, 2010
As of July 21, 2011

Facility or Division	Total Claims	Total Payments	Average Cost per Claim
Chester MHC	1,180	$9,284,039	$7,868
Jacksonville MH/DC	797	$6,212,642	$7,795
Murrary DC	954	$5,484,000	$5,748
Field Operations	484	$5,073,571	$10,483
Shapiro DC	1,052	$4,977,399	$4,731
Choate MH/DC	355	$3,614,146	$10,181
Alton MHC	319	$3,489,789	$10,940
Admin & Support	165	$2,583,022	$15,655
Mabley DC	584	$2,411,350	$4,129
Ludeman DC	600	$2,228,388	$3,714
Home Services	111	$2,100,974	$18,928
Elgin MHC	347	$2,000,775	$5,766
Howe DC	405	$1,950,076	$4,815
Kiley DC	327	$1,601,955	$4,899
McFarland MHC	178	$1,288,422	$7,238
Rushville TDF	66	$835,924	$12,666
Sch. for the Deaf	77	$826,983	$10,740
Fox DC	229	$804,960	$3,515
Chicago-Read MHC	148	$444,428	$3,003
Madden MHC	173	$429,126	$2,480
Tinley Park MHC	151	$421,029	$2,788
Singer MHC	158	$334,953	$2,120
Sch. for Vis. Impair.	37	$258,730	$6,993
Earnfare	52	$8,035	$155
Lincoln DC	1	$412	$412
Grand Total	**8,950**	**$58,665,127**	**$6,555**

Note: Totals may not add due to rounding.

Source: OAG analysis of CMS payment data for claims filed January 1, 2007 – December 31, 2010.

Payments for DHS Employees

Like the Department of Corrections, the Department of Human Services also has facilities located throughout the State. These include Mental Health and Developmental Disabilities Centers that provide direct services to clients. Even though employees at DHS facilities filed nearly twice as many workers' compensation claims as employees with the Department of Corrections, the total payments related to those claims were only about half as much. **The average cost per claim for DHS employees as of July 2011 was $6,555** for claims filed during the four-year period under audit.

Chester Mental Health Center, which is a forensic unit housing criminal defendants who are found not guilty by reason of insanity or mentally unfit to stand trial, had the most claims and payments of any DHS facility. For the four-year period, Chester MHC employees filed 1,180 claims that resulted in $9,284,039 in payments. The average cost per claim at Chester MHC as of July 2011 was $7,868.

The next closest Mental Health Center to Chester MHC in terms of total payments was Jacksonville which is a Mental Health and Developmental Center (see Exhibit 1-13). The average cost per claim at Jacksonville MH & DC as of July 2011 was $7,795.

COMPARISON OF STATE EMPLOYEE CLAIMS HISTORY

The Illinois Workers' Compensation Commission does not consistently track claims filed by State employees. The Commission is only required to receive reports from employers of injuries in which the employee is off work more than three days. Even for these cases, the Commission does not input data for hard copy reports, other than the name and address of the employee. Therefore, it is not possible to use data from the Commission to compare claims history of State workers with that of other employees.

Although CMS' workers' compensation data has certain limitations, we were able to obtain data for claims filed by State employees, excluding the University of Illinois and the Illinois State Toll Highway Authority. The data for the four-year period January 1, 2007, to December 31, 2010, showed that 26,101 claims were filed with CMS by State employees. Claims data was also obtained from the Illinois State Toll Highway Authority, the University of Illinois, and the Bureau of Labor Statistics for comparison purposes. For the four-year period, 800 claims were filed by employees of the Illinois State Toll Highway Authority and 4,552 claims were filed by employees of the University of Illinois. We found that the rate of claims filed at ISTHA and U of I was consistent with the rate of claims filed by other State agencies that are subject to CMS procedures.

Exhibit 1-14
ILLINOIS INCIDENT RATES OF NON-FATAL OCCUPATIONAL INJURIES AND ILLNESSES BY INDUSTRY AND CASE TYPE

Illinois Industry	2010 Average Annual Employment (in thousands)	Incident Rate per 100 Employees
All Industry Including State and Local Govt.	5,429.3	3.6
Private Employment		
Private Industry	4,697.6	3.3
Construction	209.4	3.2
Manufacturing	557.9	4.5
Health Care and Social Assistance	682.8	4.7
Mining	9.0	4.3
Governmental Employment		
State and Local Govt.	731.7	5.9
State Correctional Institutions	11.2	6.4
State Hospitals	7.6	21.3

Source: Bureau of Labor Statistics, U.S. Department of Labor, Survey of Occupational Injuries and Illnesses, in cooperation with participating State agencies.

The U.S. Department of Labor Bureau of Labor Statistics collects injury incident rates each year. Exhibit 1-14 shows the incident rates for non-fatal occupational injuries and illnesses for selected segments of employees. Bureau of Labor statistics for the year 2010 showed the overall injury rate for all employees is 3.6 per 100 employees. For State and local government employees the rate is slightly higher at 5.9 per 100 employees. For State hospitals the rate is 4 times that rate at 21.3 injuries per 100 employees.

Claim Rates for State Agencies

Exhibit 1-15 summarizes the claim rates per 100 employees for all State agencies in which an employee filed a claim with CMS during the four-year period 2007-2010. The rates varied from 26 claims filed per 100 employees at the Department of Military Affairs to .1 claims per 100 employees at the Department of Insurance. Several factors can have an effect on the agency claims rate, such as the nature and type of work at the agency. Also, small agencies may be disproportionately affected by even a few claims.

Toll Highway Authority Claims

The Illinois State Toll Highway Authority (ISTHA) utilizes a third party to administer its workers' compensation program. We obtained information from the Illinois State Toll Highway Authority regarding workers' compensation claims for the period 2007-2010. The ISTHA had 800 workers' compensation claims filed during the four-year period and made payments of $16.3 million related to these claims. For FY10, the ISTHA had an average of 1,535 total employees. That equates to an average annual rate of 13 claims for every 100 employees during the four-year period. This rate is also what IDOT averaged overall for the period. However, IDOT District One (Schaumburg) and IDOT District Six (Springfield) averaged over 18 claims per 100 employees for the same time period.

University of Illinois Claims

We obtained information from the University of Illinois (U of I) regarding workers' compensation claims at its campuses for the period 2007-2010. Data showed that the U of I had 4,552 workers' compensation claims for the four-year period and payments of $32.7 million related to these claims. Since the U of I was not able to provide claims information in a single record format, it took a considerable amount effort to produce a usable record format to conduct analysis. Because of this, we were not able to sort the information by work unit or title. Overall, for FY10, the U of I had a total of 34,868 employees. This equates to average annual claims of 3 per 100 employees during the four-year period. Other State universities under CMS' workers' compensation program averaged between 4.6 claims (ISU) to .8 claims (NEIU) annually per 100 employees for the period (see Exhibit 1-15).

Exhibit 1-15
CLAIMS RATE BY STATE AGENCY
For Claims Filed 2007-2010

Department	Claims Filed 2007-2010[1]	Average Claims Filed Per Year	Employees[2]	Annual Claims Rate[3]
Attorney General	48	12	819	1.47%
Auditor General	1	0.25	104	0.24%
Capital Development Board	6	1.5	122	1.23%
Central Management Services	269	67.25	1,645	4.09%
Chicago State University	58	14.5	1,156	1.25%
Commerce & Economic Opportunity	28	7	437	1.60%
Court Officials	26	6.5	see note [4]	see note [4]
Deaf & Hard of Hearing Commission	1	0.25	7	3.57%
Department on Aging	11	2.75	161	1.71%
Department of Agriculture	123	30.75	429	7.17%
Department of Children & Family Services	279	69.75	2,968	2.35%
Department of Corrections	4,989	1247.25	11,023	11.31%
Department of Fin. & Prof. Regulation	45	11.25	525	2.14%
Department of Healthcare & Family Serv.	283	70.75	2,462	2.87%
Department of Human Rights	10	2.5	21	11.90%
Department of Human Services	8,950	2237.5	13,788	16.23%
Department of Insurance	1	0.25	249	0.10%
Department of Juvenile Justice	877	219.25	1,204	18.21%
Department of Labor	6	1.5	84	1.79%
Department of Military Affairs[5]	242	60.5	233	25.97%
Department of Natural Resources	507	126.75	1,646	7.70%
Department of Public Health	214	53.5	1,117	4.79%
Department of Revenue	181	45.25	1,955	2.31%
Department of State Police	967	241.75	3,151	7.67%
Department of Transportation	2,690	672.5	5,105	13.17%
Department of Veterans Affairs	959	239.75	1,142	20.99%
Eastern Illinois University	290	72.5	2,008	3.61%
Employment Security	98	24.5	1,931	1.27%
Environmental Protection Agency	89	22.25	936	2.38%
General Assembly[6]	19	4.75	789	0.60%
Governor's Office	2	0.5	84	0.60%
Governors State University	43	10.75	895	1.20%
Guardianship & Advocacy Commission	5	1.25	113	1.11%
Historic Preservation Agency	74	18.5	196	9.44%
Illinois Criminal Justice Information Authority	1	0.25	59	0.42%
Illinois Commerce Commission	10	2.5	275	0.91%
Illinois Council on Developmental Disabilities	1	0.25	9	2.78%
Illinois State University	699	174.75	3,806	4.59%

Illinois Workers' Compensation Commission	41	10.25	180	5.69%
Illinois Arts Council	1	0.25	18	1.39%
Illinois Emergency Management Agency	24	6	221	2.71%
Illinois Student Assistance Commission	16	4	361	1.11%
Legislative Information System	1	0.25	35	0.71%
Legislative Printing Unit	8	2	28	7.14%
Lieutenant Governor	1	0.25	7	3.57%
Law Enforcement Training and Standards Board	2	0.5	18	2.78%
Math & Science Academy	16	4	322	1.24%
Northeastern Illinois University	47	11.75	1,462	0.80%
Northern Illinois University	702	175.5	4,427	3.96%
Office of Executive Inspector General	1	0.25	62	0.40%
Governor's Office of Management & Budget	1	0.25	44	0.57%
Prisoner Review Board	2	0.5	18	2.78%
Property Tax Appeal Board	4	1	26	3.85%
Secretary of State	761	190.25	3,996	4.76%
Southern Illinois University[7]	878	219.5	10,278	2.14%
State Appellate Defender	9	2.25	269	0.84%
State Board of Education	44	11	491	2.24%
State Board of Elections	5	1.25	66	1.89%
State Comptroller	73	18.25	247	7.39%
State Employees' Retirement System	19	4.75	85	5.59%
State Fire Marshal	26	6.5	130	5.00%
State Labor Relations Board	1	0.25	27	0.93%
State Treasurer	10	2.5	186	1.34%
State's Attorneys Appellate Prosecutor	3	0.75	83	0.90%
Teachers' Retirement System	6	1.5	175	0.86%
State Universities Retirement System	5	1.25	118	1.06%
Western Illinois University	292	73	2,295	3.18%
Grand Total	**26,101**	**6,525.25**	**88,329**	**7.38%[8]**

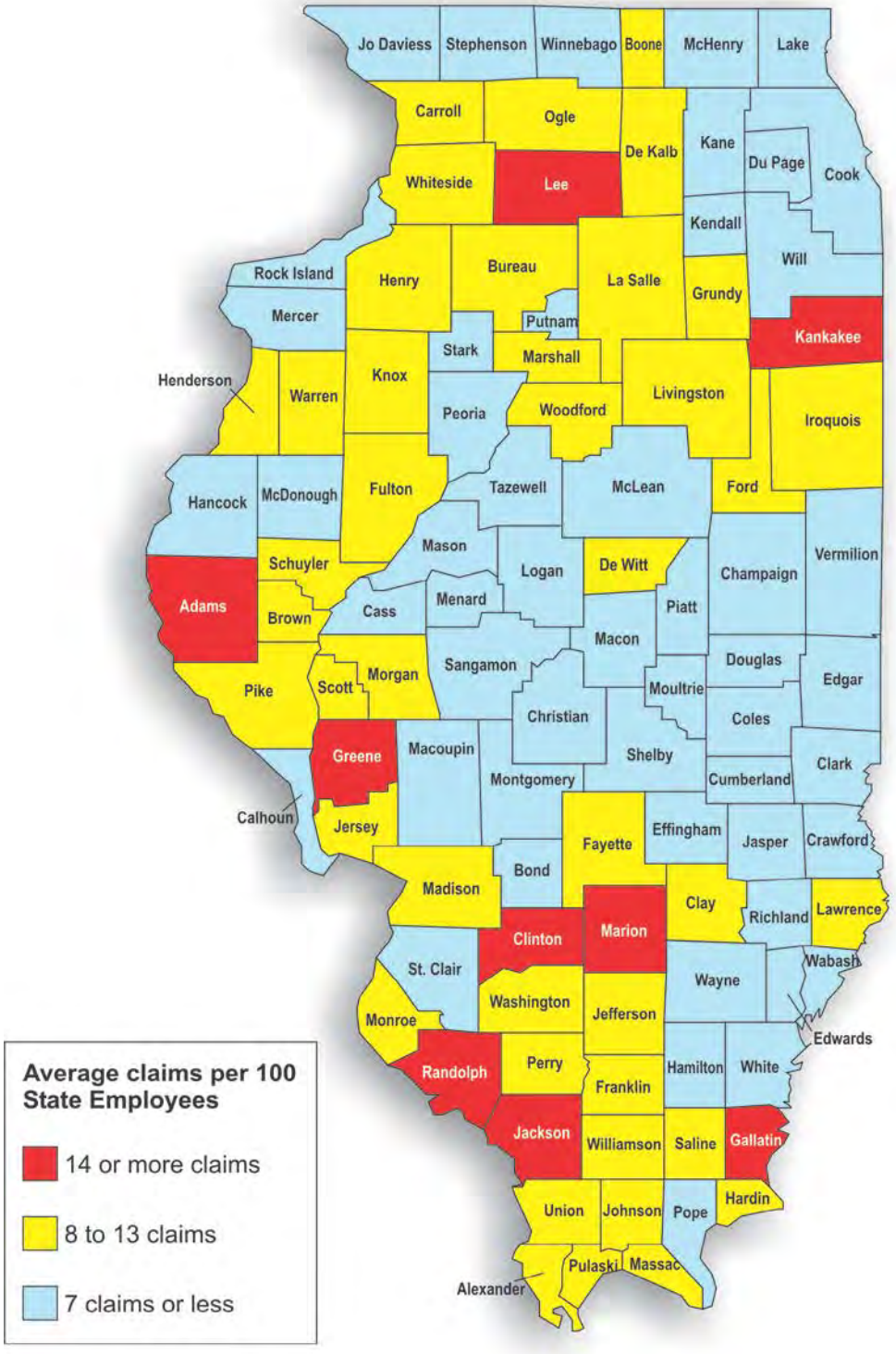
Notes:
[1] Claims filed for 2007-2010 is only for State agencies subject to CMS and excludes claims for the U of I and State Toll Highway Authority.
[2] Employees represents the average number of full-time equivalent employees reported by agencies (unaudited) for the most recent OAG financial audit or compliance examination (FY09 or FY10, as applicable).
[3] The annual claims rate is the rate of claims filed annually per 100 employees.
[4] For the agency listed as Court Officials in CMS' claims data we could not determine the agency/agencies involved and therefore the number of employees.
[5] Employees does not include covered military personnel or emergency responders for declared emergencies such as flooding, winter storms, or tornadoes.
[6] House Fiscal Office is included with the General Assembly.
[7] Southern Illinois University includes Carbondale, Edwardsville, and School of Medicine.
[8] Calculation does not include Court Officials.

Source: OAG analysis of CMS claims data 2007-2010.

Exhibit 1-16

AVERAGE ANNUAL STATE EMPLOYEE WORKERS' COMPENSATION CLAIMS BY EMPLOYEE COUNTY OF RESIDENCE

For Claims Filed 2007-2010



Note: Does not include State university or Toll Highway employees.

Source: OAG analysis of CMS claims data and Office of the Comptroller employee addresses.

State Employee Claims Filed By County of Residence

We compared State employee claims filed for the four-year period 2007 through 2010 by the county of residence. We obtained a list of all State employees by their county of residence from the Illinois Office of the Comptroller and compared it to the claims filed by State employees for the four-year period 2007 through 2010 provided by CMS. The Comptroller provided a list for all State employees paid through funds held by the State Treasurer. The list did not include university employees. The average number of claims filed annually by State employees for all counties was 7 claims per 100 State employees residing in that county.

For nine counties in the State, however, the annual rate was more than twice the average, ranging from 15 claims per 100 employees in both Clinton and Adams County to 29 claims per 100 employees in Randolph County. Chester Mental Health Center and Menard Correctional Center are both located in Randolph County. Exhibit 1-16 is a map showing the average annual number of claims per 100 State employees living in that county.

RECENT CHANGES TO THE WORKERS' COMPENSATION LAWS

Significant changes were made to the Workers' Compensation Act by Public Act 97-018, which was effective June 28, 2011. Amendatory provisions included changes to Commission operations, fraud requirements, the medical fees and schedules, utilization reviews, and insurance compliance.

Changes to the Illinois Workers' Compensation Commission

- The terms of all Arbitrators were terminated as of the end of business on July 1, 2011. Current Arbitrators continued to serve until they were reappointed or their successors were appointed.

- Arbitrators appointed by the Governor are now subject to the advice and consent of the Senate, for the initial terms immediately after the effective date of the Act.

- All new Arbitrators, not currently serving on the effective date of the Act, must now be licensed to practice law in Illinois and must keep that status current throughout their term(s) of service.

- Arbitrators and Commissioners are required to take at least 20 hours of training every 2 years while in office regarding professional and ethical standards, detection of fraud, evidence-based medical treatment, and Coal Workers' Pneumoconiosis.

- At least 3 Arbitrators are required to be assigned to each hearing site and cases must be randomly assigned to them. Arbitrators may not serve more than 2 years of any 3-year term in any single county, other than in Cook.

- All claims of current or former employees of the Commission must be adjudicated by certified independent Arbitrators not employed by the Commission. Arbitrators shall be selected by the Commission Chairman from a list generated by the Commission Review Board. Decisions of the independent Arbitrator shall become a decision of the Commission but are subject to judicial review.

- The terms of members of the Workers' Compensation Advisory Board were terminated immediately and the Governor shall make new appointments within 30 days.

- Codifies that the Petitioner has the burden of proving by a preponderance of evidence that the injuries arose out of and in the course of employment.

- Caps repetitive Carpal Tunnel Syndrome awards to 15% of the loss of the use of a hand unless the petitioner proves greater disability by clear and convincing evidence, at which time the award is capped at 30% of the loss of the use of the hand.

- Provides that to determine permanent partial disability regarding accidents on or after September 2011, a physician submitting an impairment report shall use the most recent AMA (American Medical Association) guidelines on impairment, including objective criteria. The level of disability shall be based on that impairment report, the occupation of the petitioner, the age of the petitioner, the future earning capacity of the petitioner, and evidence of disability in the treating providers' medical records. The relevance and weight of factors in addition to the impairment report shall be included in all decisions relating to permanent partial disability.

- The Act also made changes to medical fees and schedules, utilization reviews and insurance compliance provisions.

Changes Related to Workers' Compensation Fraud

- Eliminates the requirement that a report of fraud shall be forwarded to the alleged wrongdoer with the verified name and address of the complainant.

- Requires the fraud unit to refer any violation to the Special Prosecutions Bureau of the Criminal Division of the Office of the Attorney General.

- Sets penalties for workers' compensation fraud based on the amount of money involved in the attempted fraud, from a Class A misdemeanor (less than $300) to a Class 1 felony (more than $100,000). Requires restitution be ordered in workers' compensation fraud cases.

- The fraud unit shall procure software to identify waste and fraud, and shall make annual reports on instances of fraud and prosecution to the General Assembly, Governor, Director of Insurance, and Chairman of the Commission.

Other Significant Changes at CMS and Department of Insurance

- Allows the Director of CMS to implement a system, including purchasing workers' compensation insurance and/or hiring a third party administrator to administer claims of State employees.

- Establishes the State Workers' Compensation Program Advisory Board within CMS to review and assess the workers' compensation program involving State employees, and to advise CMS regarding improvements to the system. The board shall consist of 5 voting members, one appointed by the Governor who serves as Chairman, and one each by the four legislative leaders. The Board is required to meet at least three times annually and to submit an annual written report each July to the Governor, General Assembly, and CMS with recommendations for improving the system.

- Requires the Director of Insurance to submit annual reports to the General Assembly, Governor, and the Chairman of the Commission about work accidents, the workers' compensation insurance market in Illinois, and other matters relating to claims, awards, and medical expenditures.

State Workers' Compensation Program Advisory Board

Public Act 97-018 created the State Workers' Compensation Program Advisory Board located within CMS. The Board was created to review, assess, and provide recommendations to improve the State workers' compensation program and to ensure that the State manages the program in the interests of injured workers and taxpayers. The Board's make up is as follows:

- The Governor shall appoint one person to the Board, who shall serve as the Chairperson.
- The Speaker of the House of Representatives, the Minority Leader of the House of Representatives, the President of the Senate, and the Minority Leader of the Senate shall each appoint one person to the Board.
- The Director of the Department of Central Management Services, the Attorney General, the Director of the Department of Insurance, the Secretary of the Department of Transportation, the Director of the Department of Corrections, the Secretary of the Department of Human Services, the Director of the Department of Revenue, and the Chairman of the Illinois Workers' Compensation Commission, or their designees, shall serve as ex officio, non-voting members of the Board.

The Board shall meet at least three times per year or more often if the Board deems it necessary or proper. ***By September 30, 2011, the Board shall issue a written report,*** to be delivered to the Governor, the Director of the Department of Central Management Services, and the General Assembly, ***with a recommended set of best practices for the State workers' compensation program.*** By July 1 of each year thereafter, the Board shall issue a written report, to be delivered to those same persons or entities, with recommendations on how to improve upon such practices.

The State Workers' Compensation Program Advisory Board held its first meeting January 12, 2012. However, as of March 1, 2012, the Board has not issued a report of workers' compensation best practices as is required by Public Act 97-018.

STATE WORKERS' COMPENSATION PROGRAM ADVISORY BOARD	
RECOMMENDATION 2	***The Department of Central Management Services, in conjunction with the State Workers' Compensation Program Advisory Board, should develop recommended best practices for the State workers' compensation program, as required by Public Act 97-018.***
DEPARTMENT RESPONSE	Agreed. The Board, appointed by the Governor and the General Assembly, is required to issue a written report to be delivered to the Governor's Office, the Director of CMS, and the General Assembly, including a recommended set of best practices. Future reports will include recommendations for improvements. CMS will evaluate the Board's recommendations and work to implement and administer the best practice and future improvement recommendations taking into consideration relevant laws, policies and available resources.

AUDIT SCOPE AND METHODOLOGY

We conducted this audit in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. The audit's objectives are contained in House Resolution No. 131 directing the Auditor General to conduct a management audit of the workers' compensation program as it applies to State employees (See Appendix A).

Initial work began on this audit in late March 2011 and fieldwork was concluded in January 2012. We interviewed officials from the Illinois Workers' Compensation Commission, CMS, and the Attorney General's Office and conducted walkthroughs of the processes involved in workers' compensation claims in order to identify key decision points. We also met with representatives of the Department of Insurance Fraud Unit, Commission Arbitrators, and CMS Adjusters.

In conducting the audit, we reviewed applicable statutes, administrative rules, and agency policies and procedures. We reviewed compliance with those laws, rules, and policies to the extent necessary to meet the audit's objectives. Any instances of non-compliance we identified are noted as recommendations in this report. We assessed risk by reviewing recommendations from previous OAG financial audits and compliance examinations and by reviewing internal documents including policies and procedures. We reviewed management controls relating to the

audit objectives that were identified in House Resolution No. 131. The audit reports on weaknesses identified in those controls and includes them as recommendations.

We reviewed a sample of 109 settlements and awards (68 settlements and 41 awards) for claims filed during the four-year period 2007-2010. These claims files were reviewed to determine the documentation supporting the decision to compensate the employee. These cases were also reviewed to determine if the claims process, settlement process, or award process complied with applicable State laws, rules, regulations, and agency policies. We specifically reviewed settlements and awards received by employees that were associated with the process including Commission Arbitrators, Assistant Attorneys General, CMS Adjusters, and agency workers' compensation coordinators that we could identify. A complete description of our testing and analyses is in Appendix B of this report.

REPORT ORGANIZATION

The remainder of this report is organized into the following chapters:

- **Chapter Two** reviews CMS' workers' compensation claims process for State employees including claims reporting, adjudication, and Adjuster caseloads.
- **Chapter Three** discusses the process for establishing a case with the Commission including the arbitration process and Arbitrator caseloads.
- **Chapter Four** reviews the settlements and award process for State employee workers' compensation claims.
- **Chapter Five** analyzes fraud identification and control policies and procedures as well as conflict of interest policies applicable to those involved in the workers' compensation program.
- **Chapter Six** summarizes the conclusions in the audit.

Chapter Two

CMS CLAIMS REPORTING, ADJUDICATION, AND ADJUSTER CASELOADS

CHAPTER CONCLUSIONS

We identified several problems regarding notification and injury reporting. In addition to inaccurate injury dates in CMS' system, there are few requirements for documenting when notification of injury is given by State employees to their employer. Documenting supervisory notification of an injury by the employee is critical when filing a claim because by law the employee must notify the employer within 45 days of the accident or injury. Although there is a form for supervisors to complete, supervisor notification can also be verbal and is not always documented. The CMS 900-3 (Supervisor's Report of Injury or Illness) contains information regarding how (oral or in writing) and when (date and time) the supervisor was informed by the employee of the accident or injury. The Supervisor's Report was missing or incomplete in 19 percent of cases reviewed.

Although injuries are required to be reported to the employer within 45 days by law, we identified 1,318 claims (5%) that took longer than the 45 day requirement from the date of injury to the date reported in CMS' system. Of the 109 settlement and award files we reviewed, 26 (24%) took more than 45 days from the date of the injury to the date the injury was reported according to CMS data. Only 4 of these 26 claims were initially denied for compensability according to CMS responses.

For repetitive trauma cases such as Carpal Tunnel Syndrome, determining an accident date is problematic because these claims are filed only after the injury is diagnosed or manifests itself. In our file testing we found examples of Carpal Tunnel Syndrome claims in which the date of the accident was listed as years prior to the date reported. We also found instances in which the employee was no longer employed with the State when the claim was filed or was on leave for an unrelated workers' compensation claim when they filed another workers' compensation claim for repetitive trauma.

CMS needs to improve its process for adjusting claims for State employee workers' compensation. We reviewed 109 claims files at CMS involving settlements and awards and found a significant amount of missing or incomplete forms. We also found:

- **CMS was adjusting claims and making decisions regarding compensability without appropriate forms being submitted, and forms that were submitted were not always complete.**
- Determinations of compensability by adjusters were not reviewed by supervisors.

- Cases where no formal request for TTD was made by employees, but employees were receiving TTD benefits.
- CMS adjusters do not verify Average Weekly Wage information submitted by agency workers' compensation coordinators and do not have access to payroll information.
- Medical bills were not always properly approved or dated.

CMS reviews each new claim file to determine whether there is a third party that may be responsible for some of the costs associated with the injury or incident. This process is called subrogation. According to information provided by CMS, for FY10 subrogation resulted in the recovery of $1.3 million. However, we determined that timely pursuit of subrogation is an issue. For one case we reviewed, the amount was not recovered for over three and a half years after the settlement date. For subrogation, there is a two year statute of limitations for commencing a proceeding against the third party, but the State cannot commence a proceeding until three months prior to the time such action would be barred because the injured individual is allowed to file first. If subrogation is not pursued in a timely manner, the State may miss opportunities to reduce its costs by recovering funds from third parties since the passage of time makes identifying responsible third parties and collecting from them less likely.

Some employees and their beneficiaries receive monthly benefits for Permanent Total Disability, wage differentials, or because of job related deaths. CMS sends an annual affidavit but does not conduct periodic matches to determine if these employees or their beneficiaries are still eligible to receive benefits. According to CMS officials, matches are performed with Group Insurance data, but some employees are not members of Group Insurance, and it is difficult to get relevant information from other State agencies. CMS officials provided emails that showed they have been trying to gain access to Illinois Department of Employment Security (IDES) information since December 2006. Public Act 097-0621, effective November 18, 2011, allows CMS Risk Management to access information in the possession of IDES that may be necessary or useful for the purpose of determining whether a recipient of a disability benefit or a State employee receiving workers' compensation benefits is gainfully employed.

CMS does not have caseload standards and could not always provide Adjuster caseloads. As of May 2011, there were eight CMS staff to adjust workers' compensation claims and two claims supervisors. From our review of disposition codes in CMS' data, we identified 12,613 claims that were open as of July 2011. If these claims were distributed equally among adjusters, each adjuster would be responsible for 1,577 claims. If the two claims supervisors also assumed a caseload, the caseload would be 1,261 cases each. According to workers' compensation industry sources the typical adjuster caseload is 175 to 250 active claims per adjuster. The more cases an adjuster handles the less time that adjusters can spend on each case. If adjusters have too many cases to handle, this can drive less-than-desirable outcomes including medical and indemnity expenses being paid out longer than necessary. It should be noted, however, that a number of the 12,613 claims open as of July 2011 may be inactive and merely being held open by CMS until the expiration of the statute of limitations period. According to information provided by CMS, as of February 2012, there were 16,206 claims that had activity during the previous year. CMS was unable to provide the number of active cases by adjuster to the auditors.

STATE EMPLOYEE CLAIMS REPORTING

If a State employee is injured on the job or an illness is diagnosed, the first thing they should do is report the accident/illness to their immediate supervisor. The employee's immediate supervisor instructs the employee to call the 1-800 number for CareSys. CareSys is the intake vendor hired by CMS to take initial calls of injuries to State employees. By law, an employee is required to notify his or her employer of an accident ***within 45 days of the accident*** in most cases (820 ILCS 305/6 (c)).

CareSys completes and generates an IC-45 form (Employers' First Report of Injury) with the information provided through the initial phone call. CareSys, through an electronic interface, sends these reports to CMS. CMS' Bureau of Communication and Computer Services also sends a file to the Illinois Workers' Compensation Commission on the 8th and 21st of each month reporting injuries to State employees.

State Agency Workers' Compensation Coordinators

Each State agency has a workers' compensation coordinator. Some agencies such as DHS or Corrections have a coordinator at each facility. CMS officials provided a list of all workers compensation coordinators and their related agencies. As of April 2011, there were 215 workers' compensation coordinators serving agencies and facilities around the State.

The agency workers' compensation coordinator provides the injured employee with a packet of information to complete for a workers' compensation claim. This packet includes forms such as the Employee's First Notice of Injury (CMS 900-1), the Supervisor's Report (CMS 900-3), a Witness Report (CMS 900-6), etc.. These forms are also available online. The Employee's First Notice of Injury must be completed within 24 hours (some employing units of government may have other established or negotiated guidelines) or as soon as the employee is physically capable. When completed, the agency workers' compensation coordinator forwards the information to CMS Bureau of Benefits.

Untimely Reporting

Workers' compensation claims are required to be reported to the employer within 45 days of the accident in most cases. We received a download of all claims filed for the period 2007 through 2010 provided by CMS. Our analysis showed that of the 26,101 claims filed for the four-year period, 1,318 claims (5%) took longer than 45 days from the date of injury to the date reported in CMS' system. According to data provided by CMS, of the 3,621 settlements reached between the CMS, the Attorney General, and the injured employee, 317 (9%) took more than 45 days to report. For the 611 awards issued by Arbitrators with the Commission, 62 (10%) took more than 45 days to report.

Of the 109 settlement and award files we reviewed, 26 (24%) took more than 45 days from the date of the injury to the date the injury was reported according to CMS data. According to CMS responses, 4 of these 26 claims were initially denied for compensability. An award was

made by a Commission Arbitrator in 10 of the 26 cases. Issues we identified in these cases included:

- **Inaccurate dates in CMS' system for date reported**. Of the 26 claims cases that were reported more than 45 days after the injury, 9 did not match the date reported that was provided in the CMS download, and for one case we could not determine if the date reported was correct. As an example, in one case the accident date in CMS's information system was listed as January 14, 1986. The date reported in CMS's information system was May 6, 2008. This case received an award from a Commission Arbitrator in 1989. The claim was actually reported January 27, 1986, on the IC-45 according to CMS.

- **Additional claims reported while employee was on leave for a claim**. In three cases we reviewed, the injured employees while on leave filed an additional claim for carpal tunnel syndrome. For example, in one case an employee injured her neck on March 28, 2007. While this employee was on leave for nearly two years, she filed an additional claim for Carpal Tunnel Syndrome on March 26, 2009. These claims were both settled May 4, 2010, for $149,999.99 (neck injury), and $51,320.76 (carpal tunnel). As part of the settlement, the employee agreed to resign.

Repetitive Motion Injuries and Manifestation Dates

For Carpal Tunnel Syndrome and other repetitive motion claims the date of the accident was sometimes years prior to the date reported. This occurs because these claims are reported only after the injury or condition is diagnosed or ***manifests*** itself. This could occur even after leaving employment or retiring.

Example of Carpal Tunnel Syndrome Injury and Accident Date Reporting:

A secretary at a Correctional Center for 20 years ceases working on June 27, 2002. On June 19, 2006, nearly four years after leaving employment with the State, the employee filed an Application for Adjustment with the Workers' Compensation Commission for Carpal Tunnel Syndrome. The Accident Date listed on the Application is the last day worked (June 27, 2002). CMS' system shows a reported date of November 3, 2010 (eight years after leaving employment). Although the employee did not file with the Commission within three years of the accident date and CMS was not notified within 45 days of the accident date, an Arbitrator at the Commission awarded the employee 17.5% of the right dominant hand and 15% of the left hand.

In a meeting with the Attorney General's office, an official stated that claims involving repetitive motion injuries oftentimes list the diagnosis date as the manifestation date, and that it is permissible by law. The official also stated that in order to deny these types of claims a statutory change would be required. We were provided the workers' compensation statutes from another state (Kansas) which contain a more specific definition for repetitive motion manifestation dates and reporting requirements. The other state's statute also delineates that the repetitive trauma must be the ***prevailing factor*** in causing the medical condition and resulting disability or impairment rather than a contributing factor.

According to officials from the Attorney General's office, they have challenged some cases at the Commission on the basis that they were not filed timely. They provided two case examples that they had lost. In one of the examples the accident date is listed as May 10, 2006, and the injury reported date is October 23, 2008 – almost two and a half years after the accident date. The petitioner stated that she told her supervisor and a Human Resources official about her injury. Neither the Human Resources official nor the supervisor could remember conversations regarding her complaints or medical treatment. However, the supervisor did testify that he remembered the petitioner wearing splints. As part of the Arbitrator's decision, the Arbitrator stated that "… Petitioner provided Respondent with proper notice regarding her condition of ill-being…"

Officials at the Attorney General (AG) explained that part of the problem is that there is nothing to formally document when an employee notifies his or her supervisor of an injury. Sometimes it is just a verbal notification. According to AG officials, even if the supervisor can't remember, the employee can simply say that they told them and it may become a case.

Documenting supervisory notification of an injury by the employee is critical when filing a claim because by law the employee must notify the employer within 45 days of the accident or injury. Although there is a form for supervisors to complete, supervisor notification can also be verbal and is not always documented. The CMS 900-3 (Supervisor's Report of Injury or Illness) contains information regarding how (oral or in writing) and when (date and time) the supervisor was informed by the employee of the accident or injury. The supervisor then signs the form. However, this form was missing or incomplete in 19 percent of the CMS case files we reviewed. Without written notification or a completed form, it is difficult to verify whether an employee notified his or her supervisor and if it was within the required 45 days. Without documentation of notification it may also make it difficult for the State to mount a defense on the basis of untimely notification.

CLAIMS REPORTING	
RECOMMENDATION 3	***The Department of Central Management Services should take steps to:*** • ***Deny claims that are not filed within 45 days of the accident unless extenuating circumstances are documented;*** • ***Ensure that accident dates in its information system are accurate;*** • ***Define accident date for repetitive trauma cases in the Department's administrative rules or policies and procedures; and*** • ***Ensure that supervisory notification by the employee of an injury is documented in writing.***
DEPARTMENT RESPONSE	Agreed. Adjustor caseloads are at least 4 times the recommended industry standard for proper management of workers' compensation

(Department Response Continued)	claims. Improved data and documentation quality management can be achieved with additional CMS adjustor resources. • The majority of claims that are not reported in 45 days are denied by CMS. The IWCC has not always bound itself to this rule and claims can be reported verbally which may give the appearance they were reported later. • Accident dates in the system come electronically from the IC-45. • Repetitive claims are more complicated in that the date of the first medical treatment may be different than the original accident date reported. There is no actual accident date; therefore, the first date of treatment is used. This data input changes the accident date and may not match the original IC-45. Accident date definitions and supervisory sign-off requirements will be included in our updated policy and procedure manual and reinforced through training. However, this will not necessarily result in a definitive decision on the accident date for repetitive claims. Until such time as the date is delineated in statute, the date will remain open for interpretation. CMS will seek legislation to tighten up requirements.

ADJUSTING WORKERS' COMPENSATION CLAIMS

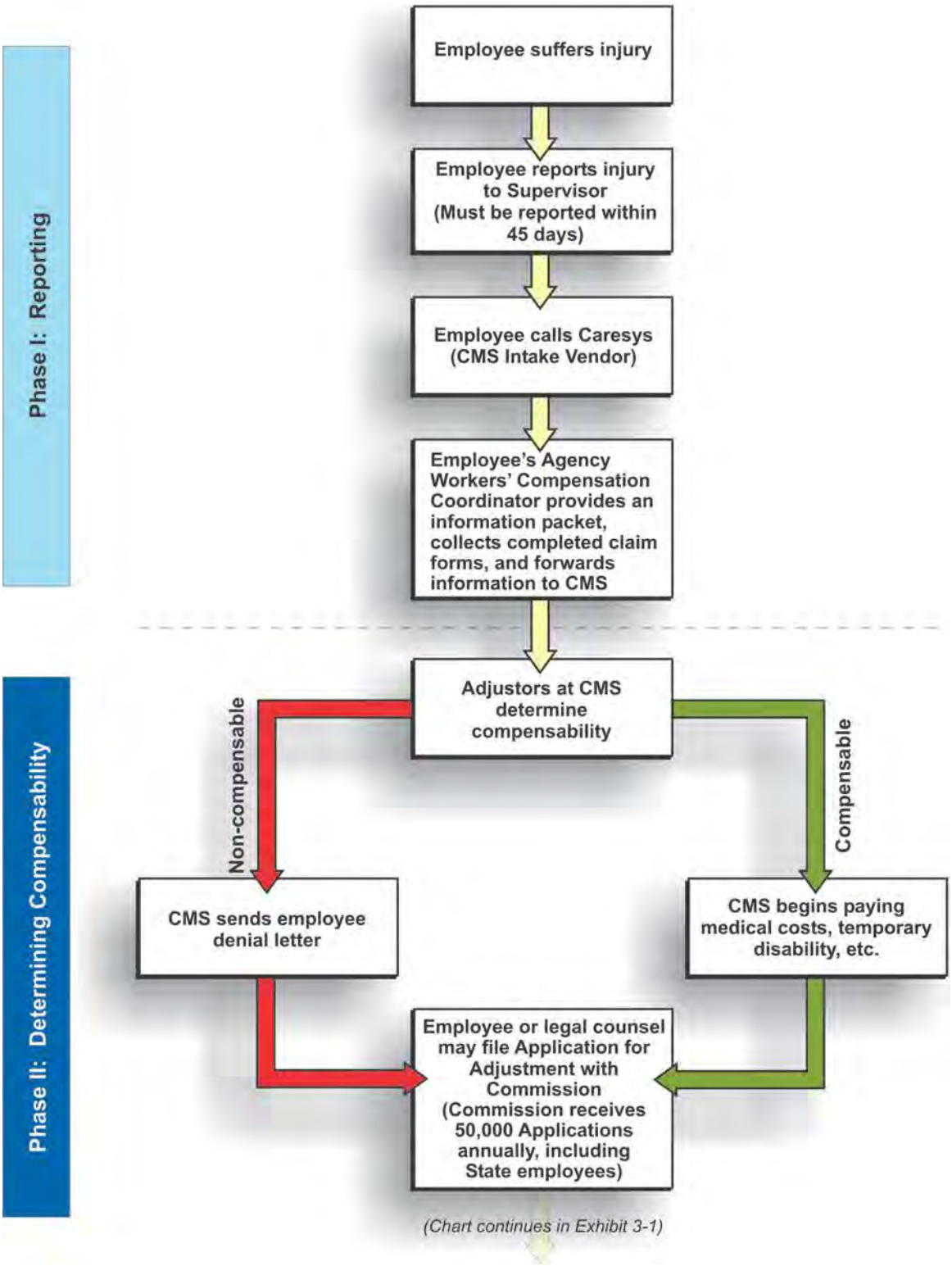
Adjusting workers' compensation claims is the responsibility of the Risk Management Division located in CMS' Bureau of Benefits. When the information from the agency workers' compensation coordinator arrives at CMS, an administrative clerk starts a file for the claim and does the following:

- Ensures the claim is not a duplicate (for example, the coordinator may send the claim twice).

- Checks to see if all of the forms were completed properly and identifies any missing information. The following are required forms:
  - ✓ IC-45 (Employer's First Report of Injury)
  - ✓ CMS 900-1 (Employee's Notice of Injury)
  - ✓ CMS 900-2 (Initial Medical Report)
  - ✓ CMS 900-3 (Supervisor's Report)
  - ✓ CMS 900-4 (Summary of Disability)
  - ✓ CMS 900-5 (Information Release Authorization)
  - ✓ CMS 900-6 (Witness Report) (if applicable)

Exhibit 2-1

REPORTING AND ADJUSTING A WORKERS' COMPENSATION CLAIM



Source: CMS flowcharts and system narrative from CMS Compliance Examination.

Without the forms listed above, the file is not considered complete. These forms not only describe the injury and how it occurred, but they also contain statements from supervisors, witnesses, and physicians that examined the injured employee. The CMS 900-7 form (Demands of the Job) is not required but is preferred. If there is information missing, the administrative clerk e-mails the agency workers' compensation coordinator to request the information.

The documents received from the agency coordinator are date stamped. If the information is complete, the administrative clerk creates a permanent file and updates the system status to pending. The file is then sent to the appropriate workers' compensation claims Adjuster. CMS workers' compensation Adjusters are assigned claims according to the agency and work location of the injured employee.

As of May 2011, there were eight CMS staff to adjust workers' compensation claims. When an Adjuster receives a claim file, he/she reviews the forms to ensure they are complete. The Adjuster specifically reviews the medical reports that the physicians complete, the CMS 900-2 (Initial Medical Report). Not all claims will have a medical report or the CMS-95 (physician's statement form). All files that have a request for medical benefits to be paid will have a medical report included in the file. Also, any file that has an award or settlement associated with it will have medical reports included as well. However, files that are for "incident only" reports may not have a medical report included in the file. "Incident only" reports are filed by employees to demonstrate that notice was given promptly that an event has occurred but at the time of filing there is no known injury or expected claim.

The Adjuster also reviews the date the injury occurred and compares it to the date that the injury was reported. If the injury is reported to the agency more than 45 days from the date of injury, CMS may deny the claim. The Adjuster also checks to see if there were any witnesses and if the witnesses completed the 900-6 Witness Report Form. Cases are coded as "pending" if they are waiting for the medical reports or other information. If there is information missing from the file, the Adjuster sends a request for more information to the agency coordinator.

When the Adjuster has all of the required information, he or she determines if the claim is compensable. According to CMS Risk Management Division Policy 06.02.00, a workers' compensation claim is determined to be compensable if: the injury or illness arose out of and in the course of employment, if notification was provided to the employer in a timely manner, and if there is a direct and causal relationship between the type of injury and the accident.

When the file is complete and a determination of compensability has been made, the Adjuster sends the claim file to the Unit Supervisor for review and concurrence. The Supervisor reviews the file and is responsible for updating the claim file status. A "Claims Status Report" form (IL 444-4220-1) is completed by the Adjuster by dating and initialing the status box and indicating the location and nature of the injury and claim status.

Prior to June 2011, a supervisor was not required to review or approve the Adjuster's determination of compensability. The Adjuster was responsible for the initial determination of compensability, ongoing medical benefits, and Temporary Total Disability benefits (TTD) until the claim was settled. ***Prior to June 2011, the supervisors were only involved if there was a***

dispute or question about the claim or if the claim was denied. According to CMS officials, Supervisors now review the claim file and the Adjuster's determination of whether the claim was compensable.

Medical bills are reviewed by staff from Coventry (a contract vendor) that is located on-site at CMS. Physicians submit medical bills related to each claim. The adjusters, along with CareSys, give payment authorization. Medical bills go to and are approved by Coventry based on the relationship of the treatment to the injury or illness of the claimant (employers are not guaranteed access to the treatment plan for the claimant). If someone from Coventry has a question about a bill, they will consult with an Adjuster.

If there is disagreement between the Adjuster and supervisor, or there are problem medical bills, independent medical exams, or settlements, the Manager of the Claims section may become involved. The Manager of Claims also gets involved if there is a request for surveillance or a request to refer a case to the DOI Fraud Unit. Referrals for investigations are forwarded to the Manager of the Loss Control/Special Projects/Training Section.

Required Forms Missing

We reviewed workers' compensation claims that received a settlement or an award to determine if all required forms were contained in the file and whether those forms were completed appropriately. Exhibit 2-2 shows the forms that were missing or incomplete for the settlement and award files we reviewed.

The CMS 900-1 (Employee's Notice of Injury) contains information such as the date and time of the injury, the date the injury was reported to the injured employee's supervisor, the duty the employee was performing at the time of the injury, a detailed description of where and how the injury occurred, whether there were any witnesses, and whether a negligent third party was responsible for the injury. It also asks the employee to list any previous injuries and whether it was for workers' compensation. Of the settlement and award files we reviewed, this form was missing or incomplete in 21 percent of cases.

Exhibit 2-2
MISSING AND INCOMPLETE REQUIRED FORMS

Form	Description	Files Missing Forms	Files With Incomplete Forms	Total Missing and Incomplete
CMS 900-1	Employee's Notice of Injury	8	15	23 of 109
CMS 900-2	Initial Medical Report	39	17	56 of 109
CMS 900-3	Supervisor's Report	10	11	21 of 109
CMS 900-4	Summary of Disability	7	2	9 of 109
CMS 900-5	Information Release Authorization	9	41	50 of 109
CMS 900-6	Witness Report	10	n/a	10 of 40

Source: OAG review of 109 workers' compensation settlement and award files.

The CMS 900-2 (Initial Medical Report) contains information regarding the injured employee, the accident, the diagnosis, and details regarding the nature and extent of the injuries. The physician completing the form is also asked to list the prognosis, estimated date of return to work, and whether there are any restrictions placed on the employee. The form is also required to be signed by the examining physician. In one case we reviewed the examining physician was the injured employee.

In two different places on the 900-2 form it states, **"Your detailed completion of this report is also necessary to enable our office to process your itemized bill for payment."** In over half of the cases we reviewed (51%), the form was either not in the file or was not complete. Medical payments of $3,417,482 were made in these cases.

Supervisory notification by the employee is critical when filing a claim because by law the employee must notify the employer within 45 days of the accident or injury. Although there is a form for supervisors to complete, supervisor notification can also be verbal and is not always documented. The CMS 900-3 (Supervisor's Report of Injury or Illness) contains information including the job title of the injured employee, number of years in current job title, and whether the activity the employee was doing at the time of the injury was within the scope of his or her employment. It also contains sections to list the cause of the accident, whether any corrective action was taken, and how and when the supervisor was informed by the employee of the accident or injury. The supervisor then signs the form. The supervisor's report was missing or incomplete in 19 percent of cases reviewed.

The information used in the Average Weekly Wage (AWW) calculation is provided by the agency workers' compensation coordinator on the 900-4 form. The CMS 900-4 (Summary of Disability) shows the benefits utilized as a result of the accident, including the number of days off and the date returned to work. More importantly, it contains a section for "Computation of Workers' Compensation Rate" including the yearly salary of the employee, mandatory overtime income, the Average Weekly Wage Salary, Weekly TTD Rate, Daily TTD Rate, and PPD Rate. Workers' compensation benefits paid by CMS are based upon this information. There was no evidence that CMS conducts checks to determine if information provided for AWW is accurate. There were at least four instances in which the 900-4 AWW did not match the AWW on the award or settlement, and at least three instances in which the AWW on the IC-45 did not match the AWW on the award or settlement. As an example of the inconsistencies, for one case the initial accident report (IC-45) lists the AWW as $830.96. The Application for Adjustment from the Commission lists the AWW as $984.46. The final settlement contract lists the AWW as $916. There was no documentation contained in the file regarding verification of any of these amounts. The AWW numbers are generated by payroll at the agency of the injured employee. CMS **Adjusters do not have access to payroll information for the injured State employees and must rely on the agency for this information.** In addition to the instances in which the AWW was inconsistent on the various forms, we noted another 9 files (8% of the files we reviewed) in which the form for reporting AWW was missing or incomplete.

The CMS 900-5 (Information Release Authorization) is completed by the employee in order to allow physicians, hospitals, and other medical providers to furnish records and reports to CMS so that the claim can be adjudicated. Completion of the form is necessary to allow medical

information to be shared with relevant parties and a waiver is required by the Health Insurance Portability and Accountability Act (HIPAA). In almost half of the files reviewed, 46 percent, the form was either not in the file or was incomplete.

The CMS 900-6 (Witness Report) is to be completed by employees who witnessed the accident. Although there is not always a witness, we identified 10 cases in which potential witnesses existed but did not complete a form.

Incomplete and missing forms have been an ongoing issue for the CMS Bureau of Risk Management since at least 2005. We reviewed internal audit reports conducted in 2005 and 2010 of CMS Risk Management. In the 2005 report, there is a material finding citing incomplete forms and a lack of controls to determine timely submission of required forms. In the 2010 report, there is a material finding that the claims forms did not include all elements identified and required by the Risk Management Policy and Procedures Manual. There is also an immaterial finding in the 2010 report that the reviewed files did not contain all of the required documentation. According to the internal audit, the forms were either misfiled or were unavailable for review.

As a result of these weaknesses, CMS is determining compensability with incomplete file information. As an example of the extent of missing forms, one case that we sampled involved an Arbitrator at the Commission who was injured on November 12, 2009. The accident was reported on December 29, 2009, to CMS. On December 30, 2009, CMS authorized evaluation and treatment for the injury. Documentation that was in the file at CMS was minimal at the time of authorization. The file contained an e-mail dated May 13, 2010, to the workers' compensation coordinator at the Commission that stated "We have been going through an audit… The audit findings are that we have not received the following forms":

- 900-1 Employee's Notice of Injury
- 900-3 Supervisor's Report
- 900-4 Summary of Disability
- 900-5 Information Release Authorization
- 900-6 Witness Report

A draft settlement contract was sent to the employee by the Attorney General on May 12, 2010. Therefore, the contract had been negotiated even before the forms were in CMS' files. The settlement contract was approved by an Arbitrator on June 15, 2010.

Other Claim File Issues

In addition to missing and incomplete required forms:

- **Incomplete Claims Status Report Forms** – A Claims Status Report Form is included in each file. These forms show the date of the initial review of compensability, the Adjuster conducting the initial review, and the claims status. The Claims Status Report Form is also used by the Risk Management Division staff to make ongoing notes concerning the progress of the claim. The form also documents actions taken on the case and the date of those actions. CMS Adjusters did not

always complete Claims Status Report Forms that are used to track the claim's progress. In some cases the form was in the file but was incomplete or blank.

- **No Supervisory Review of Compensability –** Files did not contain evidence that a Claims Supervisor had reviewed the Adjuster's determination of compensability. Some files were adjusted by the Supervisor. Once compensability is determined, CMS may begin payment of benefits and these amounts can be significant. Therefore, it is critical that decisions are reviewed and approved by a Supervisor. According to CMS officials, beginning in June 2011 supervisors began reviewing all claims for compensability.

- **TTD Benefits But No Request -** For cases in which the employee had lost time and received Total Temporary Disability, we identified 27 cases in which there was no formal request in the file for these benefits.

- **Medical Bill Transmittal Forms Not Always Properly Approved** – Medical bills and the substantiating documentation are required to be accompanied by a Medical Bill Transmittal Form (IL 444-4198), which outlines the pertinent information to be utilized to enter the transaction into the Workers' Compensation Information System. The bill is then forwarded by the agency workers' compensation coordinator to CMS' Risk Management Division where status is determined and matched to the appropriate claim file. Depending upon claim file status, the bill is reviewed and liability is determined by the Medical Audit Unit. For those claim files with lost time or with a work accommodation (limited duty, return to work), the bill is forwarded to the assigned Adjuster for review and approval, followed by submission to the Medical Audit Unit. The Medical Bill Transmittal Forms that we reviewed were not always dated and were usually approved with illegible initials. Some were not dated or approved. Even large medical bills over $100,000 were not always dated and did not require any special approval. Some cases contained a "High Dollar" approval form while others did not.

CLAIMS ADJUDICATION	
RECOMMENDATION 4	***The Department of Central Management Services should:*** • ***Ensure that all applicable forms are collected prior to any determination of compensability or benefits payments;*** • ***Conduct training for all adjusters and agency workers' compensation coordinators regarding filing procedures and required forms;*** • ***Require a claims supervisor to review all determinations of compensability;*** • ***Obtain access to payroll information required to verify average weekly wage amounts for employees who submit claims;*** • ***Require employees to formally request temporary disability benefits prior to receiving benefits; and*** • ***Ensure thorough review of all medical bills prior to payment.***
DEPARTMENT RESPONSE	Agreed and partially implemented. Adjustor caseloads are at least 4 times the recommended industry standard for proper management of workers' compensation claims. Improved data and documentation quality management can be achieved with additional CMS adjustor resources. • CMS makes every effort to collect forms prior to any determination of compensability or benefit payments. However, the statute does not allow for a denial of payment merely because a form has not been received, particularly if the submission of that form is not the responsibility of the insured employee. • CMS will conduct training once updates to the policy and procedure manual are complete. It is the department's intention to move this to an annual training. • Supervisors have been reviewing all claims of compensability since June 2011. Policies and procedures will be updated and reinforced through training. • Access to payroll systems across all agencies may be difficult, especially for those agencies independent of the Central Payroll System. Sufficient documentation could be developed in coordination with the agencies as an alternative.

(Department Response Continued)	• Employees request occupational leave and TTD through their agency, which is sent to CMS on a TTD voucher for time off work. CMS considers this to be the formal request for TTD and does not require a separate document. • CorVel is our medical bill review vendor effective September 2011. All medical bills and corresponding medical reports are now reviewed and paid on-line.

Subrogation

CMS reviews each new claim file to determine whether there is a third party that may be responsible for some of the costs associated with the injury or incident. According to information provided by CMS, for FY10 subrogation resulted in the recovery of $1.3 million. The Supervisor of Pensions and Subrogation reviews files identified by the CMS Adjusters and Claims Supervisors as possible opportunities and determines if there is a possibility for recovery of funds. During our file review, we identified three cases where subrogation was pursued. In one case, $350,000 was recovered; in another case $100,000 was recovered. CMS has a default judgment against the 3rd party in the other case. The 3rd party did not show up at the hearing and CMS won the case by default for the full amount of the lien. As of February 2012, CMS had not received payment from the 3rd party.

Although CMS was able to recover funds for the State through subrogation, we determined that timely pursuit of subrogation is an issue. For one of these cases, the amount was not recovered for over three and a half years after the settlement date.

- For the case in which $350,000 was recovered, the accident occurred in March 2007. There is a January 12, 2010 note on the Claims Status Report Form that says "Nothing done on Subrogation – SoL [Statute of Limitations] expired 3/28/2009 – luckily a 3rd party suit is pending." The subrogation recovery was not recorded as received until December 9, 2010. If there had not been a pending third party suit, the State may have not been able to recover the $350,000.

- For the case in which $100,000 was recovered, the accident occurred in April of 2008, and the subrogation amount was not recorded as received until February 9, 2011. There is an April 11, 2009 note on the Claims Status Report Form that states "This file was never given to me to review for subrogation. No crash report. No lien letters sent.…"

- For the case that was awarded a default judgment, the accident occurred in October 2007, and the Claims Status Report Form states in a December 9, 2008 entry that "Due to workload and no support staff – unable to pull file until now. Will request DOT for crash report and send lien letters." The lien letters were sent to the third party on March 25, 2009.

Prior to June 2011, it was solely the Adjusters' responsibility to determine if subrogation should be pursued. Currently, the Risk Management supervisors review all files for the possibility of pursuing subrogation. For subrogation, there is a two year statute of limitations on commencing a proceeding against the third party. However, the State cannot commence a proceeding against a third party until three months prior to the time such action would be barred because the injured individual is allowed to file first. If subrogation is not pursued in a timely manner, the State may miss opportunities to reduce its costs by recovering funds from third parties since the passage of time makes identifying responsible third parties and collecting from them less likely.

DETERMINATION FOR SUBROGATION ELIGIBILITY	
RECOMMENDATION 5	***The Department of Central Management Services should ensure that cases in which subrogation can be pursued are reviewed in a timely manner.***
DEPARTMENT RESPONSE	Agreed. Currently, headcount, technology and resource limitations hamper the ability for short-term improvements in this area. Prior to consolidation in 2004, CMS had one employee devoted to subrogation and total permanency cases and, at one point, ISP had one employee devoted to just subrogation. Following consolidation, the volume of cases in which subrogation could be sought increased dramatically. CMS currently has one employee devoted to subrogation and total permanency cases statewide. This issue should be reviewed by the State Workers' Compensation Program Advisory Board for best practice recommendations.

Permanent Total Disability, Wage Differentials, and Deaths

Some employees receive Permanent Total Disability (PTD) benefits as a result of an award. A monthly benefit is paid along with medical bills related to the workers' compensation injury or illness. Each year an annual affidavit is sent to each person on PTD to make sure they are still alive, not working, and to see if anything else has changed. The benefits are provided for the lifetime of the employee on PTD. According to CMS, there were about 450 people who fell into this category as of June 2011. There are no settlements in these cases, only awards. PTD claims also receive a rate adjustment check from the Commission's Rate Adjustment Fund (820 ILCS 305/8 (g)).

Wage differentials are sometimes necessary when a person is deemed able to work after an injury but is unable to earn as much money as he or she did prior to the injury. This is necessary to compensate for reduced earnings due to his or her permanent disability. These claim files are assigned to the Pension Unit at CMS. The eligible employees get a check from the Commission's Rate Adjustment Fund if they are still able to perform some kind of work. Employees who receive wage differentials can also receive social security benefits, social security settlements, etc.

Job related death cases are also processed by CMS' Pension Unit. If an injury results in death, the eligible survivor is entitled to benefits, including $8,000 for funeral expense reimbursements. Workers' compensation payments are also made to eligible survivors such as spouses and dependent children. Annual affidavits are sent to the surviving spouses in death cases to see if they have remarried. If a spouse remarries, he or she gets a two year lump sum payment and the case is closed.

We asked CMS if matches are performed to determine if a spouse of a deceased employee receiving survivor benefits has remarried. CMS officials stated that this information is requested from the survivor on the annual affidavit. However, relying on self reported data to make determinations on a recipient's eligibility status without independent verification is more likely to result in inappropriate benefit payments.

It is difficult for CMS to obtain information regarding employees receiving TTD or PTD to determine if there has been a change in wages or employment status. Matches are performed against Group Insurance data, but some employees are not members of Group Insurance, and it is difficult to get relevant information from other State agencies.

CMS officials provided e-mails that showed they have been trying to gain access to Illinois Department of Employment Security information as far back as December 2006. However, CMS' Bureau of Benefits Risk Management Division was not included in statutory language contained in the Unemployment Insurance Act, and consequently was not allowed access to this confidential information. Officials also stated that, in past years, CMS proposed legislation that would have allowed them access to the IDES information. Public Act 097-0621, effective November 18, 2011, now allows CMS Risk Management access to information in the possession of IDES that may be necessary or useful for the purpose of determining whether a recipient of a disability benefit or a State employee receiving workers' compensation benefits is gainfully employed.

PERIODIC DATA MATCHES	
RECOMMENDATION 6	***The Department of Central Management Services should perform periodic matches utilizing available information at the Illinois Department of Employment Security to ensure that employees receiving benefits are not employed elsewhere. CMS should also consider gaining access to other sources of information that may be helpful in identifying changes in marital status, deaths, and other circumstances that would affect the eligibility or amount of workers compensation benefits to which the individual is entitled.***
DEPARTMENT RESPONSE	Agreed and partially implemented. After pursuing DES data-sharing since 2006, PA 97-0621 was passed 11/18/11, allowing database access to verify claimant employment status. We currently have an Intergovernmental Agreement awaiting final execution by DES to begin the data sharing process. We also run reports to verify status for

(Department Response Continued)	claimants covered under our group insurance program. CMS has developed a new Risk Management position dedicated to improved data harvesting and sharing, reporting and fraud detection. We hope to have this position hired within the next several months.

CMS WORKERS' COMPENSATION ADJUSTER CASELOADS

CMS does not have caseload standards and could not always provide Adjuster caseloads. As of May 2011, there were 20 CMS staff processing workers' compensation claims, including preparing claims, adjusting claims, and approving medical bills and payments. Eight of the 20 CMS staff were Claims Adjusters. Prior to September 2004 when these functions were merged into CMS, there were 35 positions at all agencies related to the workers' compensation function. Only 27 of these positions were brought over to CMS when workers' compensation was consolidated in September 2004.

From our review of disposition codes in CMS' data, we identified 12,613 claims that were open as of July 2011. These claims were open because CMS was paying for medical costs, Temporary Total Disability, the claim was pending further information, or was open because the statute of limitations had not run out. If these claims were distributed equally among Adjusters, each Adjuster would be responsible for 1,577 claims. If the two claims supervisors also assumed a caseload, the caseload would decrease to 1,261 cases each. According to workers' compensation industry sources, the typical adjuster caseload is 175 to 250 active claims per adjuster. It should be noted, however, that a number of the 12,613 claims open as of July 2011 may be inactive and merely being held open by CMS until the expiration of the statute of limitations period. According to information provided by CMS, as of February 2012, there were 16,206 claims that had activity during the previous year. CMS was unable to provide the number of active cases by adjuster to the auditors.

There are many factors that affect adjuster caseloads, including how complex each case is or whether it is a questionable claim that may need investigation. Regardless, the more cases an adjuster handles the less time that adjusters can spend on each case. If adjusters have too many cases to handle, this can drive less-than-desirable outcomes including medical and indemnity expenses being paid out longer than necessary.

We asked CMS if they have reports that would show the number of open cases by Adjuster. CMS officials responded that they have a report that would show the number of lost time cases (cases in which the employee was on TTD) for each Adjuster. However, this would not include all claims cases.

While CMS staffing has remained static with eight Claims Adjusters and two Claims Supervisors to determine compensability of claims, the Attorney General's Office has increased the size of its workers' compensation bureau since 2004. The Attorney General had an average number of 17 employees in its workers' compensation bureau in FY 2004. By FY 10 there were 23 employees. Information provided by AG officials showed that as of January 2012, there were

a total of 22 Assistant Attorneys General (9 in Chicago, 13 Downstate) and a total of 37 staff in the workers' compensation bureau.

CMS ADJUSTER CASELOADS	
RECOMMENDATION 7	***The Department of Central Management Services should track Adjuster caseloads and consider establishing caseload standards for Adjusters.***
DEPARTMENT RESPONSE	Agreed. Adjustor caseloads are at least 4 times the recommended industry standard for proper management of workers' compensation claims. Improved data and documentation quality management can be achieved with additional CMS adjustor resources. CMS assigns caseloads by lost-time cases. The Claims Manager in Risk Management monitors adjustor caseloads by number of claims on TTD, extended benefits and light duty. Caseload standards could be beneficial, but caseloads are dictated by the number of adjustors available, authorized headcount and funding levels. Data and documentation issues are a direct result of high caseloads, as demonstrated by the comparison with industry standards. This issue should be reviewed by the State Workers' Compensation Advisory Board for best practice recommendations. Currently, headcount, technology and resource limitations hamper the ability for short-term improvements in this area.

Chapter Three

WORKERS' COMPENSATION COMMISSION AND ARBITRATOR CASELOADS

CHAPTER CONCLUSIONS

Establishing a case with the Workers' Compensation Commission is a separate process from filing a claim with CMS. Simply because an employee is injured on the job does not mean there will be a case filed with the Commission related to the injury claim. Many employees simply seek medical treatment and are back on the job quickly without filing with the Commission. In these cases, if there was a claim filed with CMS, CMS would have made a determination whether the costs of medical treatment should be paid to the medical provider by the workers' compensation program. However, the injured employee would not have received any form of monetary settlement or award. We were unable to determine the number of claims filed with CMS that were subsequently filed with the Commission because the workers' compensation information systems at each agency used different tracking numbers.

We found that improvements need to be made in the process for establishing a case with the Commission. We reviewed case files and found Applications for Adjustment of Claim were not always being filed with the Commission. An Application for Adjustment is a key document for the Commission because it is used to establish a case file, assign a case number, and establish the city in which the accident occurred so that a call site and Arbitrator can be assigned. **Of the 109 settlements and awards sampled, 13 (12%) did not contain an Application for Adjustment in the file at the Commission. There were also three case files in our sample that could not be located.**

Commission rules provide that cases that were filed three years ago or more must proceed to arbitration unless the parties show they have good reason to wait. These are known as "red-line" cases. Because of data accuracy issues, the status call and red-line reports were not accurate. The Commission has even posted a request on its website for assistance from parties in removing settled cases from the call lists. According to Commission data (received in August 2011), as of June 1, 2011, 2,515 cases were more than three years old, according to the date of the Application for Adjustment, but had not been closed out. However, because of the inconsistency of employer names in the Commission's system, it was not possible to determine how many of these were cases filed by State employees. Of the 109 cases we sampled that received a settlement or award, 15 (14%) were more than three years old and could have been dismissed. These cases were 36 to 164 days past the three year mark.

Data that we received from the Workers' Compensation Commission has severe limitations because the data has missing, inaccurate, and/or inconsistent information. Although we were able to analyze the overall caseloads for Arbitrators, we were unable to determine with any accuracy the number of cases involving a State employee assigned to each Arbitrator by employing unit (i.e. State agency) or by type of injury.

The Workers' Compensation Act requires annual performance reviews for Arbitrators. However, in our review of the personnel files for 31 Arbitrators assigned to call sites as of April 2011, we found that there were **no annual reviews being conducted to evaluate Arbitrator performance**. The personnel files did not contain any other information to indicate that reviews of Arbitrators' performance had been conducted.

ESTABLISHING A CASE WITH THE COMMISSION

Establishing a case with the Workers' Compensation Commission is a separate process from filing a claim with CMS. Simply because an employee is injured on the job does not mean there will be a case filed with the Commission related to the injury claim. Many employees simply seek medical treatment and are back on the job quickly without filing with the Commission. In these cases, if there was a claim filed with CMS, CMS would have made a determination whether the costs of medical treatment should be paid to the medical provider by the workers' compensation program. However, the injured employee would not have received any form of monetary settlement or award. We were unable to determine the number of claims filed with CMS that were subsequently filed with the Commission because the workers' compensation information systems at each agency used different tracking numbers.

We found that improvements need to be made in the process for establishing a case with the Commission. We reviewed case files and found Applications for Adjustment of Claim were not being filed with the Commission. An Application for Adjustment is a key document for the Commission because it is used to establish a case file, assign a case number, and establish the city that the accident occurred in so that a call site and Arbitrator can be assigned. Of the 109 settlements and awards sampled, 13 did not contain an Application for Adjustment in the file at the Commission.

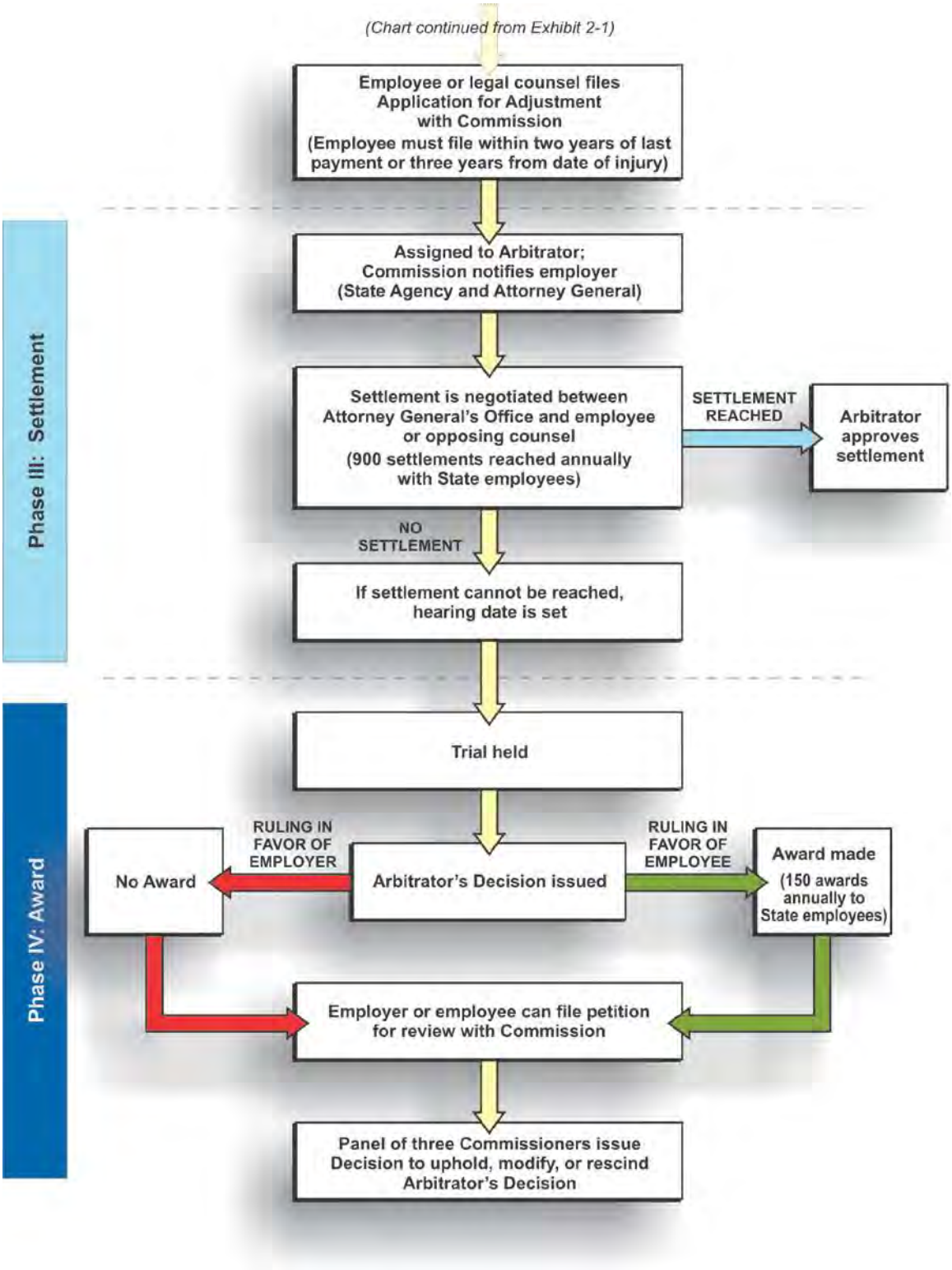
Because there was no Application for Adjustment filed for these cases, no file existed, a case number and call site had not been assigned, and an Arbitrator was not assigned in the information system.

Filing an Application for Adjustment

A case file is established at the Commission when an employee or the employee's attorney files an Application for Adjustment of Claim. ***Employees must file with the Commission within three years of the date of the accident or within two years after the last payment of compensation to the employee,*** except in cases of exposure to hazardous material. In the latter cases, the employee must file a claim with the Commission within 25 years after the last day an employee worked in such an environment (820 ILCS 305/6 (d)).

Exhibit 3-1

SETTLEMENT AND AWARD PROCESS FOR WORKERS' COMPENSATION CLAIMS



Source: Workers' Compensation Commission flowcharts and system narratives.

A case number is assigned at the Commission office in Chicago when the Application for Adjustment of Claim is received. If a claim is filed by the employee's attorney, an attorney representation agreement must also be filed. By law, attorney's fees are capped at no more than 20 percent of the recovery (820 ILCS 305/16a(B)).

Mail is received in the Commission's Chicago Office, opened, and all of the documents are date stamped. If the incoming document is an Application for Adjustment of Claim, in addition to date stamping, it is also given a sequential case number from a machine at the front desk that stamps the number on the application form. In addition to the Chicago Office, the Commission also has four other satellite offices (Collinsville, Rockford, Peoria and Springfield). If the application is received by a satellite office it is forwarded to Chicago where it is assigned a number just like the forms which are originally received in Chicago. Even though information may be sent to the satellite offices, all information and files are sent to and kept in the Commission's Chicago Office. There are 15 data coordinators and one assistant who perform the data entry. After data entry, the Application for Adjustment of Claim is filed in a hard copy file.

The Commission's computer system automatically generates a notice to the petitioner (the employee or the employee's attorney) and the respondent (the employer). For State employees, a notice is sent to the petitioner, the employee's agency, and the Attorney General's Office. As the insurer for the State, CMS does not receive this notification.

File Review and Applications for Adjustment

An Application for Adjustment is a key document for the Commission because it is used to establish a case file, assign a case number, and establish the city that the accident occurred in so that a call site and Arbitrator can be assigned. According to the Commission's rules, upon receipt of an Application for Adjustment of Claim the Commission shall assign a place for hearing and a date for initial status before an Arbitrator of the Commission in accordance with the applicable Act. "The place designated shall be a hearing site located in or nearest geographically to the vicinity in which the alleged accident or exposure occurred" (50 Ill. Adm. Code 7020.50). Of the 109 settlements and awards sampled, 13 did not contain an Application for Adjustment in the file at the Commission. According to the Commission's administrative rules:

> ***"Applications for Adjustment of Claim with a certificate setting forth the date of service shall be filed in triplicate on an appropriate form provided by the Commission. The filing party shall serve one copy of the Application which has been filed on all opposing parties."*** (50 Ill. Adm. Code 7020.20 (a))

The Commission's rules further state that:

> ***Application for Adjustment of Claim should be completed in full and must provide a description of how the accident occurred, the part of the body injured, the geographical location of the accident <u>for purposes of establishing venue</u>, and a description of <u>how notice of the accident was given or acquired by the Respondent</u>.*** (50 Ill. Adm. Code 7020.20 (c)) (*Emphasis added*)

According to Commission officials there are several reasons why there would be no Application for Adjustment in the case file. If the case was settled pro se (without an attorney), there is no application in the file and the Commission is not aware of the case until it receives, or

is notified of, a settlement agreement. This would also be the case if the case is settled by the petitioner and respondent's attorney if no application has been filed by the injured worker. In the case of State workers, CMS decides whether to pay benefits. At some point, the injured party may enter into an agreement with the Office of the Attorney General to settle the case. An Arbitrator approves the settlement agreement (which has already been agreed to between the worker and the AG) and then sends the settlement agreement to the Commission. Starting in the Spring of 2011, procedures were established and communicated to the Arbitrators that they are not allowed to approve settlement agreements without the party first notifying the Commission and being assigned a case number. Previously most of these cases were pre-assigned case numbers but these new written procedures improved file controls.

We also found that 3 of 109 files did not exist at the Commission. For one case that we sampled in which the petitioner was an Arbitrator with the Commission, there was no Application for Adjustment form filed with the Commission and officials had to create a file for us for this case. There is evidence in CMS' files that the injured Arbitrator had spoken directly with another Arbitrator about getting his settlement contract signed. The Arbitrator who signed the settlement contract was not the Arbitrator who was located at the call site nearest the location of the accident. The AG's file for this case contained a notice from the Commission (8 months after the settlement was approved) assigning a different Arbitrator to the case than the one who signed the settlement.

Because the Application for Adjustment lists the location of the accident for purposes of establishing a venue, it is not clear how the status call location/Arbitrator was determined in instances in which there was no application in the file. Not requiring injured employees to file an Application for Adjustment allows injured employees and/or the attorneys representing them to go to the Arbitrator of their choice instead of the call site nearest to the location of the accident as required by Commission rules.

According to the Commission, downstate settlement contracts were being reviewed by Arbitrators before the case was assigned a case number. The Commission estimates that this happened over 3,500 times in Calendar Year 2010. The Commission's system did not give it a way to determine if any of those contracts were getting entered into the Commission's system. The Commission changed its process as of March 1, 2011, and stated on its website that no settlement contracts will be approved until the case has been assigned a case number and setting. The case number and setting must now be entered on the face of each contract.

APPLICATIONS FOR ADJUSTMENT	
RECOMMENDATION 8	***The Illinois Workers' Compensation Commission should require an Application for Adjustment to be filed and a case file established in all cases, prior to the approval of any settlement agreements.***
COMMISSION RESPONSE	The Commission disagrees with this recommendation. The Commission believes that there are adequate safeguards for the current approval process for settlement contracts. The Arbitrator reviewing the settlement contract verifies that the contract has been presented to the correct venue for approval, based on the location of the accident.

(Commission Response Continued)	In addition, the parties themselves are an important check in this system. As Exhibit 4-1 of this Audit states, a settlement contract represents an agreement by both the employee and the employer, both of whom have consented to the submission of a settlement contract to an Arbitrator. However, if there were any malfeasance on the part of an Arbitrator in approving a settlement contract, this would be reportable to the Judicial Inquiry Board, the Commission Review Board, or possibly the Attorney Registration & Disciplinary Commission. Starting March 1, 2011, the Commission requires that each settlement contract presented to an Arbitrator for approval must have a Commission case number. Requiring an Application for Adjustment for settlement contracts would provide both duplicative information and also unnecessarily slow the approval of settlement contracts, a process which provides finality to both injured employees, who desire to obtain compensation for their claim, and employers, who strive to remove the pending liability for outstanding workers' compensation claims. ***Auditor Comment #1*** ***The Application for Adjustment helps ensure all necessary information is collected, maintained, and recorded and that a venue is established in accordance with Commission rules. Further, as recommended in Recommendation 14, the Application for Adjustment can be a useful tool in identifying when the claimant is a State employee.***

Arbitrator Assignments

When the case is input into the computer system it is assigned to an Arbitrator. The assignment process, however, varies depending on the area of the State in which the accident, injury, or illness occurred.

When a case is filed with the Commission, the Arbitrator assignment and hearing place are determined by the site of the accident. If the case is located in the Chicago area, the computer system randomly assigns the case to an Arbitrator in the Commission's Chicago office. If the case originates outside of Cook County, it goes to the nearest location. However, these assignments are not random downstate because certain locations are assigned to certain Arbitrators. Sometimes there is also a split call (two Arbitrators at one site). In these cases the computer assigns the site and the Arbitrator. If the accident occurred outside the State of Illinois and the petitioner is an Illinois resident, the case is assigned to a hearing location closest to the petitioner's home address.

Public Act 97-018 (effective June 28, 2011) now requires that at least three Arbitrators be assigned to each hearing site and cases must be randomly assigned to them. Arbitrators may not serve more than two years of any three-year term in any single county, other than in Cook.

Status Calls

After the case is assigned to an Arbitrator it goes on the Arbitrator's "Call Sheet" or pre-trial conference list. The notice of hearing is automatically generated by the computer system and sent to the employee or their attorney and the employer. Each Arbitrator holds a monthly status call of cases which appear on the Arbitrator's docket that month. At the status call half of the cases for each Arbitrator are heard each month. In Cook County these calls are at 2 p.m. on the date of the Arbitrator's assigned status call date. During the status call, all cases on the Arbitrator's call list are either continued, set for hearing/trial, or dismissed. The injured parties or their attorneys (law firm clerks usually) request trial dates at the call dates. If a trial date is not set, the case comes back up every two months on the status call list. Once a case is more than three years old, it can be set for trial without notice or be dismissed. These are referred to as "red-line" cases. Most cases are continued for another two months on the call date. After an Arbitrator hears his/her status call and sets cases for trial, the Arbitrator then hears and rules on other motions. These motions usually include consolidating cases for the same employee or dismissal of cases.

Arbitrators in the Commission's Chicago office have 10 trial dates per month. Cases involving petitions for immediate hearing under 19(b) and 19(b-1) of the Act are given preference for trial on the trial day.

The status call process for the downstate Arbitrators is different from the Cook County Arbitrators. Downstate Arbitrators have a status call and trial cycle per month for each location they are assigned, as is the process in Cook County. However, in areas outside of Cook County, each Arbitrator's monthly status call begins at 9 a.m. In addition, downstate Arbitrators begin hearing cases on the status call days. If the case cannot be heard on the call date itself, the Arbitrator will move the case over until the following day or a later day during the same trial cycle. Parties can also select a trial date later in the Arbitrator's schedule.

Status Calls and Red-Line Case Information

Commission rules provide that cases that were filed three years ago or more must proceed to arbitration unless the parties show they have good reason to wait. These are known as "red-line" cases. These cases can be dismissed by filing an IC-19 (Motion to Voluntarily Dismiss) or an IC-17 (Order to Dismiss for Want of Prosecution). If dismissed for Want of Prosecution, the parties have 60 days from the receipt of the order to file a Petition to Reinstate. At each call date the Arbitrator reviews the list of red-line cases and their status.

According to the Commission's rules, in all cases which have been on file at the Commission for three years or more, the parties or their attorneys must be present at each status call on which the case appears. The case will be set for trial unless a written request has been made to continue the case for good cause. Such requests shall be made part of the case file. The written request must be received by the Arbitrator at least fifteen days in advance of the status call date and contain proof of service showing that the request for a continuance was served on all other parties to the case and/or their attorneys. Any objection to a continuance must be received by the Arbitrator at least seven days prior to the status call date and contain a similar proof of service. The Arbitrator shall rule on such requests for continuances or objections thereto at the status call. The parties must appear at the status call even if there is no objection to the continuance. Failure of the petitioner or the petitioner's attorney to request or answer a request for a continuance as described above, or to appear at the monthly status call, shall result in the case being dismissed for want of prosecution, except upon a showing of good cause (50 Ill. Adm. Code. 7020.60 (b)(2)(C)(i)&(ii)).

Because of data accuracy issues (see Chapter One) the call status red-line reports are not accurate. At one call that we visited, during the reading of the red-line cases we observed that there were several errors in the status call report and attorneys who were present at the call had to tell the Arbitrator several times that cases listed as red-line cases had either been settled, a trial had occurred, or the cases had been dismissed months ago. For instance, in one case, the attorney told the Arbitrator that the case was settled four months ago; however, the case still appeared on the call list as a red-line case. According to the Arbitrator, incorrect data has been an ongoing problem with call lists for some time and either some of the information is not being input or it has been input incorrectly or not timely. The Commission has even posted a request on its website for assistance from parties in removing settled cases from the call lists.

According to Commission data (received in August 2011), as of June 1, 2011, 2,515 cases were more than three years old, according to the date of the Application for Adjustment, but had not been closed out. However, because of the inconsistency of employer names in the Commission's system it was not possible to determine how many of these were cases filed by State employees. Of the 109 cases we sampled that received a settlement or award, 15 (14%) were more than three years old and may have warranted dismissal. These cases were 36 to 164 days past the three year mark.

COMMISSION CALL LIST ACCURACY AND RED-LINE CASES	
RECOMMENDATION 9	***The Commission should take steps to ensure that the data on the call lists is correct and updated timely in order to accurately reflect the status of pending cases. The Commission should be proactive in removing cases that have been on the call list for more than three years.***
COMMISSION RESPONSE	The Commission agrees with this recommendation. There are several common reasons why a case remains on the status call after three years. Because of the nature of workers' compensation cases, some cases cannot be tried or settled until an injured worker has reached maximum medical improvement, which may, depending on the nature and extent of the injury, take longer than the three- year period set forth in the Commission's Administrative Rules. The case may have been remanded back to the arbitration level pursuant to an order issued by the Commission on review or even the State circuit or appellate courts. The parties may be waiting for a trial because of a factor external to the Commission or the injured worker, such as approval for a Medicare Set-aside Arrangement (MSA) from the federal Centers for Medicaid and Medicare Services (CMS). As part of its overall IT improvement plan, the Commission will search for a case management system that will facilitate the removal of settled, tried, or dismissed cases from the status call, a process which is impacted by the logistical challenge of documents originating from the Commission's 16 statewide hearing sites that are then processed in Chicago.

ARBITRATOR CASELOADS

Data that we received from the Workers' Compensation Commission has severe limitations because the data has missing, inaccurate, and/or inconsistent information. Because the data field in the Commission's information system used to identify State employees is not always accurate and because of the inconsistent methods used to record the employer name for each claim, **we were unable to determine with any accuracy the number of cases involving a State employee assigned to each Arbitrator** by employing unit (i.e. State agency) or number assigned by type of injury. We were, however, able to analyze the overall caseloads for Arbitrators including all private and governmental cases.

Although the Commission information system contains the employer/agency name it is entered inconsistently and multiple ways making it impossible to determine the employer with any degree of accuracy. For example, for Chester Mental Health Center we identified at least twelve different spellings or abbreviations. For the four-year period we identified 647 cases listed 54 different ways that start with the word "Menard." Further, some employers' listings contain only abbreviations. Therefore, **to obtain an accurate number of <u>State employees</u> for the four-year period, a manual review of the Commission's data (218,376 records) and files would need to be conducted.** Further, for **injury information associated with each case, we determined that 63 percent of cases did not contain this information** (138,573 of 218,376).

The data provided by the Commission contained 218,376 total cases. Of those, 9,794 cases had no Arbitrator assigned (see Exhibit 3-2). Commission officials responded that these cases were closed due to settlement on or before the date the case was entered. According to Commission officials, this occurred because the case was brought before arbitration the same day it was entered into the mainframe. This generally happens with pro se cases because the settlement contract is brought to the Arbitrator before filing an Application for Adjustment of Claim.

Cases are not assigned to arbitrators when they are closed on the same day the case is filed or if the Application for Adjustment of Claim lacks address information necessary for the computerized randomizer to determine a hearing location. Of these cases, at least 246 appeared to involve State employees.

Arbitrator Cases Assigned

For the cases that had an Arbitrator listed as assigned, there was a wide variance in the number of cases assigned to each Arbitrator during the four-year period. Because we could not break the cases out by employer, Exhibit 3-2 represents cases for all employees, both private and governmental.

The Arbitrator with the highest number of cases assigned was Jeffery Tobin with 8,754 cases. The Arbitrator with the lowest number of cases assigned that was with the Commission for the entire time period was Robert Lammie with 3,373 cases. Paula Gomora had 980 cases assigned but left the Commission in 2008.

The actual number of cases assigned to each Arbitrator is likely inaccurate because there were also 9,794 cases which were classified as Arbitrator/Commissioner Not Assigned, and 5 cases that were left blank in the assigned field.

The total number of cases assigned for the time period was 218,376, while the total number of cases closed for the same time period was 134,391. This represents a backlog of 83,985 cases that were open as of the date the data was received (August 2011).

Arbitrator Cases Closed

The number of cases closed by Arbitrators also varied greatly as well (see Exhibit 3-2). However, there is some question as to the reliability of closed case data. We observed during the reading of "red-line cases" at a status call that there were several errors in the status call report and that attorneys had to tell the Arbitrator several times that cases listed as red-line cases had either been settled, a trial had occurred, or the case had been dismissed months ago. According to the Arbitrator, incorrect data has been an ongoing problem with call lists for some time. The Arbitrator said that the status call lists are printed in Chicago and either some of the information is not being input or it has been input incorrectly or not timely.

It should also be noted that, just because an Arbitrator is assigned a case, it does not necessarily mean that the same Arbitrator will close the case because the Commission sometimes redistributes caseloads. This is particularly true in Chicago because of the random assignment of cases.

Exhibit 3-2
ARBITRATOR AND COMMISSIONER CASES ASSIGNED AND CLOSED
For All Cases Both Private and Governmental
2007-2010

Arbitrator/ Commissioner Name	Cases Assigned	Cases Closed	Percent Cases Closed
Unassigned	9,794	9,408	96%
Stephen Mathis	8,569	5,358	63%
Jeffery Tobin	8,754	5,343	61%
Jennifer Teague	5,414	5,142	95%
John Dibble	5,331	5,056	95%
Neva Neal	8,629	4,958	57%
Douglas Holland	7,450	4,925	66%
Ruth White	8,563	4,878	57%
Anthony Erbacci	7,758	4,606	59%
Andrew Nalefski	7,481	4,556	61%
Peter O'Malley	7,234	4,214	58%
Jacqueline Kinnaman	7,793	4,117	53%
Peter Akemann	7,345	4,095	56%
Leo Hennessy	3,947	3,897	99%
Gerald Jutila	6,239	3,618	58%
Edward Lee	5,655	3,601	64%
Joseph Prieto	6,174	3,575	58%
Gilberto Galicia	6,137	3,570	58%
Robert Williams	6,216	3,545	57%
Milton Black	6,116	3,525	58%
Richard Peterson	6,158	3,518	57%
Kurt Carlson	6,119	3,516	57%
Kathleen Hagan	6,235	3,509	56%
Charles DeVriendt	6,074	3,498	58%
David Kane	6,269	3,451	55%
Maureen Pulia	6,211	3,450	56%
Joann Fratianni	6,243	3,424	55%
James Giordano	6,192	3,370	54%
George Andros	5,916	3,305	56%
Gregory Dollison	6,030	3,259	54%
Brian Cronin	5,821	3,240	56%
Robert Falcioni	6,145	3,086	50%
Paula Gomora	980	975	99%
Robert Lammie	3,373	793	24%
(Blank)	5	4	80%
Valerie Peiler	3	3	100%
Comm. Donohoo	1	1	100%
Comm. Demunno	1	1	100%
Comm. Dauphin	1	1	100%
Grand Total	**218,376**	**134,391**	62%

Source: OAG analysis of Workers' Compensation Commission data.

Benefit Amount by Arbitrator

Although the Commission does not track actual payments for workers' compensation claims, the Commission provided us data regarding the benefit amount for each case (376,000 records). We conducted an analysis of the amount of benefits paid by the Arbitrator assigned to the case. For the four-year period 2007-2010, there were 29 Arbitrators who were assigned to cases that totaled more than $100 million in benefits. This includes all public and private sector employees.

Exhibit 3-3 shows total benefit and average benefit amounts by Arbitrators for the period. **As can be seen in the exhibit, for $233 million there is no Arbitrator or Commissioner assigned according to the data we received.** The top two Arbitrators, John Dibble ($236 million) and Jennifer Teague ($184 million), were both downstate arbitrators and were placed on administrative leave February 15, 2011 and are no longer with the Commission (one resigned and the other was not reappointed).

Exhibit 3-3
TOTAL BENEFITS AND AVERAGE BENEFITS BY ARBITRATOR
For All Cases Both Private and Governmental
2007-2010

Arbitrator Name	Total Benefit Amount	Average Benefit Amount[1]
John Dibble	$236,052,869	$46,688
Unassigned	$233,307,624	$24,799
Jennifer Teague	$183,868,768	$35,758
Anthony Erbacci	$159,513,840	$34,632
Andrew Nalefski	$159,214,275	$34,946
Douglas Holland	$158,428,037	$32,168
Jeffery Tobin	$158,004,634	$29,572
Jacqueline Kinnaman	$151,950,726	$36,908
Peter O'Malley	$151,169,871	$35,873
Stephen Mathis	$147,913,255	$27,606
Richard Peterson	$138,293,609	$39,310
Leo Hennessy	$137,402,829	$35,259
Neva Neal	$134,603,108	$27,149
Ruth White	$132,603,655	$27,184
Charles DeVriendt	$131,685,178	$37,646
Kurt Carlson	$128,426,964	$36,526
Kathleen Hagan	$128,324,892	$36,570
Edward Lee	$122,783,489	$34,097
Robert Falcioni	$122,071,204	$39,556
Milton Black	$120,791,419	$34,267
Joann Fratianni	$117,882,707	$34,428
David Kane	$117,322,825	$33,997
Joseph Prieto	$116,394,533	$32,558
Gilberto Galicia	$115,610,768	$32,384
Gerald Jutila	$111,926,868	$30,936
Gregory Dollison	$110,706,275	$33,969
Brian Cronin	$107,634,939	$33,221
James Giordano	$105,888,905	$31,421
Robert Williams	$105,056,998	$29,635
George Andros	$101,252,430	$30,636
Peter Akemann	$99,626,748	$24,329
Maureen Pulia	$99,425,055	$28,819
Robert Lammie	$45,044,726	$56,803
Paula Gomora	$20,854,593	$21,389

Note: [1]Based on the number of cases closed in Exhibit 3-2.

Source: OAG analysis of Workers' Compensation Commission data.

Cases Involving State Employees

Determination six of HR 131 asked us to conduct an analysis of Arbitrator caseloads over the four-year period, including the number of cases closed, classification of the types of alleged injuries involved in those cases, the employing unit involved in the claims, and the claims dispositions and payments. Because the Commission and CMS' information system for workers' compensation are not linked and do not interface with each other, we attempted to match cases and claims using social security numbers of the State employees. We encountered several problems in trying to match records between the two systems. These included:

- The Social Security Number is not always valid;
- The Arbitrator's name is listed as not assigned; and
- Injury type is not specific.

Of the 26,101 claims filed by State employees with CMS, we were only able to determine the Arbitrator for 9,700 (37%) claims. Even for these, there were 236 claims in which Arbitrator was listed as "Not Assigned."

Trials Held by Arbitrators

The number of trials held by Arbitrators varies widely. We obtained data from the Commission regarding the number of trials held by Arbitrators for FY07-FY11. While some Arbitrators average more than 200 trials a year, others averaged less than 100 trials a year (see Exhibit 3-4). The two Arbitrators who averaged the most trials were placed on administrative leave on February 15, 2011. Of these two Arbitrators, one resigned and the other was not reappointed to the position.

Exhibit 3-4
TRIALS HELD BY ARBITRATORS
For All Cases Both Private and Governmental

Arbitrator	Average Number of Trials Over Five Year Period	FY07	FY08	FY09	FY10	FY11	Total
John Dibble[1]	226	239	278	243	256	115[1]	1,131
Jennifer Teague[1]	215	203	197	258	286	129[1]	1,073
Jeffery Tobin	210	204	199	203	233	212	1,051
Andrew Nalefski	207	133	185	218	238	263	1,037
Stephen Mathis	174	237	212	145	151	126	871
Ruth White	172	211	154	165	157	174	861
Jaqueline Kinnaman	127	126	136	97	132	143	634
Robert Falcioni	117	160	163	110	81	71	585
Neva Neal	109	123	109	90	111	110	543
Edward Lee (**C**)	105	132	102	86	112	92	524
Charles DeVriendt (**C**)	102	110	85	100	101	115	511
Gilberto Galicia (**C**)	100	99	95	109	93	106	502
Maureen Pulia (**C**)	98	83	101	73	169	65	491
Kathleen Hagan (**C**)	92	95	79	82	108	95	459
Gregory Dollison (**C**)	91	86	106	69	100	95	456
Richard Peterson (**C**)	90	84	117	95	79	76	451
Robert Williams (**C**)	89	112	94	78	105	55	444
Kurt Carlson (**C**)	86	76	97	72	105	82	432
Joseph Prieto (**C**)	85	93	82	84	94	72	425
Anthony Erbacci	82	76	107	80	91	57	411
Gerald Jutila (**C**)	82	107	112	67	68	56	410
Brian Cronin (**C**)	80	45	64	89	114	89	401
George Andros	78	97	100	46	81	66	390
Milton Black (**C**)	78	97	82	73	92	44	388
Peter O'Malley	77	105	60	62	69	87	383
Peter Akemann	74	72	132	59	52	56	371
David Kane (**C**)	71	81	83	62	77	52	355
Leo Hennessy	69	74	91	73	85	24	347
Douglas Holland	69	48	55	70	99	73	345
James Giordano	65	97	77	26	69	54	323
Robert Lammie (**C**)	60	69	31	44	64	94	302
Joanne Fratianni	57	72	69	42	48	55	286
Paula Gomora[2]	54	35	73	0	0	0	108
Total		**3,681**	**3,727**	**3,170**	**3,720**	**3,003**	**17,301**
Avg. number of trials:		**112**	**113**	**99**	**116**	**94**	

Note: [1]Placed on administrative leave Feb. 15, 2011.
[2]Paula Gomora left the Commission in 2008.
(**C**) denotes arbitrators located in Chicago for FY09 and FY10
Source: OAG analysis of Workers' Compensation Commission data.

Annual Review of Arbitrators

The Workers' Compensation Act requires annual performance reviews for Arbitrators. The Act states that:

> ***All Arbitrators shall be subject to the provisions of the Personnel Code, and the performance of all Arbitrators shall be reviewed by the Chairman on an annual basis*** (820 ILCS 305/14).

We reviewed the personnel files for 31 Arbitrators assigned to call sites as of April 2011 and found that there were **no annual reviews being conducted to evaluate their performance**. The personnel files did not contain any other information to indicate that reviews of Arbitrators' performance had been conducted.

We asked the Commission why Arbitrator personnel files did not contain annual performance reviews as is required by the Workers' Compensation Act. In July 2011, the Commission provided auditors with "Closed Proof Reports" and responded that:

> ***While formal employee reviews have not occurred for Arbitrators for a number of years, these Closed Proof Reports have been and continue to be reviewed monthly by the Chairman to determine productivity of the Arbitrators and follow up with them as necessary. This includes follow up with Arbitrators with Decisions pending after 60 and 90 days. Current policy is to follow up with Arbitrators with any cases outstanding over 90 days, or with more than six cases outstanding over 60 days. In order to ensure their judicial independence, Arbitrator evaluation has been informal plus regular contacts regarding productivity and timeliness of deciding cases.***
>
> ***At this time all arbitrators are being reviewed by the Chairman, General Counsel and the Governor's office as part of the new legislation to terminate all Arbitrators and appoint new arbitrators or re-appoint existing Arbitrators. Policy going forward will include formal employee evaluations for Arbitrators on an annual basis.***

We reviewed the closed proof reports that were provided by the Commission and found that they were not always consistent and some months were missing. For instance, 4 of the 12 monthly reports for 2010 were missing and the Commission could not provide them.

ANNUAL EVALUATIONS OF ARBITRATORS	
RECOMMENDATION 10	***The Commission should conduct annual evaluations of Arbitrators and include them in their personnel files.***
COMMISSION RESPONSE	The Commission agrees with this recommendation. The Commission has revised and started its evaluation of Arbitrators to implement the changes mandated by House Bill 1698. Specifically, House Bill 1698 provides that upon expiration of each Arbitrator's term, the Chairman shall evaluate the performance of the Arbitrator and may recommend

(Commission Response Continued)	that he or she be reappointed to a second or subsequent term by the full Commission. The terms of the first group of appointed Arbitrators are set to expire on July 1, 2012. Thus, the Commission has been in the active process of developing and implementing Arbitrator evaluation procedures since January of 2012. The new evaluation procedure for Arbitrators with expiring terms includes a statistical analysis of case load, an in-person evaluation by Commissioners, and also surveys to be distributed to attorneys who have appeared before that Arbitrator.

Chapter Four

SETTLEMENTS AND AWARDS PROCESS

CHAPTER CONCLUSIONS

There are significant differences between resolving a workers' compensation claim by reaching a settlement or by receiving an award through a trial with a Commission Arbitrator. A **settlement** is a contract negotiated between an injured employee and the employer in order to resolve any dispute regarding the benefits due to the injured employee under the Illinois Workers' Compensation Act or Occupational Diseases Act. If an employer and injured employee cannot reach an agreement or choose not to, either party may petition for a trial with an Arbitrator at the Commission and a trial will be held. If an Arbitrator's decision rules in favor of the injured employee this is termed an **award**.

CMS provided auditors with a listing of all claims filed for the four-year period January 1, 2007, to December 31, 2010. Of the 26,101 workers' compensation claims filed during the four-year period, **3,621 (14%) received a settlement** as of July 2011. According to our analysis of CMS' data, these **3,621 settlements involved 3,299 individuals who received a total of $107,362,741**. Of the 26,101 workers' compensation claims filed during the four-year period, **611 (2%) received an award** as of July 2011. According to our analysis of CMS' data, these **611 awards involved 567 individuals who received a total of $17,806,709**.

Settlements Process

Settlements are those claims that are resolved through a settlement contract, signed by the injured employee, CMS and the AG. Settlement contracts are reviewed and approved by a Commission Arbitrator. We reviewed the settlement process and found that **CMS needs to establish clearer policies regarding settlement contracts and approval limits for Risk Management employees.** For instance, we found job title descriptions and the policies in CMS' Risk Management Policy Manual contained conflicting amounts above which settlements must be approved by the Manager of the Risk Management Division and the CMS Director. Also, because the lump sum payments to employees do not always contain all agreed payments, the actual amount of some settlements is understated for purposes of determining the approval limit, thereby allowing approval limits to be circumvented.

CMS Risk Management Supervisors were negotiating, and in some cases finalizing, settlement contract terms directly with the injured employee's legal counsel. According to CMS Risk Management policies, upon determination of a proper and appropriate settlement amount by the Unit Supervisor, the Office of the Attorney General is provided with settlement authority not to exceed that specified amount. The Office of the Attorney General, not CMS Risk Management, is responsible for negotiating a settlement with the employee's attorney.

CMS' files did not always contain support for all injuries compensated as part of the settlement. Although most CMS files generally contained medical support for the injuries listed in the settlement contract, we identified settlement contracts that did not contain medical evidence. Settlement files at the Commission also did not always contain medical evidence. In these instances, the evidentiary basis for the Arbitrator's approval of the settlement contract is not apparent.

The Commission's Application for Adjustment does not contain a specific question regarding whether the employer is the State of Illinois. Although the Commission's information system contains a data field used to identify State employees, the field is not always accurate. CMS is not notified directly that an employee has filed a case with the Commission. Therefore, unless the workers' compensation coordinator at the agency or the AG notifies CMS, CMS may be unaware of the case. If the Commission were to provide CMS with access to its workers' compensation information systems it would allow CMS to more easily identify cases that have been filed with the Commission and would assist in record keeping and identifying trends in workers' compensation claims filed by State employees.

Because of the decentralized nature of the workers' compensation program for State employees, communication among the various entities involved is critical. **Each workers' compensation case for a State employee may have up to four separate files with different entities (i.e., the employing unit, CMS, the Commission, and the AG).**

Awards Process

In those instances where a claim is not resolved through the settlement process, an employee may take the case to the Commission and a trial before a Commission Arbitrator is held. An award decision is required to be written for each case for which a trial is held. The award decision is then signed by the Arbitrator and sent to the Commission. All 41 award files we reviewed contained an award decision. According to Commission officials trial dates are tracked based on self-reporting by the Arbitrators, but independently of the mainframe. However, because the Commission does not track the trial date in its primary information system, it cannot ensure that Arbitrators are submitting decisions in a timely manner. The Commission's internal policy requires certain Arbitrator decisions to be filed within 60 days of the trial. For 19(b) (expedited) awards, however, the Commission's rules require the Arbitrator's decision to be filed with the Commission within 25 days after proofs are closed (50 Ill. Adm. Code 7020.80 b)(3)(B)).

We reviewed award decisions to determine the trial date and the date that the Arbitrator's decision was filed. For the award files reviewed that did not involve an expedited hearing, the time from the trial to the date the decision was filed ranged from 13 to 83 days. The decisions in five cases were filed more than 60 days after the trial. Our sample of 41 award decisions included nine 19(b) (expedited) cases. For the 19(b) cases, the decision was filed between 7 to 66 days after the trial date. Of these nine cases, 7 decisions were filed more than 25 days after the trial date. Three of these 7 decisions were filed more than 60 days after the trial date.

Award files generally contained medical information to support the decision. However, we found two cases with no medical information in the file. Since Commission files do not contain trial transcripts, we could not determine who testified, what was discussed at the trial, or how certain elements of the decision were supported. According to Commission officials, it is common practice throughout all trial courts in Illinois not to order a transcript before issuing a ruling. The Arbitrator attended the trial and heard the testimony first hand so there usually is no need to review transcripts. Commission officials stated that requiring a transcript for every case would be unnecessary, burdensome, and slow down the decision process. Transcripts are ordered only when an Arbitrator's decision is appealed to the Commission.

The Commission does not have guidelines for Arbitrators regarding awards. We reviewed awards and found that many are inconsistent for the same type of injury to the same body part. These inconsistencies involved the percent loss of use as well as the manner of determining loss. For instance, for Carpal Tunnel Syndrome claims, the amount awarded for cases we reviewed ranged from as little as 5 percent loss of a hand to as much as permanent total disability for life. **Repetitive motion injury awards varied with some Arbitrators awarding the same percentage loss amount for either hand while others awarded more for loss of the dominant hand.**

DIFFERENCES BETWEEN A SETTLEMENT AND AN AWARD

There are significant differences between resolving a workers' compensation claim by reaching a settlement or by receiving an award through a trial with a Commission Arbitrator (see Exhibit 4-1).

A **settlement** is a contract negotiated between an injured employee and his or her employer in order to resolve any dispute regarding the benefits due to the injured employee under the Workers' Compensation Act or Occupational Diseases Act. The advantage for the employee is that the employee gets a lump-sum cash settlement for the loss. The advantage for the employer is that, by signing a settlement contract, the injured employee gives up:

- The right to a trial before an Arbitrator;

Exhibit 4-1
DIFFERENCES BETWEEN SETTLEMENTS AND AWARDS

Settlement	Award
Employee and employer *agree* on settlement offer.	Employee and employer *disagree or cannot reach* settlement.
Amount of payment is negotiated between the employee and employer and then is *approved* by an Arbitrator.	Arbitrator *decides* amount employer should pay employee.
Employee and employer, or their representatives, go to a *Commission status call* for settlement approval.	A *trial* is held in front of an Arbitrator and an amount is awarded by the Arbitrator.
Employee has no future recourse on the injury and the *employer's liability ends* (in most cases).	*Case remains open* and the employer must pay future medical bills and costs associated with the injury.

Source: OAG analysis of settlements and awards.

- The right to appeal the Arbitrator's decision to the Commission;
- The right to any further medical treatment, at the employer's expense, for the results of the injury; and
- The right to any additional benefits if the condition worsens as a result of the injury.

If an employer and injured employee cannot reach an agreement or choose not to, either party may petition for a trial with an Arbitrator at the Commission and a trial will be held. If an Arbitrator's decision rules in favor of the injured employee this is termed an **award**. The most significant disadvantage of an award for the employers is that, unlike a settlement contract, an award can and generally does leave future medical costs open at the employer's expense.

Arbitrator Role in Settlements vs. Awards

All workers' compensation settlement contracts require the approval of an Arbitrator at the Illinois Workers' Compensation Commission. The Arbitrator's role in the settlement process is to approve the contract that has been negotiated between the injured employee or the attorney and the employer. In pro se cases (without representation), according to Arbitrators we met with, the Arbitrator reviews the case and informs the employee that by signing the settlement it extinguishes all of their future rights to the claim. The injured employee is required to appear before the Arbitrator for pro se settlement cases. If a settlement is not reached and a trial is held, the Arbitrator issues a decision and determines the amount of compensation through an award.

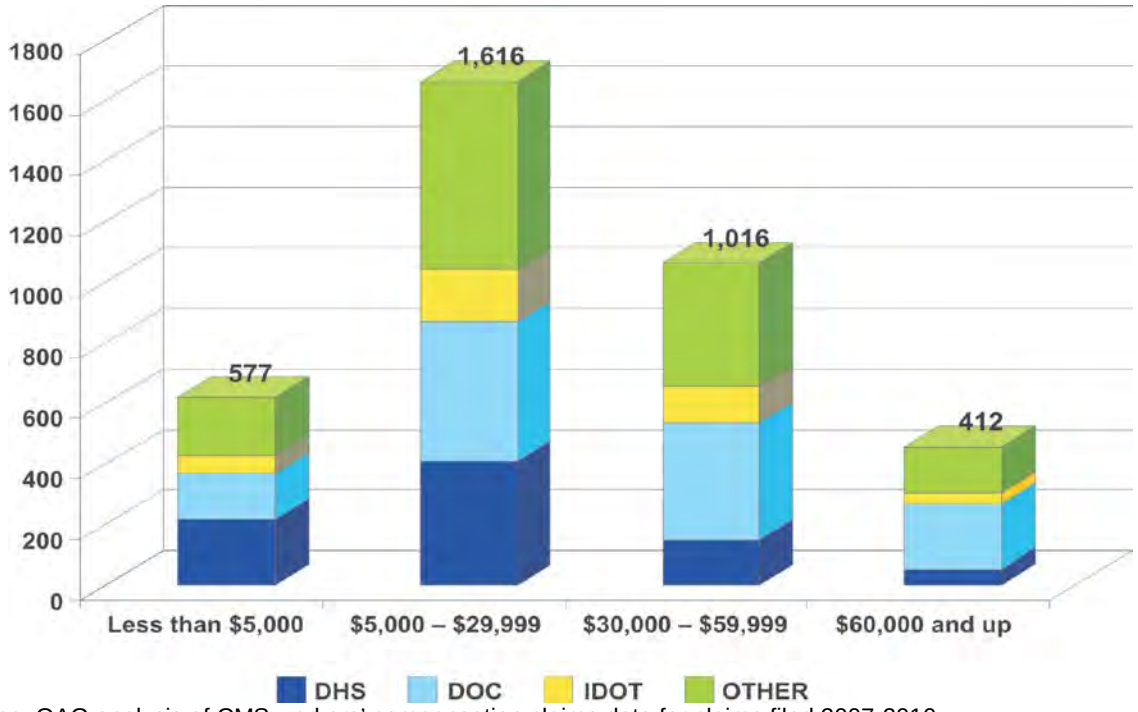
SETTLEMENTS AND AWARDS TO STATE EMPLOYEES

CMS provided auditors with a listing of all claims filed for the four-year period January 1, 2007, to December 31, 2010. Of the 26,101 workers' compensation claims filed during the four-year period, **3,621 (14%) received a settlement** as of July 2011. According to our analysis of CMS' data, these **3,621 settlements involved 3,299 individuals who received a total of $107,362,741**. Of the 26,101 workers' compensation claims filed during the four-year period, **611 (2%) received an award** as of July 2011. According to our analysis of CMS' data, these **611 awards involved 567 individuals who received a total of $17,806,709**. Exhibits 4-2 and 4-3 show the breakdown by the size of the settlement and award for State employees.

Settlements

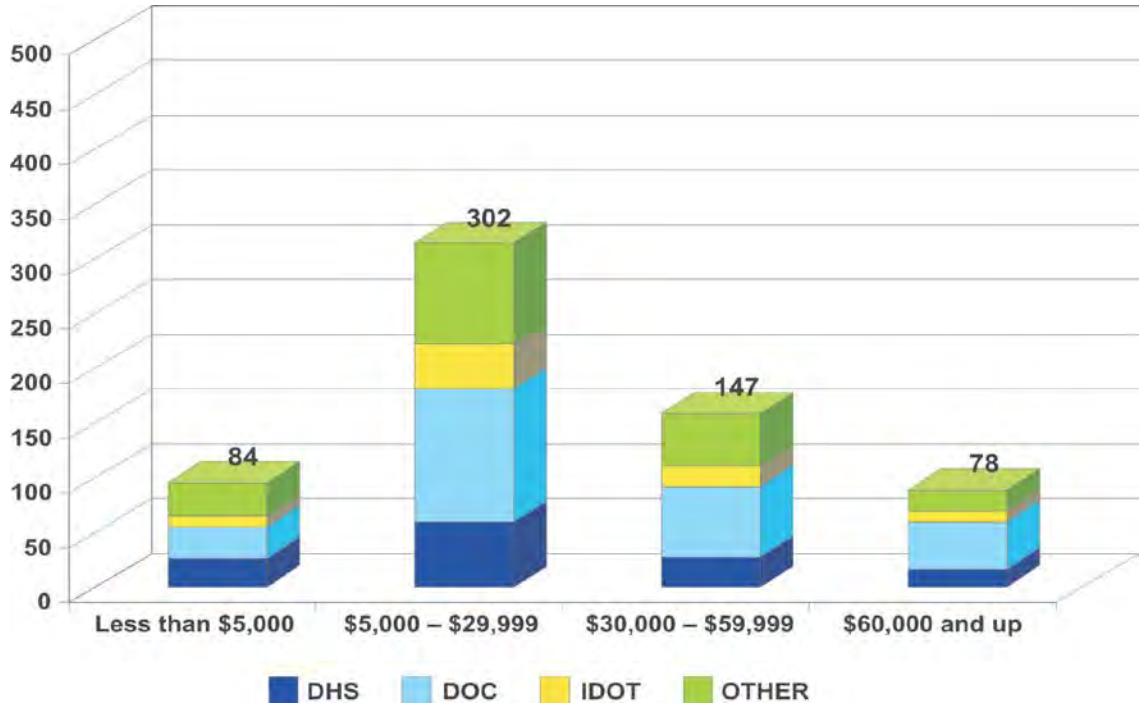
The average claim settlement was $29,650. The majority of settlements (about 61%) are less than $30,000. However, some settlements are over $100,000. There were 136 settlements for the four-year period that were over $100,000. The largest settlement ($181,420) went to an employee with the Department of Corrections who injured his neck in a motor vehicle accident. Of the 136 settlements over $100,000, 20 were for $149,999-$149,999.99. This amount is just below the $150,000 threshold, contained in CMS job descriptions for the Manager of the Risk Management Division, above which approval of the settlement is required from the Director of CMS. Of the 20 settlements just below the approval threshold, 8 involved Department of Corrections employees.

Exhibit 4-2
SETTLEMENTS TO STATE EMPLOYEES
For Claims Filed 2007-2010



Source: OAG analysis of CMS workers' compensation claims data for claims filed 2007-2010.

Exhibit 4-3
AWARDS TO STATE EMPLOYEES
For Claims Filed 2007-2010



Source: OAG analysis of CMS workers' compensation claims data for claims filed 2007-2010.

On the low end, 34 settlements were for $1. The overwhelming majority of the injuries for these $1 settlements were caused by motor vehicle accidents. In these cases, settling the claim relieves the State of any further liability. These claims may also have involved a third party settlement paid directly to the State employee.

Awards

The average award was $29,144. Exhibit 4-3 shows a breakdown by the size of the award for State employees who filed claims between January 1, 2007, and December 31, 2010. The majority of awards (63%) were less than $30,000. There were 19 awards for the four-year period that were over $100,000. The largest award ($273,826) went to a correctional employee at Stateville Correctional Center. The lowest award was for $51.18.

Employees with Multiple Settlements or Awards

Data provided by CMS showed that some individuals received multiple settlements during the four-year period examined (see Exhibit 4-4). Of the 3,299 individuals who received a settlement, 301 received more than one settlement. One employee with the Department of Corrections received five settlements during the four-year period for a total of $48,695. An IDOT employee received three settlements for a total of $223,499. The State employee who received the highest total amount in settlement payments was a Department of Corrections employee at Menard Correctional Center who received two settlements for a total of $248,007.

Exhibit 4-4
EMPLOYEES WITH MULTIPLE SETTLEMENTS AND AWARDS
For Claims Filed 2007-2010
As of July 2011

Number of Settlements or Awards to Employees	Number of Employees with Settlements	Number of Employees with Awards
Employees with **1** Settlement or Award	2,998	526
Employees with **2** Settlements or Awards	283	38
Employees with **3** Settlements or Awards	16	3
Employees with **4** Settlements or Awards	1	0
Employees with **5** Settlements or Awards	1	0

Source: OAG analysis of workers' compensation claims data from CMS for claims filed in 2007-2010.

Of the 611 awards, 41 individuals received more than one award during the four-year period. Three employees received three awards each for claims filed during the four-year period. A Department of Healthcare and Family Services employee received three awards for a total of $165,979.

SETTLEMENT PROCESS FOR STATE EMPLOYEES

Once injured employees reach maximum medical improvement, they have reached a point where their condition cannot be improved any further. However, the claimant may continue to need medication or treatment. At this point the claim can be evaluated for settlement or award.

The settlement process usually begins with either the injured employee or the employee's attorney filing an Application for Adjustment of Claim with the Illinois Workers' Compensation Commission. All workers' compensation claims settlements require the approval of an Arbitrator at the Illinois Workers' Compensation Commission. By law, an injured employee must file an Application for Adjustment ***with the Commission within three years of the date of the accident, where no compensation has been paid, or within two years after the last payment of compensation to the employee*** (820 ILCS 305/6(d)).

With Representation

If the injured employee has obtained legal representation, the settlement negotiation process will usually be initiated by the employee's attorney. The CMS Unit Supervisors from the Risk Management Division work through the Office of the Attorney General to determine a settlement. Upon determination of a proper and appropriate settlement amount by the Unit Supervisor, the Office of the Attorney General is provided with settlement authority not to exceed that amount.

The Unit Supervisors use the Workers' Compensation Summary Settlement Guide to determine the appropriate settlement amount. This involves looking for similar injuries and what the settlement amount was in those cases. CMS uses a website that tracks workers' compensation cases and the settlement amounts. It includes both public employees as well as private employee settlements.

The Office of the Attorney General is responsible for negotiating a settlement with the injured employee's attorney. If all parties concur with the proposed settlement language and amount, a lump sum contract is prepared by either the employee's attorney or by the Office of the Attorney General. The contract is forwarded to all parties for review and signature (the claimant, the claimant's attorney, the CMS supervisor, and the Assistant Attorney General). Once signed, the settlement contract is presented to an Arbitrator at the Illinois Workers' Compensation Commission for approval. The signature and official stamp of the Arbitrator indicates approval of the contract. Once approved by the Arbitrator, the employee has no further recourse for that injury. The contract is then returned to the CMS Risk Management Division for processing of payment.

Pro Se

If the injured employee does not have legal representation (pro se), the settlement offer may originate at CMS in the Bureau of Benefits. The offer is the result of a request for settlement, in writing, by the claimant. Upon determination of a proper and appropriate settlement amount, the employee is provided with a written notice of a settlement offer through CMS or an Assistant Attorney General assigned to the case. If the employee agrees to the offered amount, a lump sum contract is prepared by the Office of the Attorney General and forwarded to the Unit Supervisor. The Unit Supervisor reviews the contract and makes any corrections. A representative from the Office of the Attorney General and the employee, together, go to the Illinois Workers' Compensation Commission for approval of the contract by the Arbitrator. All

pro se settlement contracts are signed by the claimant, the CMS Supervisor, the Assistant Attorney General, and the Arbitrator.

If the Arbitrator approves the settlement, a signature and official stamp indicate approval of the contract by the Arbitrator. The Arbitrator then returns the contract to the Risk Management Division which processes the payment. If the Arbitrator does not approve the contract as submitted, CMS or the Attorney General must then renegotiate the contract with the employee or go to trial with an Arbitrator from the Commission.

CMS Settlement Contract Approval Limits

Unit Supervisors review settlement agreements (pink sheets) and sign off on the contracts for the settlements. According to CMS officials and job title descriptions, if the settlement amount is under $60,000, it requires only the approval of the Claims Unit Supervisor from CMS. The authority and approval levels for settlement contracts are:

- Settlement authority for the Claims Section Manager and the Unit Supervisors is up to $60,000;

- For settlements over $60,000 but under $150,000, a Claim Valuation and Settlement Form or "gold sheet" is used to authorize authority. If the settlement is over $60,000, it requires the recommendation of the Claims Section Manager (settlement authority is defined in the position description) and approval of the Interim Director of the Risk Management Division; and

- If the settlement is over $150,000, it requires the approval of the Director of CMS.

Once a settlement contract is finalized, the contract is forwarded to all parties for review and signature. Once signed, the contract is then sent back to the Office of the Attorney General for presentation to an Arbitrator from the Illinois Workers' Compensation Commission. Once a settlement is final, the injured employee cannot get TTD or other benefits unless stipulated in the settlement. If the settlement contract includes a provision for a 180 day deferral or a provision for the employee's resignation, however, TTD will often continue until the settlement is processed for payment.

Inconsistent Approval Limits and Calculation of Total Settlement Amounts

CMS needs to establish clearer policies regarding settlement contracts and approval limits for Risk Management employees. We found conflicting limits between CMS' job title descriptions and the policies in CMS' Risk Management Policy Manual. According to the Risk Management Policy Manual:

> ***"The Unit Supervisor possesses settlement authority up to $50,000. The Manager of the Risk Management Division possesses settlement authority up to $100,000. The Director of the Department of Central Management Services possesses settlement authority greater than $100,000."***

Job title descriptions provided by CMS allow the Unit Supervisor settlement authority up to $60,000 and the Manager of Risk Management independent authority up to $150,000.

In addition to conflicting approval limits between job descriptions and the policy manual, during our file testing of settlement contracts we identified settlements that totaled more than $150,000 but were not approved by the Director of CMS. We identified two settlements over $150,000 and 20 settlements that were between $149,999 and $149,999.99. We reviewed 10 of these settlements.

The two settlements in the claims data provided by CMS were listed as $181,419.56 and $156,174.82. For the settlement contract listed in CMS claims data as $181,419.56, the actual settlement contract was for $149,000. However, in addition to the amount listed on the settlement contract, an additional $32,419.56 was paid as a separate part of the settlement to correct the amount of TTD that was paid and provide a wage differential until the settlement could be paid by CMS. The TTD in this case was paid at an incorrect rate because CMS was unaware that the employee held a second job. Although not listed on the settlement contracts, that amount was paid out as a separate part of the settlement according to e-mails contained in the file. Therefore the true cost of the settlement was $181,419.56. The file did not contain evidence that the Director of CMS approved the settlement.

The settlement for $156,174.82 was actually two settlements for the same claim number but for different injuries (one for a back injury for $143,133.75 and one for Carpal Tunnel Syndrome for $13,041.07). The claim file did not include documentation to support the carpal tunnel injury. According to the Claim Valuation and Settlement form in the file, this was because the worksite did not send the information to CMS.

In another case we reviewed, legal fees appeared to be more than the statutory limit of 20 percent. The settlement amount was listed as $149,999.99. Twenty percent of that amount would be $30,000 for legal fees. However, $34,147.20 in legal fees was actually paid. According to CMS officials, the calculation of legal fees was based on an amount included in the settlement for TTD ($20,736.04 X 20% = $4,147.21), as well as the lump sum amount listed in the settlement ($149,999.99 x 20% = $30,000) for a total of $34,147.20. Therefore, excluding legal fees, the true cost of the settlement was actually $170,736.03 (lump sum plus TTD), not $149,999.99, and the settlement contract should have been approved by the Director of CMS but was not.

CMS needs to take steps to clarify approval limits for Risk Management Division employees. However, because CMS is not including all payments that are agreed to as part of the settlement in the lump sum payment being made to the employee, the actual amount of some settlements is understated. This may allow approval limits to be circumvented. In determining the approval limit, CMS should include all amounts approved for compensation in the settlement contract.

CONTRACT APPROVAL LIMITS	
RECOMMENDATION 11	***The Department of Central Management Services should:*** • ***Clarify settlement contract approval limits in its policies for Risk Management employees; and*** • ***Include all compensation in the settlement contract as part of these approval limits.***
DEPARTMENT RESPONSE	CMS agrees that settlement contract approval limits should be clarified. These will be included in the updated policy and procedure manual and reinforced through training. We respectfully disagree with the recommendation that all compensation in the settlement contract should be part of these approval limits. This interpretation would cause inequities in the cases considered to be $150,000 or more. For example, if TTD is denied and three years later we settle the claim, the TTD portion may eat up most of the policy limits. For a case where TTD was paid during the three years, the settlement contract limits would be based on permanency only, even though the total cost for each case is the same. The intent of the approval limits is for the permanency part of the contract only. When final settlements include TTD or medical, these payments are to be made from a different pay code type and are not included in the settlement figures for financial reporting purposes. We will evaluate our data entry procedures and clarify the definitions for settlement contract limits in the policy and procedure manual.

Settlement Contract Negotiations

CMS Risk Management Supervisors were negotiating, and in some cases finalizing, settlement contract terms directly with the injured employee's legal counsel. According to CMS Risk Management policies, upon determination of a proper and appropriate settlement amount by the Unit Supervisor, the Office of the Attorney General is provided with settlement authority not to exceed that specified amount. ***The Office of the Attorney General is responsible for negotiating a settlement with the employee's attorney.***

All settlements are negotiated by the Unit Supervisor and the assigned representative from the Office of the Attorney General, with the employee's attorney or, if the employee chooses not to retain the services of an attorney, with the employee directly (*pro se*). The CMS Unit Supervisor provides the assigned representatives from the Office of the Attorney General with a maximum offer and authorizes the initiation of settlement negotiations. To start the pro se settlement process, the employee is required to submit a letter verifying no representation by an attorney for the injury and requesting to settle the claim pro se. The settlement process may then be initiated by the employee or by the Unit Supervisor.

Of the 68 settlement contract files we reviewed, we identified at least 9 cases in which the CMS Unit Supervisor was conveying offers to attorneys representing injured employees and negotiating the settlement contract. Because the Attorney General's Office is responsible for representing the State in matters of litigation, CMS should not negotiate settlement contracts directly with attorneys representing injured employees.

NEGOTIATING SETTLEMENT CONTRACTS	
RECOMMENDATION 12	***The Department of Central Management Services and the Attorney General should ensure that all settlement contract negotiations for cases in which the employee has legal representation are conducted by the Attorney General's Office.***
DEPARTMENT RESPONSE	Agreed. CMS policy is that the Attorney General should conduct settlement contract negotiations. This policy will be reinforced through the updated policy and procedure manual and training.
ATTORNEY GENERAL RESPONSES	We agree with this recommendation. The office has procedures in place to notify attorneys representing state employees in workers' compensation cases filed with the Workers' Compensation Commission of the entry of our appearance in the cases and, thus, convey the need to communicate only with our office. When we receive notice that a petition has been filed with the Workers' Compensation Commission, we file our appearance and send a letter to the employee's attorney. We will continue the practice of sending that letter at the outset of the case, and we will also emphasize both in that initial letter and in later communications with the state employees' attorneys and in communications with CMS Risk Management Supervisors that all discussions regarding the case should be exclusively with our office.

Medical Support

In our review of 68 settlement files, most files generally contained medical support for the injury. Medical support in files included:

- Doctor Examinations/Consultations;
- Nerve conduction studies;
- Surgical notes and Operative Reports;
- Progress Notes;
- Work releases;
- Independent Medical Examination (IMEs) performed at CMS' request;
- Utilization Reviews; and
- Functional Capacity Evaluations.

Although most files contained medical support, a few files did not. These included:

- A workers' compensation coordinator received a settlement with no support for one of the injuries that was compensated as part of the settlement contract and did not receive treatment for two of the injuries compensated; and
- A file had two settlements for the same claim form number and contained no support for one of the settlement contracts because, according to CMS, the work site failed to send the file.

We also found that there were settlements for claims in which no files existed prior to the settlement demand or contract. Files in at least three cases that we tested had to be created at CMS in order to process the settlement. These files contained very little medical information. For these cases it is not clear how the settlement amount was arrived at since CMS could not have authorized an amount for the Attorney General to negotiate the settlement because there was no claim file at CMS.

MEDICAL SUPPORT FOR SETTLEMENT INJURIES	
RECOMMENDATION 13	***The Department of Central Management Services should ensure that there is medical support for all injuries that are compensated in settlement contracts.***
DEPARTMENT RESPONSE	Agreed. 97% of the cases sampled had medical documentation to support the settlement in the file. There are a limited number of times when the AAG is at the call site and a claim has been filed with the IWCC but not with Risk Management. When this occurs we have to construct a file so we can either defend the claim or close it out by settlement. In these circumstances we must ensure we have the relevant information before signing any settlement. Specific to the two cases cited in the audit: In the first case, there was medical support for the compensated injuries in the electronic WebOpus medical database, in the absence of reproduced hard-copy documentation in the on-site file. For the second case, the claimant reported a back and a carpal tunnel injury to the IWCC, although the facility sent only the back injury claim to CMS. The carpal tunnel injury was diagnosed with a medical report. On the advice of the AG's office, both injuries were settled in an effort to close out all issues with that claimant to minimize overall cost.

Settlement Basis

Although it is not a requirement, some settlement contracts were not based on a percentage loss. Settlement contracts are generally structured so that the employee is compensated a percentage loss for a specific body part. That percentage is then multiplied by the number of weeks listed for the loss of that body part as defined in the Workers' Compensation Act. The number of compensable weeks is then multiplied by the Permanent Partial Disability (PPD) rate to determine the lump sum amount of settlement. The PPD rate is 60 percent of the employee's average weekly wage for the previous 52 weeks.

Settlement Calculation Case Example

A settlement is reached with an injured employee that represents 7.5% loss of use of the right arm and 5% loss of use of the right hand.

The settlement lump sum amount is based on the Permanent Partial Disability (PPD) rate and the weeks of pay for each body part. An arm is worth 253 weeks pay and a hand is worth 205 weeks pay. The weeks are multiplied by the percent loss and then by the PPD rate.

253 weeks x .075 = 18.975 weeks
205 weeks x .05 = 10.25 weeks
18.975 + 10.25 = 29.225 total weeks

29.225 weeks x PPD of $619.97 = **$18,118.62**

Of the 68 settlement contracts that we reviewed, 8 did not have a percentage loss for an injury in the settlement contract. Therefore, there was not a basis that could be used to calculate the settlement amount. These cases often required resignation as a condition of the settlement. One settlement involved 11 separate claims and the settlement contract included a provision for the employee's resignation.

Workers' Compensation Commission Role in the Settlement Process

Once an agreement is reached between the employer and the employee, settlement contracts are submitted to the Commission, sorted by Arbitrator, and sent to the Arbitrator for approval. ***Although there is no trial, the Arbitrators to whom the cases are assigned are required to approve all settlement contracts.*** When there is a pro se settlement, the injured employee is required to appear before the Arbitrator at the Commission. The Arbitrator reviews the settlement contract and medical records to ensure that the settlement is fair and to ensure that the petitioner understands that he or she is waiving any rights to future claims. If an Arbitrator rejects the settlement offer, the employee or employer may file for approval from a Commissioner.

For cases involving State employees, a settlement contract may originate with the attorney representing the injured employee or with the Attorney General's Office which represents the State. If the case is pro se, the settlement contract originates from the Attorney General's Office.

A pro se Arbitrator in the Commission's Chicago Office approves settlements on a daily basis. If the case is from outside of Chicago and is assigned to a Downstate Arbitrator, the Downstate Arbitrator hears the pro se settlement on the regular status call dates and on trial dates.

Settlement agreements were being approved by Arbitrators with little or no information about the case. We reviewed settlement contracts at the Commission and found that the files did not contain medical evidence and most contain only the application for adjustment and the settlement contract. Therefore, the evidence used by the Arbitrator to base their approval of the settlement contract is not apparent in the files.

Commission Cases Involving State Employees

We were not able to identify all cases involving State employees for several reasons. First, although the Commission's information system contains a data field used to identify State employees, the field is not always accurate. The Commission's Application for Adjustment does not contain a specific question regarding whether the employer is the State of Illinois. Also, according to the Commission, sometimes it is not clear from the name of the employer on the Application for Adjustment whether the employer is a State agency or not.

Identifying whether the employee is with the State is critical so that the Commission can generate a notification to the employer. When a State employee files an Application for Adjustment with the Commission, the Commission generates a notice to the agency where the employee works and the AG. CMS is not notified directly that an employee has filed a case with the Commission. Therefore, unless the workers' compensation coordinator at the agency or the Attorney General notifies CMS, CMS may be unaware of the case. Because there are hundreds of workers' compensation coordinators, the opportunity for miscommunication, or no communication, is greatly increased. Conversely, if the Workers' Compensation Commission directly informed the CMS Bureau of Risk Management when a case is filed, the potential of not being informed would be significantly lower.

As part of our audit, we attempted to identify the number of State employees in the Commission's data. Because the Commission and CMS' information system for workers' compensation are not linked and do not interface with each other, we matched cases and claims using social security numbers of the State employees. We encountered several problems in trying to match records between the two systems.

Further, because the same employee can have multiple claims and the Commission uses a Workers' Compensation Commission case number while CMS uses a Claim Form Number for each individual claim, there is no guarantee that when the social security number matches that the numbers are for the same injury case and claim. Therefore, each record would have to be reviewed manually to determine if it were an exact match. If the Commission were to provide CMS with access to its workers' compensation information systems it would allow CMS to more easily identify cases that have been filed with the Commission and would assist in record keeping and identifying trends in workers' compensation claims filed by State employees.

COMMISSION CASES INVOLVING STATE EMPLOYEES	
RECOMMENDATION 14	***The Commission should:*** • ***Make changes to the Application for Adjustment form to identify whether the employer is the State of Illinois;*** • ***Notify CMS of cases filed by State employees; and*** • ***Give CMS access to its workers' compensation information systems.***
COMMISSION RESPONSE	The Commission agrees with this recommendation. The Commission's Application for Adjustment form will be updated to include a field to indicate whether the employer is the State of Illinois. However, that field will only yield increased identification of cases where the State of Illinois is the employer if this field is accurately marked by Petitioners. The Commission will provide CMS with an electronic file of new applications filed by State employees on a monthly basis. In addition, the Commission will be releasing a new web-based search of its case management mainframe system for public use. This search should also facilitate the process of CMS identifying State cases that have not been reported by the individual workers' compensation coordinators at State agencies. Before this web search is implemented, the Commission can allow CMS direct access to the Commission's mainframe case management system, which is currently only available on computers physically located at the Commission.

Communication

Because of the decentralized nature of the workers' compensation program for State employees, communication among the various entities involved is critical. Each workers' compensation case for a State employee may have up to four separate files with different entities. There are also many different agents involved. This includes:

- Workers' compensation coordinators at the agency and facility level, which are located around the State, who distribute and collect information to be sent to CMS;
- CMS adjusters who determine the initial compensability of claims;
- The Workers' Compensation Commission that receives applications for adjustment and notifies parties involved that a case has been filed;
- Arbitrators who approve settlements and decide awards; and

- The Attorney General's Office that represents the State in employee workers' compensation cases.

During our file testing, we identified several cases in which no file existed prior to a demand for settlement being sent to CMS. Some claim files included documentation that showed the work site did not send the file while for others the claim date was the same date as the demand for settlement. There were also CMS files that may have been lost. For one case, the file stated "original file cannot be found." In these cases, CMS was forced to create a file in order to settle the case.

We also found instances of miscommunication between CMS and the AG during our file review. In one case, for example, an Independent Medical Examination (IME) was scheduled by CMS to be conducted after the case had already been awarded. IMEs can be used to help provide information so a defense can be assembled for the case. In other cases, it was evident that the Assistant Attorney General assigned to the case and the Adjuster at CMS did not always have the same information.

Since information for State employee workers' compensation claims may exist in files in four different locations for each case, communication and sharing information is critical to the successful adjudication of a claim. CMS does not receive notification directly from the Commission regarding cases filed with the Commission. CMS also does not have access to the Commission's information system or the AG's case file system. As a result, CMS may be unaware of some cases.

COMMUNICATION	
RECOMMENDATION 15	***The Department of Central Management Services and the Attorney General should work to improve communications regarding workers' compensation claims and cases.***
DEPARTMENT RESPONSE	Agreed. CMS is beginning a nine month project to scan all files into Docuware. Once completed, this will enable CMS adjusters, agency coordinators and AAG's to view a consistent and complete file. In addition, in coordination with the other agencies, CMS would like to develop a web-based paperless system granting access and data-sharing as appropriate. Currently, headcount, technology and resource limitations hamper the ability for short-term improvements in this area.

ATTORNEY GENERAL RESPONSE	We agree with this recommendation and, based on it, have taken added steps to improve communications with CMS concerning workers' compensation litigation. When a state employee files an Application for Adjustment of Claim with the Workers' Compensation Commission, the Commission sends notice of the filing to the employing state agency and our office. The CMS Workers' Compensation Coordinator Manual details the responsibilities of the employing agencies' Coordinators, including "[p]roviding the liability claims adjuster with a copy of all legal notices pertaining to the adjustment of claim." (CMS Bureau of Benefits, Risk Management Division Workers' Compensation Coordinator Manual, Revised: November 2004, Part II, Sec. C, page 15.) Pursuant to this policy, our office understood that the Coordinators were required to provide CMS with a copy of the Commission's notice. When we receive this notice, our office sends a letter to the appropriate Coordinator at the employing agency providing the Coordinator with the name of the assigned Assistant Attorney General, requesting a copy of the Coordinator's entire file regarding the claim, and asking that the Coordinator continue forwarding all additional materials on this claim to our office. Based on the discussion in this audit report indicating that CMS may be unaware of some cases before the Commission, we have, out of an abundance of caution, changed our practice and now copy CMS Risk Management on the letter that we send to the Coordinators to ensure that CMS is aware of the case. Additionally, on October 12, 2011, we met with CMS management regarding the claims management process and discussed the need to provide annual training for all Coordinators. We committed to participating in any helpful way in this training.

AWARD PROCESS

If an injured employee and the State cannot agree on a settlement amount or terms, the employee may seek a hearing with an Arbitrator at the Workers' Compensation Commission. Through an Arbitrator at the Commission, the injured employee may receive an award, which in many cases leaves the medical liability open. A settlement in most cases closes out the medical liability, in which case the State is no longer responsible for medical costs. A settlement is final unless the claimant meets the qualifications for open medical due to provisions of Medicare set-aside. The Medicare set-aside does not apply to settlements of less than $25,000. Some settlements also contain special provisions for further medical costs.

If a settlement cannot be reached, a trial is held and the Arbitrator decides if there should be an award. If either party disagrees with the Arbitrator's decision, they can appeal the decision to the Illinois Workers' Compensation Commission to be heard by a panel of three Commissioners.

Trials

If there is disagreement or a settlement cannot be reached by the petitioner and respondent involved in the case, a trial is held with an Arbitrator. Once a case is assigned a trial date, the parties are required to appear on the morning of the trial. On trial dates, the Arbitrator determines the order in which the cases will proceed that day. Many of the cases that are set for trials are settled, dismissed, or continued prior to the trial date.

After the docket is set for the day, the Arbitrator will handle motions and settlements and then start hearing cases. Once an Arbitrator starts an arbitration hearing, he or she must complete it within 60 days.

Prior to the commencement of an arbitration hearing, the parties must complete a request for hearing form. At the conclusion of the evidence, the Arbitrator requires that both parties submit a proposed decision on forms supplied by the Workers' Compensation Commission. The proposed decisions must be drafted in a form which can be adopted by the Arbitrator.

After the hearing, the Arbitrator sends back a "closed proof" form and the "closed proof" information is input into the Commission's computer system. Closed proof means that all information required to enter a decision has been received. Also after the hearing, the Arbitrator sends a decision receipt form and the case status is updated in the computer system. The attorneys are required to file a brief within 14 days from the date proofs are closed. The Arbitrator has 60 days from the date proofs are closed to file the written decision.

Requests for Immediate or Emergency Hearings

If a petitioner is unable to work because of a disability and is not receiving TTD or medical benefits, he or she can file a petition for an immediate or emergency hearing. These cases are referred to as "19 (b)" and "19 (b-1)" cases because of the sections in the Workers' Compensation Act that allow for immediate and emergency hearings. These cases are given precedence over other cases. If either lost-time benefits or medical bills are unpaid, a party may petition for an emergency hearing.

19(b) – Immediate Hearings

Whether the injured employee is working or not, if the employee is not receiving or has not received medical, surgical, hospital, or other services, under Section 19(b) of the Workers' Compensation Act the employee may at any time petition for an expedited hearing by an Arbitrator on the issue of whether he or she is entitled to receive payment of the services and compensation. A final decision must be issued within 180 days of the date the petition for review was filed with the Commission.

An employer that is paying TTD may also file a 19(b) petition, as long as they keep paying medical and/or TTD until:

a) the Arbitrator rules on the petition;
b) the worker's medical provider releases him or her back to regular work; or

c) the employee starts work of any kind.

Neither the employee nor the employer is entitled to a 19(b) hearing if the employee has returned to work and the only benefit in dispute amounts to less than 12 weeks of TTD.

19 (b-1) – Emergency Hearings

An employee who claims to be unable to work as the result of an injury and who is not receiving medical benefits or TTD may file a 19(b-1) petition to obtain a quick ruling on the medical care and/or TTD issues. An emergency petition has priority over all other petitions regarding a hearing with an Arbitrator. Under Section 19(b-1), a final decision is required to be filed within 90 days from the date of the petition but in no event later than 180 days from the date the petition was filed with the Commission.

According to the Commission's rules, for 19 (b-1) cases, the Arbitrator's decision is to be filed with the Commission within 25 days after proofs are closed.

Appeals to the Commission

Arbitrator decisions can be appealed to the Commission. Parties have 30 days from receipt of the decision to file a petition for review with the Commission. If an appeal or petition for review is not filed, the decision of the Arbitrator becomes final.

Cases in which a petition for review is filed are randomly assigned to a Commissioner. Two times a year the Commission redistributes pending cases to equal out the work load. The Commissioner assigned becomes the lead person on that case before a panel of three Commissioners.

On or before the date of review, the appealing party must file an authenticated arbitration transcript with the Workers' Compensation Commission. Once the authenticated transcript is submitted to the Commission, the appealing party or parties have 30 days to file a brief outlining the grounds for the appeal. The non-appealing party has 15 days after that to file a response brief. All the issues related to the appeal must be raised in the petition for review and in the brief submitted to the Workers' Compensation Commission. Once the briefs are filed, the case is then scheduled for hearing and oral arguments.

Exhibit 4-5, which **includes all cases for private and governmental employees**, shows that about half of all decisions issued by Arbitrators are appealed to the Commission. The panel of three Commissioners meets with the petitioner and respondent for each case in either Chicago or Springfield. After the hearing, the Commissioners discuss each case and make a decision. The staff attorneys for the Commissioners then write up the decision and the Commission issues the decision/opinion. The Commission may also simply adopt the findings of the Arbitrator as its own. Although private sector employers/employees may appeal through the courts, decisions are final for cases involving employees of the State of Illinois. Therefore, **for claims involving State employees, the Workers' Compensation Commission is the court of last resort for settling disputes.**

Exhibit 4-5
APPEALS TO THE COMMISSION
For All Cases Both Private and Governmental
2007-2010

Fiscal Year	Arbitrator Decisions Issued	Percent Appealed	Commission Decisions Issued
2007	3,644	49%	1,613
2008	3,594	48%	1,777
2009	3,541	48%	1,470
2010	3,581	49%	1,503

Source: Workers' Compensation Commission FY10 Annual Report (unaudited).

Award Decisions

An award decision is required to be written for each case for which a trial is held. The award decision is then signed by the Arbitrator and sent to the Commission's Chicago Office. All 41 award files we reviewed contained an award decision. According to Commission officials trial dates are tracked based on self-reporting by the Arbitrators, but independently of the mainframe. However, because the Commission does not track the trial date in its primary information system, it cannot ensure that Arbitrators are submitting decisions in a timely manner. The Commission's internal policy requires certain Arbitrator decisions to be filed within 60 days of the trial. For 19(b) (expedited) awards, however, the Commission's rules require the Arbitrator's decision is to be filed with the Commission within 25 days after proofs are closed (50 Ill. Adm. Code 7020.80 b)(3)(B)).

We reviewed award decisions to determine the trial date and the date that the Arbitrator's decision was filed. For the award files reviewed that did not involve an expedited hearing, the time from the trial to the date the decision was filed ranged from 13 to 83 days. The decisions in five cases were filed more than 60 days after the trial. Our sample of 41 award decisions included nine 19(b) (expedited) cases. For the 19(b) cases, the decision was filed between 7 to 66 days after the trial date. Of these nine cases, 7 decisions were filed more than 25 days after the trial date. Three of these 7 decisions were filed more than 60 days after the trial date.

If the Commission does not monitor award decisions, especially for the 19(b) expedited cases, it cannot ensure that decisions are being filed within the required time frames. Further, employees will not begin receiving benefits until the decisions are filed. According to the Commission, trial dates are tracked based on self-reporting of closed proofs by the Arbitrators.

This self-reported information is entered into a Closed Proof Application to produce aging of cases reports by Arbitrator for the Chairman.

TIMELINESS OF AWARD DECISIONS	
RECOMMENDATION 16	***The Commission should include trial dates and decision dates in its workers' compensation system in order to track award decisions to ensure that they are filed in a timely manner.***
COMMISSION RESPONSE	The Commission agrees with this recommendation. Currently, the Commission internally tracks its trial dates with a program that does not interface with the Commission's case management mainframe system. Any replacement to this system will need to include trial dates and decision dates in order to serve as a means to track whether decisions are filed within the time periods set forth in the Workers' Compensation Act, allow for the compilation of statistical information, and ensure easy access to trial dates by the public to promote transparency.

Award files generally contained medical information to support the decision. However, we found two cases with no medical information in the file. Since Commission files do not contain transcripts, we could not determine who testified, what was discussed at the trial, or how certain elements of the decision were supported. According to Commission officials, it is common practice throughout all trial courts in Illinois not to order a transcript before issuing a ruling. The Arbitrator attended the trial and heard the testimony first hand so there usually is no need to review transcripts. Commission officials stated that requiring a transcript for every case would be unnecessary, burdensome, and slow down the decision process. Transcripts are ordered only when a case is appealed from an Arbitrator decision to the three-member Commission panel.

Percentage Loss Consistency

The Commission does not have guidelines for Arbitrators regarding awards. We reviewed awards and found that many are inconsistent for the same type of injury to the same body part. These inconsistencies involved the percent loss of use as well as the manner of determining loss. For instance, for Carpal Tunnel Syndrome claims, the amount awarded for cases we reviewed ranged from as little as 5 percent to as much as a life award. Repetitive motion injury awards varied with some Arbitrators awarding the same percentage loss amount for either hand while others awarded more for loss of the dominant hand. Below are examples of awards for repetitive trauma cases involving hands and arms:

- 20 percent loss use for each hand and 20 percent loss use for each arm;
- 17.5 percent loss use for each hand and 20 percent loss use for each arm;
- 17.5 percent loss use of right (dominant hand) and 15 percent loss use left hand; and

- 15 percent loss use of right hand and 5 percent loss use of left hand.

In some cases we reviewed, employees continue to be compensated for the same injury and body part multiple times. In one case that we sampled, the employee received settlements for her right arm in 1994 for 15 percent loss and again in 1999 for 20 percent loss. In May 2011, she received an award from an Arbitrator for 17.5 percent loss of use of the left hand; 18 percent loss of use of the right hand; and 6.5 percent loss of her right arm. Through two settlements and one award, the employee received a total of 41.5 percent loss of her right arm. It is unclear how past settlements and awards are taken into account or how many times an employee can be compensated for the same injury type and body part.

In some cases the award was based on the body part, while in other cases it was based on "Man as a Whole." It is not clear when the body part should be used or the "Man as a Whole" basis. As an example, for one case that we reviewed involving a knee injury, the Arbitrator awarded the injured employee 50 percent of the left leg ($499.54 PPD x 107.5 weeks = $53,700.55). This was in addition to 22.5 percent that the employee had received for her left leg in a previous case (for a total of 72.5% of the left leg). The case was appealed to the Commission who vacated the Arbitrator's award of 50 percent of a left leg and awarded 55 percent person as a whole ($499.54 PPD x 275 weeks = $137,373.50) or an additional $83,672.95.

Public Act 97-018 established criteria for Carpal Tunnel Syndrome awards. The Act states if the accidental injury involves Carpal Tunnel Syndrome due to repetitive or cumulative trauma, the permanent partial disability shall not exceed 15 percent 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 percent loss of use of the hand. Some states such as New York have established guidelines regarding the amount of compensation for other types of injuries as well. Such guidelines provide a range of loss of use to encourage consistency in awards.

To improve the consistency of awards, the Commission should establish guidelines regarding the percent of loss or disability for certain injuries. These guidelines should also include guidance regarding compensation for the same injury type on multiple occasions and how previous settlements and awards should be taken into account in determining loss of use for compensation.

AWARD GUIDELINES	
RECOMMENDATION 17	***The Commission should develop written guidelines to ensure consistency of Arbitrator awards for certain types of injuries. These guidelines should also discuss how prior awards and settlements for the same injury type should be taken into account in determining percentage loss for injuries.***
COMMISSION RESPONSE	The Commission partially agrees with this recommendation. The current "guidelines" that are used by Arbitrators are the Workers' Compensation Act, the Commission's Administrative Rules, and case law from both the Commission and the courts of the State of Illinois. The Commission believes that the most effective way to ensure consistent application of the law is through providing educational and training opportunities for Arbitrators. The Commission has increased the frequency of training seminars for both Arbitrators and Commissioners from annual to semi-annual and increased the number of hours for both sessions. These seminars include training on ethics, substantive workers' compensation law, and also recent appellate cases interpreting the provisions of the Workers' Compensation Act. Any guidelines that affect the private rights of parties outside of the Commission must be promulgated through the rulemaking process set forth in the Illinois Administrative Procedure Act. 5 ILCS 100/1-70. It is well established case law that administrative rules promulgated by an agency can neither expand nor contract the rulemaking authority set forth in its authorizing statute. Thus, the Commission may not be able to ensure consistency of awards through rules if the law and the facts dictate divergent results.

Chapter Five

CONFLICTS OF INTEREST AND FRAUD IDENTIFICATION POLICIES

CHAPTER CONCLUSIONS

Conflict of Interest Policies

Although the Illinois Workers' Compensation Commission has promulgated rules regarding conflicts of interest for Commissioners and Arbitrators, we identified several relationships that may have posed a conflict for the Arbitrator. Public Act 97-018, effective June 28, 2011, requires Arbitrators and Commissioners to follow the Canons of the Code of Judicial Conduct as adopted by the Supreme Court of Illinois for hearing and non-hearing conduct. In our review we identified several relationships that involve Arbitrators including:

- An Arbitrator whose spouse is a high ranking public employee union official hearing workers' compensation cases involving State employees;
- An Arbitrator hearing cases in which the injured employee was represented by an attorney that he had previously been a partner with in a law practice; and
- An Arbitrator hearing testimony from a doctor who had also performed surgery on the Arbitrator for his own workers' compensation claim/case.

Another situation that poses a possible conflict of interest for Arbitrators is one in which the Arbitrator has a workers' compensation case pending with CMS. Six different Arbitrators filed cases with CMS during the four-year period that we reviewed. If these Arbitrators are hearing cases involving State employees, this creates a possible conflict because the respondent in these cases is CMS which is represented by the Attorney General's Office, the same entities that are adjudicating the Arbitrator's own claim.

The Commission's Review Board is responsible for conducting investigations of complaints against Arbitrators and Commissioners. The Board is required to meet quarterly and to call a meeting within 15 days of any complaints received. **The Board did not meet for 3 ½ years (February 11, 2008-September 9, 2011).** During this timeframe, we found several allegations regarding Arbitrators and Commissioners alleging fraud, unethical practices, and favoritism. In addition, on February 15, 2011, the Commission placed two Arbitrators on administrative leave while they were being investigated.

The Department of Central Management Services has no formal policies or guidelines for conflicts of interest for Adjusters or other employees who process workers' compensation claims. CMS provided two e-mails from 2004 and 2006 as documentation of its conflict of interest

policies. However, all Adjusters employed by CMS during the audit period were not included in the e-mail.

The Attorney General's Office has established policies regarding conflicts of interest for Assistant Attorneys General. Additionally, Attorney General officials stated that the Assistant Attorneys General are bound by the rules of professional conduct and are subject to discipline by the Attorney Registration and Disciplinary Commission (ARDC) if they do not follow them.

Fraud Identification Policies

We found the **Workers' Compensation Commission does not have a formal policy or specific procedures to identify fraud and does not conduct statistical reviews or analyses to identify fraud or trends that might warrant review or investigation.** According to a Commission official, the Workers' Compensation Commission monitors complaints and allegations, and all fraud allegations are referred to the Department of Insurance Fraud Unit for follow-up. However, we found **the Commission did not refer any cases to the DOI Fraud Unit during the four-year period subject to our audit.**

CMS has policies that require Risk Management Division employees to act on any reports of workers' compensation disability benefit abuse and to assist law enforcement officials in efforts toward prosecuting abuses. Although CMS has established policy guidance for identifying possible fraud, as well as procedures for reporting cases for investigation, we found that **CMS does not conduct statistical analyses to identify trends and patterns in claim reporting that might be indicators of fraudulent activity**. According to CMS officials, the agency's computer system's data integrity problems and a shortage of staff made it difficult to conduct statistical reviews of the data to analyze and identify fraudulent trends.

We found the Office of the Attorney General does not have specific policies or procedures to identify or control fraud for Workers' Compensation cases referred to them. Attorney General officials stated that they are limited in identifying trends or fraud through data analysis because they only have a small number of the total workers' compensation cases (i.e., those cases in which a settlement contract is negotiated and/or approved by the Attorney General's Office, or which are taken to the Commission and the Attorney General represents the State at trial). Therefore, any analysis that could be conducted would be limited. Attorney General officials also stated that their focus is on assembling a defense in order to set beneficial precedent and prevent fraudulent trends from occurring.

Public Act 94-277, codified at 820 ILCS 305/25.5 and effective July 20, 2005, created a Workers' Compensation Fraud Unit within the Illinois Department of Insurance (formerly the Division of Insurance at DFPR). The Unit's sole purpose is to examine reports of workers' compensation fraud and noncompliance with insurance requirements by employers. **On October 17, 2011, we inquired with the Department of Insurance (DOI) about the number of workers' compensation referrals, investigations, and convictions for State employee workers' compensation claims the DOI Fraud Unit had been involved in.** DOI officials responded that "we cannot search our records by 'state employee' because none of the captured information in the system specified the targets place of employment in a searchable field. As

such we will have to search our records manually in order to get the numbers." **DOI responded to our inquiry more than four months later, on February 27, 2012, by saying that there had been a total of eight investigations of State employee workers' compensation claims resulting in no convictions during the four-year time period subject to our audit.**

Public Act 97-018, effective June 28, 2011, imposed additional requirements on DOI for the purpose of identifying and detecting workers' compensation fraud. The Fraud Unit at the Department of Insurance is required to procure and implement a system utilizing analytics such as predictive modeling, data mining, social network analysis, and scoring algorithms for the detection and prevention of fraud, waste, and abuse. The Act states that this system must be implemented **on or before January 1, 2012**. **As of February 28, 2012, the DOI Fraud Unit had not procured or implemented the required system.**

CLAIMS FILED BY EMPLOYEES IN THE PROCESS

To identify claims filed by individuals involved in the workers' compensation process we reviewed 26,101 claims records provided by CMS for the claims filed during the four-year period 2007-2010. We identified at least 53 claims filed by 44 individuals who were Commissioners or Arbitrators with the Illinois Workers' Compensation Commission, employees of CMS' Bureau of Benefits, employees of the Attorney General's Workers' Compensation Division, or workers' compensation coordinators at State agencies. Of the 53 claims filed, 18 claims resulted in settlements totaling $483,662 as of July 21, 2011. One resulted in an award for $15,711. Of the 44 individuals identified:

- 7 individuals were Arbitrators (6) or Commissioners (1) with the Illinois Workers' Compensation Commission. Two Arbitrators received settlements-- one for $48,790 and another for $18,119;
- 5 individuals were employees of CMS' Bureau of Benefits (1 was an Adjuster). Three of these employees received settlements totaling $97,251. The Adjuster's claim was settled for $40,794; and
- 5 individuals were employees of the Attorney General's Workers' Compensation Division. Three individuals were Assistant Attorneys General (AAG) in the Workers' Compensation Division. One AAG received a settlement for $9,542. A legal secretary received two settlements totaling $36,157 and a lead worker in the Division received a settlement for $23,512.

Of the 53 claims for these 44 individuals having a role in the workers' compensation claims process, 17 of those claims (32%) listed the injury as Carpal Tunnel Syndrome. However, others types of injuries listed, such as ulnar nerve, sprain, or strain, may also be for repetitive motion injuries.

CONFLICT OF INTEREST AND ETHICS POLICIES

The Illinois Workers' Compensation Commission has promulgated rules regarding conflicts of interest for Commissioners and Arbitrators. These rules delineate situations in which a Commissioner or Arbitrator is disqualified from hearing a case.

The Department of Central Management Services has no "formal" policies for conflicts of interest for Adjusters or others that process workers' compensation claims. CMS provided two e-mails from 2004 and 2006 as documentation of its conflicts of interest policies. Some of the CMS Adjusters were not employed as Adjusters at the time these e-mails were sent.

The Attorney General's Office has established policies regarding conflicts of interest for Assistant Attorneys General. The conflict of interest and ethics policies for employees of the Illinois Office of the Attorney General are found in the Policy and Procedures Manual provided by Attorney General officials. Employees are subject to rules concerning statements of economic interests, conflicts of interest, and outside practice of law and employment. Additionally, Attorney General officials stated that the Assistant Attorneys General are bound by the rules of professional conduct and are subject to discipline by the Attorney Registration and Disciplinary Commission (ARDC) if they do not follow them.

WORKERS' COMPENSATION COMMISSION

The *Rules Governing Practice Before the Illinois Workers' Compensation Commission* contains policies specific to complaints against Arbitrators and Commissioners and their disqualification from hearing certain cases (50 Ill. Adm. Code 7030.30). The rules for disqualification of Commissioners and Arbitrators include situations in which he or she is a party to the proceedings (50 Ill. Adm. Code 7030.30 (b)(6)(A)).

Disqualification of Commissioners and Arbitrators

Arbitrators and Commissioners are prohibited from hearing cases in which they have any interest in the case, financial or otherwise. The following are examples from the Commission's rules of instances in which an Arbitrator or Commissioner should be disqualified from a case:

- He or she has personal knowledge of disputed evidentiary facts concerning the proceedings;
- He or she has served as an attorney in the matter in controversy;
- He or she is a material witness concerning the matter;
- He or she was, ***within the preceding two years***, associated in the practice of law with any law firms or attorneys currently representing any party in the controversy;
- He or she was, ***within the preceding two years***, employed by any party to the proceeding or any insurance carrier, service or adjustment company, medical or rehabilitation provider, labor organization or investigative service involved in the claim; or

- He or she negotiated for employment with a party, or a party's attorney or insurance carrier or service or adjustment company, in a matter in which the Arbitrator or Commissioner is presiding or participating in an adjudicative capacity (50 Ill. Adm. Code 7030.30(b)).

An Arbitrator or Commissioner is also disqualified if **he or she,** or his or her spouse, or up to a third degree relative of either, is any of the following:

- **A party to the proceeding**, or an officer, director or trustee of a party;
- Acting as an attorney in the proceeding;
- Is known by the Arbitrator or Commissioner to have a substantial financial interest in the subject matter in controversy; or
- Is to the Arbitrator's or Commissioner's knowledge likely to be a material witness in the proceeding (50 Ill. Adm. Code 7030.30(b)).

***(Note:** Third degree relatives include an individual's immediate family (parent, brother, sister, child), grandparents, great-grandparents, grandchildren, great-grandchildren, aunts, uncles, nephews and nieces.)*

In most instances, Arbitrators or Commissioners in any of the circumstances listed above should withdraw from the case. The Arbitrator withdrawing from the case is required to notify the Commission, which will assign a new Arbitrator. If the case is being heard in Cook County, the Commission will assign a randomly chosen Arbitrator. If the case is being heard outside of Cook County, the geographically closest Arbitrator will be assigned to the case. If a Commissioner withdraws from a case, he or she must also notify the Commission, who will transfer the case to a new Commissioner. According to information provided by the Commission regarding Arbitrators recusals, Arbitrators recused themselves in 153 cases in FY09 and 153 cases in FY10 or about .25 percent of all cases. One Arbitrator accounted for 98 of the recusals in FY09 and 99 of the recusals in FY10. For some disqualifications, however, if the parties and attorneys involved all agree in writing that the Arbitrator's or Commissioner's interest is immaterial, the Arbitrator or Commissioner may participate in the proceeding.

Arbitrators and Commissioners complete the same training and disclosure forms as are required of most other State employees, including annual ethics training by the Office of the Executive Inspector General and Statement of Economic Interest forms filed with the Secretary of State.

Commissioner and Arbitrator Independence Issues

Commissioners must devote full time to their duties and may not practice law nor hold an office or position of profit under any federal, state or municipal government, or any other political subdivision. Each Arbitrator must also devote full time to his or her duties and cannot engage in the practice of law or hold any other office or position of profit under the United States or this State or any municipal corporation or political subdivision of this State (820 ILCS 305/13 and 14).

We reviewed the Statements of Economic Interest filed with the Secretary of State by Arbitrators and Commissioners and identified the following relationships:

- Income in excess of $1,200 from law firms owned by the individual;
- Income in excess of $5,000 from legal services from general practice and criminal defense;
- Income in excess of $1,200 from a county government;
- Serving as Director of a bank that had income in excess of $1,200 from the State of Illinois; and
- Serving as President or Director in a corporation.

There are various explanations for these disclosures, according to Commission officials. For example, legal fees disclosures reflect prior fees earned and accrued but not yet paid for work in the period prior to appointment as an Arbitrator. Regarding the statement with income from a county government, this involved a pension benefit for prior employment.

In our review of personnel files and workers' compensation claims files, we also identified several other relationships involving Arbitrators. One Arbitrator's spouse is a high ranking public employee union official in the State. This Arbitrator was a Commissioner but resigned in 2004 because of ethics legislation that was passed. The ex-Commissioner was hired back the same year as an Arbitrator and has arbitrated workers' compensation cases involving State employees who may have been members of the union represented by the spouse. According to Commission officials, this individual's status as an Arbitrator has been challenged several times in circuit court and the courts have upheld her appointment. By analyzing data provided by the Commission, we were able to identify at least 100 cases involving State employees that were arbitrated by this individual. According to Commission officials, the Arbitrator is aware of the potential conflict. The Arbitrator has advised that it is difficult to discern whether someone before her is a dues paying member or an employee of a unit entitled to representation by the union. When the matter has arisen regarding a claimant and the union, the Arbitrator advises the respondent counsel (Assistant Attorney General) and asks whether they object to her proceeding. Thus far no objections have been noted. If objection is raised, the Arbitrator will recuse herself.

For another Arbitrator, we found that the Arbitrator was hearing cases in which the injured employee was represented by an attorney that he had previously been a partner with in a law practice. According to the Arbitrator's personnel file, he had been a partner for over 7 years in the firm and left in August 2002. By analyzing data for the period 2007-2010 provided by the Commission, we were able to identify 448 total cases in which the Arbitrator heard a case represented by his past law practice partner. Some of these cases involved State employees. However, this is allowable under the Commission's current rules which require disqualification if the Arbitrator was, within the preceding two years, associated in the practice of law with any law firm or attorney currently representing any party in the controversy.

We also sampled one case in which an Arbitrator heard testimony from a doctor who had also performed surgery on the Arbitrator for his own workers' compensation claim/case. Payment of medical claims is an integral component of most workers' compensation claim decisions.

Another situation that poses a possible conflict of interest for Arbitrators is one in which the Arbitrator has a workers' compensation case pending with CMS. Six different arbitrators filed cases with CMS during the four-year period that we reviewed. If these Arbitrators are hearing cases involving State employees, this creates a possible conflict because the respondent in these cases is CMS which is represented by the Attorney General's Office, the same entities that are adjudicating the Arbitrator's claim and with which the Arbitrator may be negotiating a settlement of his or her claim. Data provided by the Commission shows that these Arbitrators heard cases involving State employees during the audit period.

New Code of Judicial Conduct Requirements

Public Act 97-018, effective June 11, 2011, requires Arbitrators and Commissioners to follow the Canons of the Code of Judicial Conduct as adopted by the Supreme Court of Illinois for hearing and non-hearing conduct. The Act also allows the Commission to set additional rules and standards for Arbitrators so long as they are not less stringent than the rules and standards established by the Code of Judicial Conduct.

The Judicial Code of Conduct requires that the duties of the Judicial Office should be conducted impartially and diligently. To achieve an unbiased judgment, a judge must disqualify himself or herself from a proceeding ***in which their impartiality might be questioned***. Instances of impartiality include:

1. the judge served as a lawyer in the matter of controversy;
2. the judge is associated in the private practice of law with any law firm currently representing any party in the controversy within the ***three preceding years***;
3. the judge, judge's spouse or child has an economic interest in the subject matter in controversy or in a party to the proceeding; and
4. the judge, judge's spouse or a person within third degree of relationship cannot be:
    a. a party to the proceeding, or an officer, director, or party trustee,
    b. an acting lawyer in the proceeding,
    c. have a minimal interest that could be substantially affected by the proceeding, or
    d. is a material witness in the proceeding (Supreme Court Rule 63, Canon 3(C).

In any of these situations, the judge should recuse himself or herself, to prove he or she has no personal involvement in the proceeding. Because these requirements now apply to Arbitrators and Commissioners, the Commission should update its rules to include these new statutory changes. The Commission should also establish a formal recusal process for Arbitrators and Commissioners.

COMMISSION CONFLICT OF INTEREST POLICIES	
RECOMMENDATION 18	***The Commission should revise and clarify its conflict of interest policies to incorporate provisions from the Judicial Code of Conduct and set forth a formal process for recusal of Arbitrators and Commissioners in cases in which their impartiality may be questioned.***
COMMISSION RESPONSE	The Commission agrees with this recommendation. The Commission is in the process of revising Section 7030.30 of its Administrative Rules in order to both reflect the application of the Code of Judicial Conduct to the Arbitrators and Commissioners, which was set forth in House Bill 1698, and establish a process by which parties can petition for disqualification of an Arbitrator or Commissioner.

Ethics and Fraud Training Requirements in Public Act 97-018

Arbitrators and Commissioners of the Workers' Compensation Commission are now required to receive training in ethics and in the detection of workers' compensation fraud. Although ongoing training has been a requirement since 2005, Public Act 97-018 contains additional requirements for training Commissioners and Arbitrators, including:

- Professional and ethical standards; and
- Detection of workers' compensation fraud and reporting obligations of Commission employees and appointees.

The Commission provided training to Commissioners and Arbitrators in October 2011 regarding the changes made by Public Act 97-018. The training included the Code of Judicial Conduct, fraud, and American Medical Association guidelines.

Complaints Against Arbitrators and Commissioners

The *Rules Governing Practice Before the Workers' Compensation Commission* set policies to address complaints against Arbitrators and Commissioners. The Workers' Compensation Review Board receives written complaints against Arbitrators or Commissioners when the following issues occur:

- Allegations of ***misconduct*** committed as part of the Commissioner's or Arbitrator's duties have been made ***which would factually support an indictment under the criminal law of Illinois***;
- Allegations that the Arbitrator's or Commissioner's conduct demonstrates ***favoritism toward one party*** in the conduct of the proceeding;
- Allegations that the Arbitrator or Commissioner did not follow the procedures and rules set by the Commission or the procedures set forth in the Workers' Compensation Act; and

- Allegations that an Arbitrator or Commissioner had a ***conflict of interest*** (50 Ill. Adm. Code 7500.10(a)(1).

The Review Board is required to conduct investigations of the complaints listed above. A regular meeting is required to be scheduled to be held at least once per calendar year quarter according the Commission's rules. Additional meetings can be held pursuant to the call of the Chairman or at the request of three or more members. The Board is also required to call a meeting within 15 days of any complaints received (50 Ill. Adm. Code 7500.10(C)(1). **The Board did not meet for 3 ½ years (February 11, 2008-September 9, 2011).**

Members of the Review Board are prohibited from participating in proceedings involving a complaint against them. In these cases, a Commissioner is only allowed to hear and defend against the complaint (50 Ill. Adm. Code 7500.10(b)).

In August 2011, we reviewed complaints sent to the Commission for the period 2007-2010. We found at least six complaints against arbitrators alleging fraud, unethical practices, and favoritism. We also found at least one complaint regarding a Commissioner. In addition, on February 15, 2011, the Commission placed two Arbitrators on administrative leave while they were being investigated. Both of these Arbitrators were the subject of complaints that we reviewed.

The Commission was not compiling and summarizing reports received regarding complaints. According to Commission officials, beginning in 2011, an employee of the Commission began preparing complaint summary reports. After not meeting for 3 ½ years, the Board met in September 2011 following an on-site review of complaints by the auditors. The minutes for the September 2011 meeting stated that there had been no formal complaints filed with the Commission based on allegations of improper communication. The Board also agreed that it should meet at least quarterly in the meeting minutes.

By not holding regular meetings and not meeting within 15 days of receipt of a complaint against an Arbitrator or Commissioner, the Commission Review Board did not fulfill its statutory duty to investigate allegations of misconduct, favoritism, or conflicts of interest involving Arbitrators.

WORKERS' COMPENSATION REVIEW BOARD	
RECOMMENDATION 19	***The Commission should ensure that the Workers' Compensation Commission Review Board meets quarterly and within 15 days of receipt of a complaint against an Arbitrator or Commissioner.***
COMMISSION RESPONSE	The Commission agrees with this recommendation. The Commission Review Board is scheduled to meet quarterly this year. In addition, the Commission is in the process of reviewing Part 7500 of its Administrative Rules, which governs the procedures of the Commission Review Board. Part of this review is an examination of how the function of the Commission Review Board has been affected by the changes instituted by House Bill 1698 and whether the 15-day meeting requirement is adequate to ensure that the Commission Review Board fulfills its statutory purpose in the most efficient manner.

CENTRAL MANAGEMENT SERVICES

CMS' Division of Risk Management does not have formal written policies and procedures related to conflicts of interest for Adjusters or other employees processing workers' compensation claims and payments. From information provided by CMS, the issue of conflicts of interest has only been addressed through emails. CMS provided two e-mails from 2004 and 2006 as documentation of its conflicts of interest policies.

The first e-mail, sent on September 17, 2004, was regarding the disclosure of a relationship between an Adjuster and a claimant. This e-mail was sent to the current CMS Workers' Compensation Claims Section Manager, who at the time was with the Department of Human Services. The e-mail was then forwarded to others, including many of the current CMS workers' compensation claims Adjusters. Some of these Adjusters were then with DHS and IDOT. However, all Adjusters employed by CMS during the audit period were not included in the e-mail. The e-mail contained the following policy statement:

> ***"It is the policy of the Division of Risk Management that all Workers' Compensation and Auto Liability claims be immediately identified and reported by the responsible adjuster if the claimant is a friend, relative, personal acquaintance, or business acquaintance of the responsible adjuster."***

In this situation, the e-mail instructs Adjusters to notify their supervisor of the relationship in writing. The supervisor will discuss the matter with the Claims Manager and the Division Manager. The Claims Manager or Division Manager will write a note back to the file regarding the disposition of the file. Options for handling the file include:

- Allow the Adjuster initially responsible for the file to retain it;
- Assign the file to another Adjuster within the Division;
- Assign the file to a Claims Supervisor within the Division; or

- If the Division Manager deems it appropriate, the Workers' Compensation Division within the Attorney General's Office could be requested to handle the settlement of the file.

The second email sent July 10, 2006, by the CMS Workers' Compensation Claims Section Manager, addressed situations in which a State agency workers' compensation coordinator files a workers' compensation claim. CMS Adjusters are assigned to claims by State agency and work closely with the agency's workers' compensation coordinators in obtaining information for claims involving the agency. As a result, conflicts of interest can arise when the claimant is also the agency's workers' compensation coordinator. As a result, if this occurs the assigned Adjuster should notify the Claims Manager and the case will be transferred to another Adjuster.

During our sample of workers' compensation claims, we identified relationships between Adjusters and claimants. As part of our sample of settlements and awards, we matched workers compensation coordinators' names with the claims provided by CMS. CMS in some cases did reassign cases because of an Adjuster conflict, including claims in which the claimant was the agency's workers' compensation coordinator. However, even in these cases the Adjuster was still involved sometimes in correspondence with the agency and in processing temporary disability payments for the claimant.

Other claims we sampled included individuals located within CMS Bureau of Benefits and the Risk Management Division:

- A workers' compensation claims Adjuster in CMS' Risk Management Bureau received a settlement for a repetitive trauma injury for $40,794;
- A member of management at the Bureau of Benefits received a settlement for Cubital Tunnel Syndrome for $33,635; and
- A nurse in CMS' Risk Management Division who approves medical bills received a settlement for Carpal Tunnel Syndrome for $22,822.

For the three settlement contracts involving employees from CMS Risk Management, no representative of CMS Risk Management signed the contract agreement. According to CMS officials, these files were turned over to the Attorney General's office for all issues and Risk Management was not involved in the settlements because of the conflict of interest. Therefore, the settlement contracts were neither signed by nor approved by CMS.

According to CMS officials, for these cases the AG reviews the claim for all issues including compensability. However, because the AG does not have the ability to input information into the CMS workers' compensation information system, the claim still needs to be managed. This would include tasks such as entering data into the workers' compensation system and approval of medical bills for payment. For these types of cases there is no written procedure regarding how the claim should be adjudicated and compensated in order to avoid a conflict of interest or the appearance of a conflict.

CMS CONFLICT OF INTEREST POLICIES	
RECOMMENDATION 20	***CMS should develop formal written policies for conflicts of interest, including how the claims of employees within CMS' Bureau of Benefits and Division of Risk Management will be processed. CMS should also provide training to Adjusters regarding those policies.***
DEPARTMENT RESPONSE	Agreed. Formal written policies have been drafted and will be further developed based upon the recommendations from this audit report and the State Workers' Compensation Program Advisory Board. Finalized guidelines will be included in the updated policy and procedure manual and reinforced through additional statewide training. Fraud and conflict of interest awareness training was provided to internal staff in August 2011.

ATTORNEY GENERAL

The Attorney General's Office has established policies regarding conflicts of interest for Assistant Attorneys General. The conflict of interest and ethics policies for employees of the Illinois Office of the Attorney General are found in the Policy and Procedures Manual provided by Attorney General officials. Employees are subject to rules concerning statements of economic interests, conflicts of interest, and outside practice of law and employment. Additionally, Attorney General officials stated that the Assistant Attorneys General are bound by the rules of professional conduct and are subject to discipline by the Attorney Registration and Disciplinary Commission (ARDC) if they do not follow them.

All employees who are or function as the head of a division, bureau or other administrative unit, have direct supervisory authority over contracts, or have supervisory responsibility for more than 20 or more employees are required to file statements of economic interest on the form provided by the Secretary of State on or before May 1st each year. Additionally, the Ethics Officer for the office is required to review these statements.

Assistant Attorneys General are required to notify their immediate supervisor as soon as possible of any actual or potential conflict of interest in the representation of any client or agency. Additionally, Assistant Attorneys General are prohibited from engaging in any outside activity that would ***create or appear to create a conflict of interest***. Furthermore, Assistant Attorneys General may not engage in the private practice of law or hold themselves out as being associated with a law firm or a member of any law firm. Violations of the rules for outside practice of law are grounds for termination.

According to officials at the Attorney General's Office, if an attorney such as an Assistant Attorney General, files a workers' compensation claim, it is transferred to a different office location outside of the individual's supervisory chain. In our sample of settlement and awards, we identified three employees of the AGs Workers' Compensation Bureau who filed a claim and received a settlement. These included:

- An Assistant Attorney General received a settlement for $9,542 for an automobile accident that occurred on his way to a call site;
- A Lead Worker II received a settlement for $23,512 for a carpal tunnel injury; and
- A legal secretary received two settlements for $19,710 and $16,447 for carpal tunnel/trigger finger.

According to AG officials, none of these instances constitutes a conflict of interest under any legal definition.

FRAUD IDENTIFICATION AND CONTROL POLICIES AND PROCEDURES

Neither the Workers' Compensation Commission, Central Management Services, or the Attorney General have formal written policies or rules related to identifying and controlling fraud for workers' compensation claims filed by State employees. Although there is a Workers' Compensation Fraud Unit within the Department of Insurance which is required to conduct investigations of workers' compensation fraud, the Fraud Unit only conducts investigations based on referrals. The Fraud Unit does not attempt to identify possible fraudulent claims or trends.

Public Act 97-018, effective June 28, 2011, required the Fraud Unit at the Department of Insurance to procure and implement a system utilizing analytics such as predictive modeling, data mining, social network analysis, and scoring algorithms for the detection and prevention of fraud, waste, and abuse. The Act required this system to be implemented **on or before January 1, 2012**. As of February 2012, the DOI Fraud Unit had not procured or implemented a system to identify workers' compensation fraud.

Department of Central Management Services

CMS has established policies that require the Risk Management Division to act on any reports of workers' compensation disability benefit abuse and to assist law enforcement officials in efforts toward prosecuting abuses. Investigations may be authorized by the Manager of Loss Control/Special Projects/Training Section. CMS policies further state that, *"it is the responsibility of the Risk Management Division Staff to act on any reports of suspected workers' compensation fraud"* or where the claim file records indicate an investigation may be warranted. Investigations may be warranted where:

- There is a failure to file the injury report in a timely manner;
- The injury does not resolve within the normal resolution period;
- The employee has a history of multiple settlements or awards via the workers' compensation system;
- Questionable circumstances surround how the injury took place;
- Inconsistent medical records are contained in the file;
- Difficulty in getting the employee back to regular duty occurs; or
- Reports of employee's activities are inconsistent with the injury.

The CMS claims Adjuster is required to document the rationale for a claim investigation in writing on a Claims Status Report Form (IL444-4220-1). The form is then sent to the Unit Supervisor for approval, after which it is forwarded to the Manager of Loss Control/Special Projects/Training Section. The latter person is responsible for gathering information and forwarding the claim file to the DOI Fraud Unit or to the Office of the Executive Inspector General (OEIG). We reviewed information provided by CMS regarding referrals for investigation. For the four-year period subject to our audit, 39 cases were referred for surveillance, 7 were referred to the DOI Fraud Unit, and 1 case was referred to the OEIG.

CMS also provided a list of trainings and seminars that Claims Section staff attended, some of which addressed identifying, investigating, and referring fraud. We noted three training sessions between 2007 and 2010 with a topic that addressed fraud. However, only one of the trainings, held in February 2008, involved all employees of the Claims Section. The other two trainings were just for supervisors and above.

Although CMS has established policy guidance for identifying possible fraud and procedures for reporting possible cases for investigation, CMS does not conduct statistical analyses to identify trends and patterns in claim reporting. According to CMS officials, the agency's computer system's data problems and a shortage of staff made it difficult to conduct statistical reviews of the data to analyze and identify fraudulent trends. However, officials stated that they do keep track of the amount of TTD from each agency. According to CMS officials its tracking is more geared towards performance measures and cost savings, rather than fraud detection. We requested examples of management reports from CMS, but reports provided were not intended for fraud identification. Public Act 97-018, effective June 28, 2011, requires the Fraud Unit at the Department of Insurance to procure and implement a system utilizing analytics,

including predictive modeling, data mining, social network analysis, and scoring algorithms for the detection and prevention of fraud, waste, and abuse. This is discussed later in this chapter.

Independent Medical Exams (IMEs)

As the employer, the State has the right and the obligation to require an employee to submit to an independent medical examination. A Liability Claims Adjuster can request an independent medical examination for many reasons, such as the injury does not appear to be resolving, the treating physician fails to provide a diagnosis or prognosis, or the injury has kept the employee off work for six months or longer.

Additional factors indicating a probable need for an independent medical examination include a soft tissue injury, a co-mingling of an occupational injury with a non-occupational illness, a complaint of pain or other symptoms with no objective findings and suspected malingering. According to CMS data, they have conducted more than 1,000 IMEs for the period FY07 through FY10. In FY09 and FY10, 305 and 247 IMEs were performed respectively.

Illinois Workers' Compensation Commission

The Workers' Compensation Commission does not have specific procedures to identify fraud and does not conduct statistical reviews or analyses to identify fraud or trends. The Commission can, however, refer individual cases to the DOI Fraud Unit. According to a Commission official, the Workers' Compensation Commission monitors complaints and allegations, and all fraud allegations are referred to the DOI Fraud Unit for follow-up. However, there is no formal policy that addresses fraud or what to do if a fraudulent workers' compensation claim is suspected or identified. According to Commission officials, for the period 2007-2010 no cases were referred to the DOI Fraud Unit.

Attorney General

We found the Office of the Attorney General does not have specific policies or procedures to identify or control fraud for workers' compensation cases referred to them. Attorney General officials stated that they are limited in identifying trends or fraud through data analysis because they only have a small number of the total workers' compensation cases (i.e., those cases in which a settlement contract is negotiated and/or approved by the Attorney General's Office, or which are taken to the Commission and the Attorney General represents the State at trial). Therefore, any analysis that could be conducted would be limited. Attorney General officials also stated that their focus is on assembling a defense in order to set beneficial precedent and prevent fraudulent trends from occurring. Officials at the AG provided us with two cases that they had referred to the DOI Fraud Unit during the four-year audit period.

FRAUD REFERRAL POLICIES AND PROCEDURES	
RECOMMENDATION 21	***The Commission and the Attorney General should establish specific policies and procedures regarding referrals for fraud investigations.***
COMMISSION RESPONSE	The Commission agrees with this recommendation. While the Commission has not established a formal policy for the referral of fraud investigations, the Office of the General Counsel of the Commission actively began referring any party with concerns regarding workers' compensation fraud to the Department of Insurance Fraud Unit starting in Fiscal Year 2011. The Commission also maintains a link on the front page of its website with information regarding workers' compensation fraud. The Commission has provided training to its Information Department staff, which are the Commission team members who answer phone calls from the public, on the changes to the fraud provisions of the Workers' Compensation Act in House Bill 1698.
ATTORNEY GENERAL RESPONSE	We strongly agree that policies and procedures must be in place to require reporting all possible illegal conduct in workers' compensation cases. We have taken a comprehensive approach when establishing such policies that is consistent with this recommendation and has been intended to mandate that Assistant Attorneys General report any conduct that they reasonably believe may constitute a violation of the law. Specifically, the Office of the Attorney General has written policies which require the reporting of all potentially illegal conduct, not only fraud. Based on these policies, this office has reported issues that have arisen in workers' compensation cases to (1) the U.S. Attorney's Office, (2) the Illinois Attorney Registration and Disciplinary Commission (ARDC), (3) the Office of the Executive Inspector General for the Agencies under the Governor, and (4) the Department of Insurance (DOI) Fraud Unit. First, the Office of the Attorney General has a written policy which requires all Assistant Attorneys General in the Workers' Compensation Bureaus to report to their senior supervisors any conduct by any person that they reasonably believe may constitute a violation of a criminal statute. A fraudulent workers' compensation claim may constitute a violation of Illinois criminal laws. The Government Representation Litigation Policy Manual, which provides the written policies that attorneys handling workers' compensation cases must follow, specifically requires that an **"Assistant Attorney General and the Bureau Chief shall notify the Division Chief and the Deputy Attorney General, Civil Litigation of any conduct which the assistant reasonably believes may constitute a violation of a criminal statute."** (Government Rep.

(Attorney General Response Continued)	Division, Litigation Policy Manual, Art. VI.) Pursuant to this policy, any Assistant Attorney General who suspects that a workers' compensation claimant or any other participant in a workers' compensation case is engaged in fraud must report that suspicion to the Division Chief and the Deputy Attorney General, Civil Litigation. The policy is not limited to reporting fraud because it is intended to cover all possible misconduct that an attorney in our office might suspect is occurring in a case. As a result, the policy does not merely mandate that the Division Chief and Deputy Attorney General, Civil Litigation report the conduct to DOI's Fraud Unit. Given the breadth of possible misconduct that an Assistant Attorney General might come across in a workers' compensation case, it is critical that we have a policy in place to require that attorneys report all suspicions of possible illegal conduct to a senior supervisor and to allow senior supervisors the ability to evaluate the facts to determine the appropriate law enforcement agency for referral. As attorneys, we have an obligation to refer allegations of criminal conduct to the appropriate prosecutorial agency, which, in some instances, may require referral to an agency other than the DOI Fraud Unit. Second, to ensure that all potentially improper conduct is reported (including conduct that might not necessarily violate a criminal law), the Attorney General's Policy and Procedures Manual includes a broader reporting requirement that provides: (g) Reporting Violations (1) An employee who has information which he or she reasonably believes indicates the existence of an activity constituting 1) a possible violation of a rule or regulation of the office; 2) mismanagement, a gross waste of funds, or abuse of authority; or 3) a substantial and specific danger to the public health and safety, shall immediately report such information to his or her supervisor, the Inspector General's Office, the Ethics Officer or any management official of the office. … (Attorney General's Policy and Procedures Manual, Article 4, Section 4.1.10(g)(1).) This policy imposes an additional requirement that all employees of the office report all concerns of misconduct. Third, in instances where an Assistant Attorney General has reason to believe that an attorney involved in a workers' compensation case in any capacity (such as counsel for the claimant, an arbitrator or a Workers' Compensation Commissioner) might be involved in misconduct, the Attorney General's Policy and Procedure Manual and the ethical rules governing the practice of law in Illinois mandate an additional reporting step beyond the requirements described above.

(Attorney General Response Continued)	All attorneys in the office must adhere to the Illinois Rules of Professional Conduct and actively cooperate with the ARDC in reporting any violations of the Rules of Professional Conduct. (Attorney General's Policy and Procedures Manual, Sec. 8.1.2 and 8.1.10.) Rules 8.3(a) and 8.4(b) and (c) of the Rules of Professional Conduct require that an attorney inform the ARDC of any knowledge that another attorney has "commit[ted] a criminal act that reflects adversely on the lawyer's honesty, trustworthiness, or fitness as a lawyer in other respects[ ]" or "engage[d] in conduct involving dishonesty, fraud, deceit, or misrepresentation." Additionally, the Illinois Supreme Court has held that the failure of an attorney to report a violation of Rule 8.4(b) or (c) can be grounds for disciplining the attorney who fails to report. (*See In re Himmel*, 125 Ill. 2d 531 (1988).) Thus, under the office policy and procedures manual and the Rules of Professional Conduct, an Assistant Attorney General is required to report any concerns of attorney misconduct to the ARDC. Implementation of the Office Policies and Procedures: Every attorney receives these policies and is trained on these policies and procedures when the attorney is hired with the office. Training on the policies and procedures is repeated and reinforced through (1) annual ethics training written by the Inspector General for the Office of the Attorney General, and (2) ethics CLE programs provided to all attorneys in the office by the Ethics Officer and Inspector General. In all of the trainings, attorneys are encouraged to reach out to the Ethics Officer, the Inspector General or a supervisor if they have any concerns or questions about possible illegal or unethical conduct by anyone.

WORKERS' COMPENSATION FRAUD UNIT

Public Act 94-277, later codified as Section 25.5 of the Workers' Compensation Act (820 ILCS 305/25.5), created a Workers' Compensation Fraud Unit (WCFU) at the Illinois Department of Insurance (formerly the Division of Insurance at DFPR). The Unit's sole purpose is to examine reports of workers' compensation fraud and noncompliance with insurance requirements by employers. Section 25.5(c) of the Act provides that:

> ***"It shall be the duty of the fraud and insurance non-compliance unit to determine the identity of insurance carriers, employers, employees, or other persons or entities who have violated the fraud and insurance non-compliance provisions…..of the Workers' Compensation Act"*** *(820 ILCS 305/25.5(c)).*

The Fraud Unit investigates individual cases of workers' compensation fraud and refers cases for prosecution to the Attorney General and the county State's Attorneys. Also, the Fraud Unit's 2010 annual report states, "The WCFU reporting system records and tracks reports of workers' compensation fraud." Although the Fraud Unit tracks reports of workers' compensation fraud, it does not analyze trend data or use other statistical tools to identify possible workers' compensation claims fraud.

On October 17, 2011, we inquired with the Department of Insurance as to the number of workers' compensation referrals, investigations, and convictions for State employee's workers' compensation claims for the DOI Fraud Unit. DOI officials responded that "we cannot search our records by 'state employee' because none of the captured information in the system specified the targets place of employment in a searchable field. As such we will have to search our records manually in order to get the numbers." Four months later, on February 27, 2012, we received a response from the Fraud Unit regarding the number of State employees referred, investigated, or convicted. For the four-year period 2007-2010, the DOI Fraud Unit investigated 8 possible cases of workers' compensation fraud involving a State employee. Although three of these cases were subsequently referred for prosecution, none of the investigations resulted in a conviction. According to DOI officials, for the three cases referred for prosecution: the 2007 case was referred to the Perry County State's Attorney, the 2009 case was referred to the Knox County State's Attorney, and the 2010 case was referred for prosecution to the Illinois Attorney General.

Exhibit 5-1
DEPARTMENT OF INSURANCE FRAUD UNIT STATISTICS FOR STATE EMPLOYEES

	2007	2008	2009	2010
Total Complaints	77	28	38	151
State Employee Cases				
Complaints	2	2	3	13
Investigations	2	1	2	3
Referred for Prosecution	1	0	1	1
Convictions	0	0	0	0

Source: OAG analysis of Department of Insurance Fraud Unit data.

New Fraud Requirements and Public Act 97-0018

Public Act 97-018, effective June 28, 2011, imposed additional requirements on DOI for the purpose of identifying and detecting workers' compensation fraud. The Fraud Unit at the Department of Insurance is required to procure and implement a system utilizing analytics such as predictive modeling, data mining, social network analysis, and scoring algorithms for the detection and prevention of fraud, waste, and abuse. The Act states that this system must be implemented **on or before January 1, 2012**. The Act also requires that the system be procured using a request for proposals process governed by the Illinois Procurement Code.

Additionally, Public Act 97-018 (820 ILCS 305/25.5 (e-5)) requires the Fraud Unit to provide a report detailing its activities and providing recommendations regarding opportunities for additional fraud, waste, and abuse detection and prevention **on or before July 1 annually beginning in 2012**. The report must be provided to the following individuals: the President of the Senate, the Speaker of the House of Representatives, the Minority Leader of the Senate, the

Minority Leader of the House of Representatives, the Governor, the Chairman of the Workers' Compensation Commission, and the Director of the Department of Insurance.

DOI is also required to submit another report to the Chairman of the Commission, the Workers' Compensation Advisory Board, the General Assembly, the Governor, and the Attorney General by January 1 and July 1 of each year (820 ILCS 305/25.5 (h)). This report shall include, at the minimum, the following information:

- The number of allegations of insurance noncompliance and fraud reported to the fraud and insurance non-compliance unit;
- The source of the reported allegations (individual, employer, or other);
- The number of allegations investigated by the fraud and insurance non-compliance unit; and
- The number of criminal referrals made and the entity to which the referral was made.

As of February 28, 2012, the DOI Fraud Unit had not procured and implemented a system utilizing analytics such as predictive modeling, data mining, social network analysis, and scoring algorithms for the detection and prevention of fraud, waste, and abuse. Without a system in place for analyzing workers' compensation data for trends that may identify fraud, the DOI Fraud Unit cannot fulfill its statutory requirements.

DEPARTMENT OF INSURANCE FRAUD UNIT	
RECOMMENDATION 22	***The Department of Insurance Workers' Compensation Fraud Unit should:*** • ***Enhance its case tracking to ensure that data is available regarding the number of State employee workers' compensation cases referred, investigated, and convicted; and*** • ***Ensure that it complies with the requirements of Public Act 97-018 to procure and implement a system utilizing advanced analytics inclusive of predictive modeling, data mining, social network analysis, and scoring algorithms for the detection and prevention of fraud, waste, and abuse.***
DEPARTMENT OF INSURANCE RESPONSE	The Workers' Compensation Fraud Unit (WCFU) of the Department of Insurance has already made the necessary changes in its data base to be able to track claims for state employees in the future. The Department has also initiated the procurement process for the purchase of predictive modeling software purchase for use by the WCFU.

Chapter Six

REPORT CONCLUSIONS

CONCLUSIONS

Throughout this audit we identified numerous shortcomings in both the structure and operations of the workers' compensation program as it applies to State employees. These problems have led to a program that is ill designed to protect the State's best interests as it relates to processing and adjudicating workers' compensation claims for State employees.

For workers' compensation claims filed during the four-year period 2007-2010, benefits resulted in costs to the State of $295 million. Almost $96 million or about one-third of the $295 million in workers' compensation claims paid during the four-year period was for Department of Corrections' employees. As of July 2011, Menard Correctional Center workers' compensation claims filed for the past four years resulted in over $30 million in payments. DHS claims accounted for $58.7 million of the $295 million in State payments for workers' compensation claims filed during 2007-2010.

Structural Issues

Prior to September 2004, large State agencies such as the Department of Human Services (DHS), Department of Corrections (Corrections), Illinois Department of Transportation (IDOT), and State Police performed the workers' compensation claims function in-house for their agencies. In addition to processing and adjudicating claims, these agencies also bore the financial responsibility associated with the cost of workers' compensation claims filed by their employees.

Effective July 30, 2004, Public Act 93-839 consolidated the workers' compensation function within CMS. As a result, in September 2004, these functions were merged into CMS. The Act also created a revolving fund to receive inter-fund transfers resulting from billings issued by CMS to State agencies for the cost of workers' compensation. Because funding and transfers have been insufficient to pay the cost of claims, CMS had a backlog of unpaid medical bills and other benefits for workers' compensation of $61.5 million as of May 18, 2011 according to CMS officials.

The decentralized nature of the workers' compensation program for State employees, has led to poor communication and miscommunication among the various entities involved in the process. Moreover, it has led to an inefficient workers' compensation program. Each workers' compensation case for a State employee may have up to four separate files with different entities. The current decentralized structure of the program involves a number of entities in the process for State employees. These include:

- 215 State agency workers' compensation coordinators located at agencies and facilities around the State;

- 8 CMS adjusters;
- 31 Arbitrators with the Workers' Compensation Commission located at call sites around the State; and
- 18 Assistant Attorneys General with the Attorney General's Office located around the State.

In addition to the challenges of coordination among these entities, CMS does not receive direct notification regarding cases filed with the Commission. CMS also does not have access to the Commission's information system or the AG's case file system. As a result, in some cases CMS may be unaware of claims until the time of settlement or award.

Operational Issues

In our review of agency operations for the workers' compensation program as it relates to State employees, we found that there was a lack of policies at agencies with a role in the process. We also found that agencies were not following existing laws, rules, and policies. These included:

- CMS was determining compensability without forms and other required information;
- Adjusters were not verifying average weekly wage information;
- CMS had conflicting settlement contract approval limits and did not always include all costs as part of the settlement amount;
- CMS was negotiating settlement contracts directly with the injured employee's attorney as opposed to those contracts being negotiated by the Attorney General's Office;
- The Commission did not require injured employees to file an Application for Adjustment of Claim prior to filing a settlement contract;
- The Commission was not evaluating Arbitrators annually as is required by law;
- The Commission has no written guidelines regarding awards; and
- The Commission Review Board was not reviewing complaints that involved an Arbitrator or Commissioner as is required by rule.

Conclusion

The scope of our audit was set by House Resolution No. 131 which required the Office of the Auditor General to conduct a management audit of the workers' compensation program as it applies to State employees for the period 2007-2010. Although Public Act 97-018 made changes to the workers' compensation statutes and may have an effect on the program's operations, it is unclear whether those changes will correct the numerous shortcomings that we have identified in this audit. Because of the extensive problems that permeate the workers' compensation program as it applies to State employees, the General Assembly should consider further actions. These actions may include changes in:

- The structure of the workers' compensation program including the nature and location of the workers' compensation function (State agency, CMS, or a third party);
- The placement and distribution of the fiscal responsibility for the cost of claims filed by agency employees; and
- Operational requirements for employees, agencies, CMS, the Commission, and the AG.

MATTER FOR CONSIDERATION BY THE GENERAL ASSEMBLY Structure and Operations of the Workers' Compensation Program As It Applies to State Employees
The General Assembly may wish to consider further changes to the structure and operations of the Workers' Compensation Program as it applies to State employees.

Note: Agencies were asked to respond to the Matter for Consideration by the General Assembly. Those responses are contained in Appendix F of this report.

APPENDICES

Appendix A
House Resolution No. 131

STATE OF ILLINOIS
HOUSE OF REPRESENTATIVES
97TH GENERAL ASSEMBLY

HOUSE RESOLUTION NO. 131

OFFERED BY REPRESENTATIVES MICHAEL J. MADIGAN-DWIGHT KAY-THOMAS HOLBROOK-FRANK J. MAUTINO-JIM WATSON, PAM ROTH, BARBARA FLYNN CURRIE, MICHELLE MUSSMAN, KEITH FARNHAM, CAROL A. SENTE, DANIEL BISS, KELLY BURKE, DEBORAH MELL, FRED CRESPO, GREG HARRIS, ELAINE NEKRITZ, ROBERT RITA, DAN REITZ, LISA M. DUGAN, DAVID REIS, ADAM BROWN, BILL MITCHELL, KAY HATCHER, JACK D. FRANKS, LINDA CHAPA LAVIA, PATRICIA R. BELLOCK, MICHAEL W. TRYON AND DONALD L. MOFFITT

WHEREAS, The Department of Central Management Services (CMS) is responsible for establishing "rules, procedures, and forms to be used by State agencies in the administration and payment of workers' compensation claims" and for the initial evaluation, determination, administration, and payment of workers' compensation claims involving State agencies [20 ILCS 405/405-105 and 405/405-411]; and

WHEREAS, According to the CMS website (http://www.cms.il.gov/cms/2_servicese_ben/workcomp.htm), "CMS Workers' Compensation Adjustors and unit supervisors are available to ensure efficient and proper claims administration in the following principal areas: 1) initial claim review for determining compensability; 2) ongoing benefit management (including payment of medical charges and temporary disability); and 3) proper negotiation of settlements based on partial or total permanent disability"; and

WHEREAS, Also according to the CMS website, the "Office of the Attorney General is responsible for the defense of claims arising from work-related injuries or disease. The CMS Workers' Compensation Adjustors work closely with the Office of the Attorney General to bring litigated cases to a resolution if such resolution is advantageous to the State. Otherwise, when both parties fail to reach an agreement, a disputed claim is heard in front of an Illinois Workers' Compensation Commission Arbitrator for disposition."; and

WHEREAS, By statute, the "hearings before the Arbitrator shall be held in the vicinity where the injury occurred after 10 days' notice of the time and place of such hearing shall have been given to each of the parties or their attorneys of record" [820 ILCS 305/19(b)]; and

WHEREAS, By rule, designation of an alternative hearing site "may be had upon showing to the Commission of extreme hardship worked upon a party or parties by the designated site, or by agreement of the parties" [50 Ill.Adm.Code 7020.50]; and

WHEREAS, According to the Illinois Workers' Compensation Commission's FY09 annual report, of 57,192 cases closed in FY09 by arbitrators, 50,610 were closed through a settlement process in which the employer and employee enter into a Settlement Contract and present it for approval to the arbitrator assigned to the case; and

WHEREAS, Parties who are dissatisfied with an arbitrator's decision may appeal that decision to a panel of three IWCC commissioners, and the panel's decision is final for cases involving State of Illinois employees; and

WHEREAS, According to the IWCC's website (http://www.iwcc.il.gov/news.htm), under a procedure in effect prior to March 1, 2011, over 3,500 pro se settlement contracts were reviewed by arbitrators before being assigned a case number in calendar year 2010, making it difficult for the IWCC to "determine if any of those contracts go astray and fail to get entered into the system"; and

WHEREAS, Recent news reports raised questions about the practices of two workers' compensation arbitrators, each of whom has since been placed on administrative leave; therefore, be it

RESOLVED, BY THE HOUSE OF REPRESENTATIVES OF THE NINETY-SEVENTH GENERAL

ASSEMBLY OF THE STATE OF ILLINOIS, that the Auditor General is directed to conduct a management audit of the Workers' Compensation program as it applies to State employees; and be it further

RESOLVED, That the audit include, but not be limited to, the following:

(1) the roles of the Department of Central Management Services, the Attorney General's Office, and the Illinois Workers' Compensation Commission in processing, reviewing, determining, and paying on workers' compensation claims filed by State workers;
(2) the number of claims filed by State workers during the last 4 years, including a classification of the types of alleged injuries, employing unit, disposition, and claims payments;
(3) a review of the settlement contract process and, in particular, documentation supporting any decisions on these claims;
(4) an analysis of any fraud identification and control policies and procedures governing the workers' compensation program;
(5) whether the processing of State employee workers' compensation claims complies with applicable State law and regulations;
(6) an analysis of arbitrator caseloads over the 4-year period, including the number of cases closed, a classification of the types of alleged injuries involved in those cases, the employing unit involved in the claims, and claim dispositions and payments;
(7) a review of conflict of interest policies applicable to arbitrators, commissioners, and other principals involved in the workers' compensation program, including any procedures for handling workers' compensation claims filed by arbitrators, commissioners, and other principals involved in the workers' compensation program; and
(8) a comparison of claims history by State workers to claims filed by all other workers covered under the Workers' Compensation program; and be it further

RESOLVED, That the Department of Central Management Services, Attorney General's Office, Illinois Workers' Compensation Commission, and any other entity having information relevant to this audit cooperate fully and promptly with the Auditor General's Office in the conduct of this audit; and be it further

RESOLVED, That the Auditor General commence this audit as soon as possible and report his findings and recommendations upon completion in accordance with the provisions of Section 3- 14 of the Illinois State Auditing Act; and be it further

RESOLVED, That copies of this resolution be presented to the Auditor General, the Director of Central Management Services, the Attorney General, and the Commissioners of the Illinois Workers' Compensation Commission.

Adopted by the House of Representatives on March 10, 2011.

Mark Mahoney

MARK MAHONEY
CLERK OF THE HOUSE

Michael J. Madigan

MICHAEL J. MADIGAN
SPEAKER OF THE HOUSE

Appendix B
Audit Methodology

Appendix B

AUDIT METHODOLOGY

House Resolution No. 131 directed the Auditor General to conduct a management audit of the Workers' Compensation Program as it applies to State employees. The Resolution specifically required a review of the settlement contract process and the documentation supporting decisions on those claims as well as whether the processing of workers' compensation claims complies with applicable State laws and regulations. The audit determinations are included in the resolution (see Appendix A).

We interviewed officials from the Department of Central Management Services Risk Management Division, the Illinois Workers' Compensation Commission, the Illinois Attorney General's Office, and the Illinois Department of Insurance. We also examined organizational structures for these agencies. We collected and analyzed electronic data from CMS, the Attorney General, and the Commission regarding claims filed and cases for the period January 1, 2007 through December 31, 2010.

We further reviewed and assessed policies and procedures related to claims processing, the settlement process, fraud identification, and conflicts of interest. We also reviewed the personnel files and backgrounds of Arbitrators at the Commission.

We assessed risk by reviewing findings from previous OAG Financial Audits and Compliance Examination, agency policies and procedures, management controls, and administrative rules. This audit identified some weaknesses in those controls, which are included as recommendations in this report.

In conducting the audit, we reviewed applicable State statutes, administrative rules, and agency policies. We reviewed compliance with these laws, rules, and policies to the extent necessary to meet the audit's objectives. Any instances of non-compliance we identified are noted as recommendations in this report.

Testing and Analytical Procedures

Initial work began on this audit in March 2011 and fieldwork was concluded in December 2011. CMS provided auditors with an electronic download in July 2011 of 26,101 workers' compensation claims filed by State employees for the period January 1, 2007 through December 31, 2010. From the 26,101 claims, we identified 3,621 settlements and 611 awards to State employees. As of July 2011, total settlements for the four-year period were $107.4 million and total awards were $17.8 million. We conducted a stratified sample of 68 settlements and 41 awards. These cases were selected judgmentally and therefore results cannot be projected to the population.

Settlements Testing

In order to test settlement contracts and the documentation supporting decisions on those claims, we stratified the 3,621 settlements into groupings including:

- Settlements to employees and principals in the process;
- Settlements with amount near approval limits;
- Settlements in which the claim was not filed in a timely manner (within 45 days);

- Settlements in which the claims had a high number of days of TTD (more than 90 days); and
- Settlements from employing units with a high number of settlements (Chester Mental Health Center and Menard Correctional Center).

We judgmentally selected 68 settlements from these stratified groups for testing.

Awards

We reviewed awards made by Arbitrators at the Illinois Workers' Compensation Commission. We stratified the 611 awards into groupings including:

- Awards to employees and principals in the process;
- Awards that included a settlement amount;
- High dollar awards (over $100,000);
- Awards in which the claim was not filed in a timely manner (within 45 days);
- Awards in which the claims had a high number of days of TTD (more than 90 days);
- Awards from employing units with a high number of awards (Chester Mental Health Center and Menard Correctional Center).

We judgmentally selected 41 awards from these stratified groups for testing.

Payments

We performed analyses of payments made related to State employee workers' compensation claims including those made for settlements, awards, medical treatment, and others. The payments data provided by CMS represents the payments made for claims filed for the four year period January 1, 2007- December 31, 2010. Because of the nature of workers' compensation claims and payments, the payment data represents a snapshot at the time we received the information (July 2011).

Appendix C

Workers' Compensation Claims
By Agency and Employing Unit
January 1, 2007 through December 31, 2010

Appendix C Workers' Compensation Claims Filed by Agency and Employing Unit Calendar Year 2007-2010		
AGENCY	**DIVISION**	**Total**
DEPARTMENT OF HUMAN SERVICES	DHS-CHESTER MHC	1,180
	DHS-SHAPIRO DEV CTR	1,052
	DHS-WARREN G MURRARY DEV CTR	954
	DHS-JACKSONVILLE MH & DEV CTR	797
	DHS-ELIZABETH LUDEMAN DEV CTR	600
	DHS-JACK MABLEY DVLPMNTL CTR	584
	DHS-FIELD OPERATIONS	484
	DHS-WILLIAM A HOWE DEV CTR	405
	DHS-CLYDE L CHOATE MH & DEV CTR	355
	DHS-ELGIN MHC	347
	KILEY DEVELOP CTR	327
	DHS-ALTON MHC	319
	DHS-WILLIAM W FOX DEV CTR	229
	DHS-ANDREW MCFARLAND MHC	178
	DHS-JOHN J MADDEN MH CTR	173
	DHS-ADMIN & PROGRAM SUPPORT	165
	DHS-H DOUGLAS SINGER MHC	158
	DHS-TINLEY PARK MHC	151
	DHS-CHICAGO-READ MHC	148
	DHS - HOME SERVICES	111
	DHS-ILLINOIS SCHOOL FOR THE DEAF	77
	DHS-RUSHVILLE TDF	66
	DHS-EARN FARE	52
	ILLINOIS SCHOOL FOR THE VISUALY IMPAIRED	37
	DHS-LINCOLN DEV CTR	1
DEPARTMENT OF HUMAN SERVICES Total		**8,950**
DEPT OF CORRECTIONS	MENARD CC	869
	STATEVILLE CC / R&C	668
	PINCKNEYVILLE CC	300
	DIXON CC	267
	PONTIAC CC	231
	LAWRENCE CC	183
	FIELD OPERATIONS	178
	HILL CC	161
	DWIGHT CC	153
	SHAWNEE CC	147

	TAMMS CC	141
	BIG MUDDY RIVER CC	140
	SHERIDAN CC	130
	CENTRALIA CC	127
	WESTERN CC	126
	VANDALIA CC	112
	LOGAN CC	102
	VIENNA CC	94
	DANVILLE CC	91
	ILLINOIS RIVER CC	88
	EAST MOLINE CC	81
	LINCOLN CC	65
	JACKSONVILLE CC	64
	GRAHAM CC	63
	SCHOOL DISTRICT	62
	SOUTHWESTERN CC	60
	DECATUR CC	51
	ROBINSON CC	49
	THOMSON CC	48
	GENERAL OFFICE ADULT	45
	INDUSTRIES	43
	TAYLORVILLE CC	30
	TRAINING ACADEMY	12
	KANKAKEE MSU	5
	GENERAL OFFICE JUVENILE	2
	TRANSITIONAL CENTERS	1
DEPT OF CORRECTIONS Total		**4,989**
DEPT OF TRANSPORTATION	DOT-DIST 1 (SHAUMBURG)	827
	DOT-DIST 8 (FAIRVIEW HTS)	339
	DOT-DIST 6 (SPRINGFIELD)	276
	DOT-DIST 4 (PEORIA)	217
	DOT-DIST 2 (DIXON)	197
	DOT-DIST 9 (CARBONDALE)	192
	DOT-DIST 7 (EFFINGHAM)	180
	DOT-DIST 5 (PARIS)	169
	DOT-DIST 3 (OTTAWA)	132
	DOT-CENTRAL ADMIN & PLANNING	122
	DOT-DAY LABOR	38
	DOT-AERONAUTICS, GEN OFF	1
DEPT OF TRANSPORTATION Total		**2,690**

DEPT OF STATE POLICE	DOSP-STATE TROOPERS	700
	DOSP-ADMINISTRATION DIV	91
	DOSP-DIV FORENSIC SERV AND ID	84
	DOSP-DIV OF CRIMINAL INVEST	46
	DOSP-INFORMATION SERVICES BUREAU	20
	DOSP-DIV OF INTERNAL INVEST	11
	DOSP-LOCAL TASK FORCES	8
	DOSP-NARCOTIC INTELLIGENCE	5
	DEPT OF STATE POLICE	1
	DOSP-OPERATION VALKYRIE	1
DEPT OF STATE POLICE Total		**967**
DEPT OF VETERANS AFFAIRS	DVA-ILL VETERAN'S HOME	469
	DVA-MANTENO VETERAN'S HOME	295
	DVA - LASALLE FACILITY	106
	DVA-ANNA VETERANS' HOME	74
	DVA-GENERAL OFFICE	10
	DVA-VETERANS' FIELD SERVICES	5
DEPT OF VETERANS AFFAIRS Total		**959**
JUVENILE JUSTICE	JUVENILE JUSTICE - ST. CHARLES	282
	JUVENILE JUSTICE - HARRISBURG	161
	JUVENILE JUSTICE - JOLIET	154
	JUVENILE JUSTICE - KEWANEE	112
	JUVENILE JUSTICE - MURPHYSBORO	81
	JUVENILE JUSTICE - WARRENSVILLE	47
	JUVENILE JUSTICE - CHICAGO	22
	JUVENILE JUSTICE - PERE MARQUETTE	10
	JUVENILE JUSTICE - SCHOOL DISTRICT	8
JUVENILE JUSTICE Total		**877**
SECRETARY OF STATE	SEC OF STATE-MOTOR VEH GROUP	484
	SEC OF STATE-GENERAL ADMIN	263
	SEC OF STATE-EXECUTIVE GROUP	9
	SECRETARY OF STATE	3
	SOS-MANDATORY AUTO INSURANCE PROGRAM	1
	SOS-COMMERCIAL MOTOR VEHICLE SAFETY PROG	1

SECRETARY OF STATE Total		**761**
NORTHERN ILL UNIVERSITY	NIU-GENERAL OPERATIONS	697
	NORTHERN ILL UNIVERSITY	5
NORTHERN ILL UNIVERSITY Total		**702**
ILL STATE UNIVERSITY	ISU-GENERAL OPERATIONS	693
	ILL STATE UNIVERSITY	6
ILL STATE UNIVERSITY Total		**699**
SIU- CARBONDALE	SIU- CARBONDALE	634
	SIU-CARBONDALE CAMPUS	1
SIU- CARBONDALE Total		**635**
DEPT OF NATURAL RESOURCES	DNR-LAND MANAGEMENT	310
	DEPT OF NATURAL RESOURCES	64
	DNR-LAW ENFORCEMENT	64
	DNR-WILDLIFE RESOURCES	25
	DNR-SURFACE MINED LAND RECLM	13
	DNR-FORESTRY RESOURCES	8
	DNR-DIVISION OF NATURAL HERITAGE	7
	DNR-CAPITAL DEVOLOPMENT BD	5
	MUSEUMS	4
	STATE GEOLOGICAL SURVEY	3
	STATE NATURAL HISTORY SURVEY	2
	STATE WATER SURVEY	1
	HAZARDOUS WASTE RESEARCH INFO CENTER	1
DEPT OF NATURAL RESOURCES Total		**507**
WESTERN ILL UNIVERSITY	WESTERN ILL UNIVERSITY	182
	WIU-GENERAL OPERATIONS	110
WESTERN ILL UNIVERSITY Total		**292**
EASTERN ILL UNIVERSITY	EIU-GENERAL OPERATIONS	290
EASTERN ILL UNIVERSITY Total		**290**
HEALTHCARE AND FAMILY SERVICES	HFS-CHILD SUPPORT ENFORCEMENT	117
	HFS-MEDICAL PROGRAMS	84
	HFS-FINANCE	27

	HFS-HEALTHCARE PURCHASING	19
	HFS-ATTORNEY GENERAL'S OFFICE	11
	HFS-PERSONNEL & ADMINISTRATIVE SERVICES	8
	HFS-GENERAL COUNSEL	5
	HFS-INSPECTOR GENERAL	4
	HFS-DIRECTOR'S OFFICE	3
	HEALTHCARE AND FAMILY SERVICES	3
	HFS-INFORMATION SYSTEMS	1
	HFS-LEGISLATIVE AFFAIRS	1
HEALTHCARE AND FAMILY SERVICES Total		**283**
DEPT OF CHILDREN & FAMILY SERV	CHILD PROTECTION - DOWNSTATE REGIONS	56
	CHILD PROTECTION - COOK REGIONS	54
	CHILD WELFARE-DOWNSTATE REGIONS	50
	CHILD WELFARE-COOK REGIONS	35
	CHILD DEVELOPMENT	15
	DCFS-LISCENSING	10
	DCFS-REGIONAL OFFICES	10
	SUPPORT SERVICERS	10
	OPERATIONS AND COMMUNITY SERVICES	9
	CHILD PROTECTION ADMINISTRATION	7
	CLINICAL SERVICES	7
	PLANNING, RESEARCH AND DEVELOPMENT	5
	ADMINISTRATIVE CASE REVIEW	4
	DAY CARE SERVICES	4
	DCFS-ADMIN JUVENILE JUST PGMS	1
	DCFS-DIRECTORS OFFICE	1
	DCFS-PLANNING AND TRAINING	1
DEPT OF CHILDREN & FAMILY SERVICES Total		**279**
CENTRAL MANAGEMENT SERVICES	CMS-BUREAU OF PROPERTY MANAGEMENT	91
	CMS-BUREAU OF SUPPORT SERV	84
	CMS-BUR OF COMMUNICATION/COMPUTER SVCS.	52
	CMS-BUREAU OF ADMIN OPER	11
	CMS-BUREAU OF BENEFITS	9

	CMS-IL INFORMATION SERVICES	9
	CMS-BUREAU OF PERSONNEL	9
	CMS-SOIC,CHI	2
	CENTRAL MANAGEMENT SERVICES	1
	CMS-OFF OF SECURITY INVEST	1
CENTRAL MANAGEMENT SERVICES Total		**269**
DEPT OF MILITARY AFFAIRS	DM&N-FACILITIES	125
	2008 FLOOD	117
DEPT OF MILITARY AFFAIRS Total		**242**
DEPT OF PUBLIC HEALTH	DPH-OFF OF HLTH REGULATION	84
	DPH-OFF OF HLTH PROTECTION	36
	OFFICE OF HEALTH AND WELLNESS	21
	DPH-OFFICE OF FINANCE AND ADMINISTRATION	15
	DPH-CHICAGO LAB	13
	DPH-EPIDEMIOLOGY AND HEALTH SYSTEMS DEV	11
	DPH-SPRINGFIELD LAB	8
	DPH-DIRECTOR'S OFFICE	7
	DPH-OFFICE OF HEALTH PROTECTION: AIDS	4
	DPH OFFICE OF WOMENS HEALTH	4
	DPH PUBLIC HEALTH PREPAREDNESS	3
	DPH HEALTH POLICY	3
	DPH-CARBONDALE LAB	2
	DPH-DIV OF EDP	2
	DPH-PUB HLTH LAB	1
DEPT OF PUBLIC HEALTH Total		**214**
DEPT OF REVENUE	REV-TAX PROCESSING	41
	REV-ENFORCEMENT	31
	REV-MANAGEMENT SERVICES	24
	REV-ELECTRONIC DATA PROCESSING	20
	REV-LOTTERY BOARD OPERATIONS	20
	REV - GOVERMENT SERVICES	12
	REV-LOTTERY BOARD	10
	REV-RIVERBOAT GAMBLING	9
	REV-LIQUOR CONTROL GENERAL OFFICE	6
	REV-RACING BOARD GENERAL OFFICE	3

	REV-RACING BOARD REG. OF RACING PROPRAM	3
	REV-RACING BOARD LABORATORY PROGRAM	1
	REV-PROPERTY TAX APPEAL BOARD	1
DEPT OF REVENUE Total		**181**
SOUTHERN ILL UNIVERSITY EDWARDSVILLE	SOUTHERN ILL UNIVERSITY EDWARDSVILLE	161
SOUTHERN ILL UNIVERSITY EDWARDSVILLE Total		**161**
DEPT OF AGRICULTURE	AGRI-FAIRS & HORSE RACING	33
	AGRI-ANIMAL HEALTH	22
	BUREAU OF WEIGHTS AND MEASURES	17
	DUQUOIN STATE FAIR	12
	ENVIROMENTAL PROGRAMS	11
	DUQUOIN BUILDINGS AND GROUNDS	8
	AGRI-PLANT INDUSTRIES/CONSUMER SERVICES	8
	HORSE RACING	3
	AGRI-CONSUMER SERVICES	3
	COUNTY FAIRS	3
	AGRI-ADMIN SERVICES	2
	AGRI-MARKETING	1
DEPT OF AGRICULTURE Total		**123**
EMPLOYMENT SECURITY	EMPSEC-CENTRAL ADMIN.	65
	EMPSEC-OPERATIONS	25
	EMPSEC-COMPREHNSVE EMP TRAINING	5
	EMPSEC-FINANCIAL MGMT SERVICES	2
	EMPSEC-MGMT INFO SYSTEM	1
EMPLOYMENT SECURITY Total		**98**
ENVIRONMENTAL PROTECTION AGENCY	EPA-LAND POLLUTION CONTROL	22
	EPA-ADMINISTRATION	21
	EPA-WATER POLLUTION CONTROL	20
	EPA-AIR POLLUTION CONTROL	19
	EPA-VEHICLE INSPECT & MAINT	3
	EPA-LABORATORY SERVICES	2
	EPA-OFFICE OF CHEMICAL SAFETY	1

	EPA-ELECTRONIC DATA PROCESSING	1
ENVIRONMENTAL PROTECTION AGENCY Total		**89**
SOUTHERN ILL UNIVER SCHOOL OF MEDICINE	SOUTHERN ILL UNIVER SCHOOL OF MEDICINE	82
SOUTHERN ILL UNIVER SCHOOL OF MEDICINE Total		**82**
HISTORIC PRESERVATION AGENCY	HPA-HISTORIC SITES	27
	GENERAL OPERATIONS	21
	HPA-PRESERVATION SERVICES DIVISION	9
	HPA-HISTORICAL LIBRARY	9
	HPA-ADMINISTRATIVE SERVICES	8
HISTORIC PRESERVATION AGENCY Total		**74**
STATE COMPTROLLER	COMPTROLLER-ADMINISTRATION	39
	COMPTROLLER-OFFICERS SALARIES	18
	COMPTROLLER-ST.WIDE FISCAL OPER	7
	STATE COMPTROLLER	4
	COMPTROLLER-EDP	3
	COMPTROLLER-ACCT DESIGN & CON	1
	COMPTROLLER-SPECIAL AUDITS	1
STATE COMPTROLLER Total		**73**
CHICAGO STATE UNIVERSITY	CSU-GENERAL OPERATIONS	58
CHICAGO STATE UNIVERSITY Total		**58**
ATTORNEY GENERAL	ATTY GEN-SPRINGFIELD OFFICE	33
	ATTY GEN- CHICAGO OFFICE	14
	ATTY GENERAL-GENERAL OFFICE	1
ATTORNEY GENERAL Total		**48**
NORTHEASTERN ILL UNIVERSITY	NEIU-GENERAL OPERATIONS	47
NORTHEASTERN ILL UNIVERSITY Total		**47**
FINANCE AND PROFESSIONAL REGULATION	FINANCE AND PROFESSIONAL REGULATION	45
FINANCE AND PROFESSIONAL REGULATION Total		**45**
STATE BOARD OF EDUCATION	SBED-GENERAL OFFICE	44

STATE BOARD OF EDUCATION Total		**44**
GOVERNORS STATE UNIVERSITY	GSU-GENERAL OPERATIONS	43
GOVERNORS STATE UNIVERSITY Total		**43**
ILL WORKERS COMPENSATION COMMISSION	IWC-GENERAL OFFICE IWC-PEORIA OFFICE	40 1
ILL WORKERS COMPENSATION COMMISSION Total		**41**
COMMERCE AND ECONOMIC OPPORTUNITY	DCEO-MIS DCEO-WORKFORCE DEVELOPMENT COMMERCE AND ECONOMIC OPPORTUNITY DCEO-BUREAU SMALL BUS DCEO-TOURISM DCEO-BUSINESS DEVELOPMENT DCEO-COMMUNITY DEVELOPMENT DCEO-FILMS DCEO-INTRNTL BUSINESS GENERAL OPERATIONS DCEO-AGENCYWIDE COSTS COAL MARKETING AND DEVLOPMENT	6 4 4 3 2 2 2 1 1 1 1 1
COMMERCE AND ECONOMIC OPPORTUNITY Total		**28**
STATE FIRE MARSHALL OFFICE	ST FIRE MARSHALL - GENERAL OFFICE	26
STATE FIRE MARSHALL OFFICE Total		**26**
COURT OFFICIALS	GENERAL OPERATIONS COURT OFFICIALS	25 1
COURT OFFICIALS Total		**26**
ILLINOIS EMERGENCY MANAGEMENT AGENCY	ILLINOIS EMERGENCY MANAGEMENT AGENCY 2009ICE SEMA-ADMIN., FISCAL, & COMMUNICATIONS	21 2 1
ILLINOIS EMERGENCY MANAGEMENT AGENCY Total		**24**
STATE EMPLOYEES RETIREMENT SYSTEMS	SERS-GENERAL OPERATIONS	19

STATE EMPLOYEES RETIREMENT SYSTEMS Total		**19**
GENERAL ASSEMBLY	GEN ASSEM - HOUSE OF REPS	13
	GEN ASSEM - SENATE	4
GENERAL ASSEMBLY Total		**17**
MATH AND SCIENCE ACADEMY	MATH & SCIENCE ACADEMY GEN'L OFFICE	16
MATH AND SCIENCE ACADEMY Total		**16**
ILLINOIS STUDENT ASSISTANCE COMMISSION	ISAC-EXEC DIV ADMINISTRATION	16
ILLINOIS STUDENT ASSISTANCE COMMISSION Total		**16**
DEPT OF AGING	AGING-GENERAL SERVICES	6
	AGING-DISTRIB ITEMS	2
	AGING-MIS SECTION	1
	AGING-OLDER AMERICAN SERVICES	1
	AGING-LONG TERM CARE	1
DEPT OF AGING Total		**11**
ILL COMMERCE COMMISSION	ICC-TRANSPORTATION	6
	ICC-ADMINISTRATIVE SERVICES	4
ILL COMMERCE COMMISSION Total		**10**
STATE TREASURER	ST TREASURER-GENERAL OFF	10
STATE TREASURER Total		**10**
DEPT OF HUMAN RIGHTS	DHR-ADMINISTRATION	10
DEPT OF HUMAN RIGHTS Total		**10**
STATE APPELLATE DEFENDER OFFICE	OAD-DEFENDER OFFICE-GENERAL	7
	OAD-POST CONVICTION RESOURCE CENTER	2
STATE APPELLATE DEFENDER OFFICE Total		**9**
LEGISLATIVE PRINTING UNIT	LEG PRINT UNIT - GENERAL OPER	8
LEGISLATIVE PRINTING UNIT Total		**8**
CAPITAL DEVELOPMENT BOARD	CDB-GENERAL OFFICE	6

CAPITAL DEVELOPMENT BOARD Total		**6**
DEPT OF LABOR	LABOR-GENERAL OFFICE	6
DEPT OF LABOR Total		**6**
TEACHERS RETIREMENT SYSTEM	TEACH RTRMNT SYS-GENERAL OFFICE	6
TEACHERS RETIREMENT SYSTEM Total		**6**
UNIVERSITIES RETIREMENT SYSTEM	UNIV RETIR SYS-GENERAL OFFICE	5
UNIVERSITIES RETIREMENT SYSTEM Total		**5**
GUARDIANSHIP & ADVOCACY COMMISSION	GAC - GENERAL OFFICE	5
GUARDIANSHIP & ADVOCACY COMMISSION Total		**5**
STATE BOARD OF ELECTIONS	GENERAL OPERATIONS	5
STATE BOARD OF ELECTIONS Total		**5**
PROPERTY TAX APPEAL BOARD	DOWNSTATE OFFICES	4
PROPERTY TAX APPEAL BOARD Total		**4**
STATE'S ATTORNEYS APPELLATE PROSECUTOR	SAA – GENERAL OPERATIONS	3
STATE'S ATTORNEYS APPELLATE PROSECUTOR Total		**3**
LOCAL GOVT LAW ENF OFF TRNG BRD	LOCL GOV LE OFF TRN BRD-GEN OFF	2
LOCAL GOVT LAW ENF OFF TRNG BRD Total		**2**
PRISONER REVIEW BOARD	PRIS REV BD-GEN OPER	2
PRISONER REVIEW BOARD Total		**2**
HOUSE FISCAL OFFICE	GENERAL OPERATIONS	2
HOUSE FISCAL OFFICE Total		**2**
GOVERNORS OFFICE	GOV-EXEC OFFICE	2
GOVERNORS OFFICE Total		**2**

DEAF AND HARD OF HEARING COMMISSION	GENERAL OFFICE	1
DEAF AND HARD OF HEARING COMMISSION Total		**1**
STATE LABOR RELATIONS BOARD	ST LAB REL BD-GENERAL OFFICE	1
STATE LABOR RELATIONS BOARD Total		**1**
AUDITOR GENERAL	AUDITOR GENERAL	1
AUDITOR GENERAL Total		**1**
OFFICE OF MANAGEMENT AND BUDGET	OFFICE OF MANAGEMENT AND BUDGET	1
OFFICE OF MANAGEMENT AND BUDGET Total		**1**
ILLINOIS ART COUNCIL	IL ART CNCL-GENERAL OFFICE	1
ILLINOIS ART COUNCIL Total		**1**
LIEUTENANT GOVERNOR	LT GOVERNOR-GENERAL	1
LIEUTENANT GOVERNOR Total		**1**
LEGISLATIVE INFORMATION SYSTEM	LEG INFO SYSTEM - GENERAL OPER	1
LEGISLATIVE INFORMATION SYSTEM Total		**1**
ILL COUNCIL ON DEV. DISABILITY	ILL COUNCIL ON DEV. DISABILITY	1
ILL COUNCIL ON DEV. DISABILITY Total		**1**
OFFICE OF EXECUTIVE INSPECTOR GENERAL	OFFICE OF EXECUTIVE INSPECTOR GENERAL	1
OFFICE OF EXECUTIVE INSPECTOR GENERAL Total		**1**
DEPT OF INSURANCE	DEPT OF INSURANCE	1
DEPT OF INSURANCE Total		**1**
IL CRIMINAL JUSTICE INFO AUTH	IL CRIMINAL JUST INFO AUTH-OPER	1
IL CRIMINAL JUSTICE INFO AUTH Total		**1**
Grand Total		**26,101**

Appendix D

Workers' Compensation Claims Filed By Type of Injury January 1, 2007 through December 31, 2010

Workers' Compensation Claims Filed by Type of Injury
Calendar Year 2007-2010

Type of Injury[1]	Number of Claims
SPRAINS	13,412
CONTUSION	6,235
CUTLACERAIN,PUNCTURE,OPEN WND	1,884
OTHER INJURY, NEC	1,139
CARPAL TUNNEL	761
FRACTURE	524
SCRATCHES, ABRASIANS	494
GENERAL INFLAMINATION	449
BURN OR SCALD -HEAT-	266
INSECT STING	233
STRESS MENTAL/MENTAL	144
RESPIRATORY DISEASE	117
CONCUSSION - BRAIN, CEREBRAL	61
POISON IVY/OAK	55
UNCLASSIFIED, NOT DETERMINED	51
DISLOCATION	39
DERMATITIS-RASH,SKIN INFLAMATION	38
HERNIA, RUPTURE	35
ASPHYXIA STRANGULATION DROWNING	34
HEAT STROKE, SUNSTROKE	27
LOSS OF CONSCIOUSNESS	22
ELECTRIC SHOCK, ELECTROCUTION	20
CONTAGIOUS/INFECTIOUS DISEASE	14
HEART ATTACK	13
HEARING LOSS OR IMPAIRMENT	8
STRAINS	7
STROKE	4
AMPUTATION	4
RADIATION EFFECTS - SUNBURN	3
MULTIPLE INJURIES	2
FREEZING, FROSTBITE	1
UNKNOWN	1
POISONING, SYSTEMIC	1
OCCUPATIONAL DISEASE, NEC	1
HUMAN BITE	1
HEMORRHOID	1
Grand Total	**26,101**

Note: [1]The Type of Injury category appears as it was provided in CMS data.
Source: OAG analysis of CMS workers' compensation claims filed 2007-2010.

Appendix E
Agency Responses

CMS

ILLINOIS
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES
Malcolm Weems, Acting Director

Pat Quinn, Governor

April 9, 2012

Mr. Michael Paoni
Office of the Auditor General
Iles Park Plaza
740 East Ash
Springfield, IL 62703

Dear Mr. Paoni:

Enclosed are the Department of Central Management Services' responses to the draft report of the management audit of the Workers' Compensation program. In addition, as requested during the exit conference, we have made recommendations for inclusion in Chapter 6, Report Conclusions.

We appreciate the opportunity to work with your staff in the evaluation of our program. The management audit will assist us in evaluating and communicating program and resource needs and will prove a valuable tool in determining options for the program moving forward.

Sincerely,

Malcolm E. Weems
Acting Director

Attachments

801 S. 7th Street, 6th Fl Main - Admin, P.O. Box 19208, Springfield, IL 62794-9208

Department of Central Management Services Responses

Exhibit 1-15: Table includes data regarding claims per headcount:

The Department of CMS (CMS) would like to point out some data interpretation issues, as discussed during our March 29th exit conference. CMS requests the following disclaimer to be presented below Exhibit 1-15:

The claims rates by state agency represented in the Exhibit 1-15 are higher than actual due to the following headcount data issues:

- OAG headcount data is based on full-time equivalents and does not include temporary, seasonal or intermittent employees;
- OAG headcount data does not include non-State workers that are covered as an employee for WC purposes only;
- OAG headcount data does not include covered military personnel or emergency responders for declared emergencies through IEMA, such as flooding, winter storms and tornadoes; and
- Employees can have multiple claims for injuries in a given year. This results in an overstatement of the annual claims rate per employee, as multiple claims are included in the claims data but each employee is only counted once.

Recommendation 1:

The Department of Central Management Services and the Illinois Workers' Compensation Commission should take steps to improve the quality of the data contained in their workers' compensation information systems, CMS and the Commission should also consider implementing and/or enhancing web based reporting systems.

Response:

Agreed. The mainframe data system currently in place is antiquated, and contains data transferred from agency pre-consolidation files and files predating the creation of the database system. As time allows, staff work through data accuracy issues, updating status codes and working towards improved programming and reporting capabilities. CMS plans to discuss options for improved computer systems and web-based reporting systems, and the associated funding, with the Illinois Workers' Compensation Commission, the Attorney General's office, and sister agencies. Currently, headcount, technology and resource limitations hamper the ability for short-term improvements in this area.

Recommendation 2:

CMS, in conjunction with the State Workers' Compensation Program Advisory Board, should develop recommended best practices for the State workers' compensation program, as required by Public Act 97-018.

Response:

Agreed. The Board, appointed by the Governor and the General Assembly, is required to issue a written report to be delivered to the Governor's Office, the Director of CMS, and the General Assembly, including a recommended set of best practices. Future reports will include

recommendations for improvements. CMS will evaluate the Board's recommendations and work to implement and administer the best practice and future improvement recommendations taking into consideration relevant laws, policies and available resources.

Recommendation 3:

The Department of Central Management Services should take steps to:

- Deny claims that are not filed within 45 days of the accident unless extenuating circumstances are documented;
- Ensure that accident dates in their information system are accurate;
- Define accident date for repetitive trauma cases in the Departments' administrative rules or policies and procedures; and
- Ensure that supervisory notification by the employee of an injury is documented in writing.

Response:

Agreed. Adjustor caseloads are at least 4 times the recommended industry standard for proper management of workers' compensation claims. Improved data and documentation quality management can be achieved with additional CMS adjustor resources.

- The majority of claims that are not reported in 45 days are denied by CMS. The IWCC has not always bound itself to this rule and claims can be reported verbally which may give the appearance they were reported later.
- Accident dates in the system come electronically from the IC-45.
- Repetitive claims are more complicated in that the date of the first medical treatment may be different than the original accident date reported. There is no actual accident date; therefore, the first date of treatment is used. This data input changes the accident date and may not match the original IC-45. Accident date definitions and supervisory sign-off requirements will be included in our updated policy and procedure manual and reinforced through training. However, this will not necessarily result in a definitive decision on the accident date for repetitive claims. Until such time as the date is delineated in statute, the date will remain open for interpretation. CMS will seek legislation to tighten up requirements.

Recommendation 4:

The Department of Central Management Services should:

- Ensure that all applicable forms are collected prior to any determination of compensability or benefits payments;
- Conduct training for all adjusters and agency workers' compensation coordinators regarding filing procedures and required forms;
- Require a claims supervisor to review all determinations of compensability;
- Obtain access to payroll information required to verify average weekly wage amounts for employees who submit claims;
- Require employees to formally request temporary disability benefits prior to receiving benefits; and
- Ensure thorough review of all medical bills prior to payment.

Response:

Agreed and partially implemented. Adjustor caseloads are at least 4 times the recommended industry standard for proper management of workers' compensation claims. Improved data and documentation quality management can be achieved with additional CMS adjustor resources.

- CMS makes every effort to collect forms prior to any determination of compensability or benefit payments. However, the statute does not allow for a denial of payment merely because a form has not been received, particularly if the submission of that form is not the responsibility of the insured employee.
- CMS will conduct training once updates to the policy and procedure manual are complete. It is the department's intention to move this to an annual training.
- Supervisors have been reviewing all claims of compensability since June 2011. Policies and procedures will be updated and reinforced through training.
- Access to payroll systems across all agencies may be difficult, especially for those agencies independent of the Central Payroll System. Sufficient documentation could be developed in coordination with the agencies as an alternative.
- Employees request occupational leave and TTD through their agency, which is sent to CMS on a TTD voucher for time off work. CMS considers this to be the formal request for TTD and does not require a separate document.
- CorVel is our medical bill review vendor effective September 2011. All medical bills and corresponding medical reports are now reviewed and paid on-line.

Recommendation 5:

The Department of Central Management Services should ensure that cases in which subrogation can be pursued are reviewed in a timely manner.

Response:

Agreed. Currently, headcount, technology and resource limitations hamper the ability for short-term improvements in this area. Prior to consolidation in 2004, CMS had one employee devoted to subrogation and total permanency cases and, at one point, ISP had one employee devoted to just subrogation. Following consolidation, the volume of cases in which subrogation could be sought increased dramatically. CMS currently has one employee devoted to subrogation and total permanency cases statewide. This issue should be reviewed by the State Workers' Compensation Program Advisory Board for best practice recommendations.

Recommendation 6:

The Department of Central Management Services should perform periodic matches utilizing available information at the Illinois Department of Employment Security to ensure that employees receiving benefits are not employed elsewhere. CMS should also consider gaining access to other sources of information that may be helpful in identifying changes in marital status, deaths, and other circumstances that would affect the eligibility or amount of workers compensation benefits to which the individual is entitled.

Response:

Agreed and partially implemented. After pursuing DES data-sharing since 2006, PA 97-0621 was passed 11/18/11, allowing database access to verify claimant employment status. We currently have an Intergovernmental Agreement awaiting final execution by DES to begin the

data sharing process. We also run reports to verify status for claimants covered under our group insurance program. CMS has developed a new Risk Management position dedicated to improved data harvesting and sharing, reporting and fraud detection. We hope to have this position hired within the next several months.

Recommendation 7:

The Department of Central Management Services should track Adjuster caseloads and consider establishing caseload standards for Adjusters.

Response:

Agreed. Adjustor caseloads are at least 4 times the recommended industry standard for proper management of workers' compensation claims. Improved data and documentation quality management can be achieved with additional CMS adjustor resources. CMS assigns caseloads by lost-time cases. The Claims Manager in Risk Management monitors adjustor caseloads by number of claims on TTD, extended benefits and light duty. Caseload standards could be beneficial, but caseloads are dictated by the number of adjustors available, authorized headcount and funding levels. Data and documentation issues are a direct result of high caseloads, as demonstrated by the comparison with industry standards. This issue should be reviewed by the State Workers' Compensation Advisory Board for best practice recommendations. Currently, headcount, technology and resource limitations hamper the ability for short-term improvements in this area.

Recommendation 11:

The Department of Central Management Services should:

- Clarify settlement contract approval limits in their policies for Risk Management Employees; and
- Include all compensation in the settlement contract as part of these approval limits.

Response:

CMS agrees that settlement contract approval limits should be clarified. These will be included in the updated policy and procedure manual and reinforced through training.

We respectfully disagree with the recommendation that all compensation in the settlement contract should be part of these approval limits. This interpretation would cause inequities in the cases considered to be $150,000 or more. For example, if TTD is denied and three years later we settle the claim, the TTD portion may eat up most of the policy limits. For a case where TTD was paid during the three years, the settlement contract limits would be based on permanency only, even though the total cost for each case is the same. The intent of the approval limits is for the permanency part of the contract only. When final settlements include TTD or medical, these payments are to be made from a different pay code type and are not included in the settlement figures for financial reporting purposes. We will evaluate our data entry procedures and clarify the definitions for settlement contract limits in the policy and procedure manual.

Recommendation 12:

The Department of Central Management Services and the Attorney General should ensure that all settlement contract negotiations for cases in which the employee has legal representation are

conducted by the Attorney General's Office.
Response:
Agreed. CMS policy is that the Attorney General should conduct settlement contract negotiations. This policy will be reinforced through the updated policy and procedure manual and training.
Recommendation 13:
The Department of Central Management Services should ensure that there is medical support for all injuries that are compensated in settlement contracts.
Response:
Agreed. 97% of the cases sampled had medical documentation to support the settlement in the file. There are a limited number of times when the AAG is at the call site and a claim has been filed with the IWCC but not with Risk Management. When this occurs we have to construct a file so we can either defend the claim or close it out by settlement. In these circumstances we must ensure we have the relevant information before signing any settlement. Specific to the two cases cited in the audit: In the first case, there was medical support for the compensated injuries in the electronic WebOpus medical database, in the absence of reproduced hard-copy documentation in the on-site file. For the second case, the claimant reported a back and a carpal tunnel injury to the IWCC, although the facility sent only the back injury claim to CMS. The carpal tunnel injury was diagnosed with a medical report. On the advice of the AG's office, both injuries were settled in an effort to close out all issues with that claimant to minimize overall cost.
Recommendation 15:
CMS and the AG should work to improve communications regarding workers' compensation claims and cases.
Response:
Agreed. CMS is beginning a nine month project to scan all files into Docuware. Once completed, this will enable CMS adjusters, agency coordinators and AAG's to view a consistent and complete file. In addition, in coordination with the other agencies, CMS would like to develop a web-based paperless system granting access and data-sharing as appropriate. Currently, headcount, technology and resource limitations hamper the ability for short-term improvements in this area.
Recommendation 20:
CMS should develop formal written policies for conflicts of interest, including how the claims of employees within CMS' Bureau of Benefits and Division of Risk Management will be processed. CMS should also provide training to adjusters regarding those policies.
Response:
Agreed. Formal written policies have been drafted and will be further developed based upon the recommendations from this audit report and the State Workers' Compensation Program

Advisory Board. Finalized guidelines will be included in the updated policy and procedure manual and reinforced through additional statewide training. Fraud and conflict of interest awareness training was provided to internal staff in August 2011.

Illinois Workers' Compensation Commission

100 W. Randolph, Suite 8-200
Chicago, IL 60601
312-814-6500

Pat Quinn, Governor — *Mitch Weisz, Chairman*

April 9, 2012

The Honorable William G. Holland
Auditor General
State of Illinois

Dear Auditor General Holland,

Enclosed with this letter are the Commission's responses to the audit performed by your office pursuant to House Resolution 131. I would like to thank you for all of the work performed by your staff and commend their professionalism and dedication to the task of examining the workers' compensation system as it relates to cases filed by State employees during the four years prior to March 10, 2011, the date that House Resolution 131 was adopted.

The audit performed pursuant to House Resolution 131 presents several detailed recommendations in relation to the operations of the Commission. Since I was appointed as Chairman of the Commission in March of 2010, the General Assembly enacted and the Governor has signed into law House Bill 1698, which introduced significant reforms to the substantive body of workers' compensation law and also introduced several changes to the Workers' Compensation Act which required reorganization of the operations of the Commission. The audit recommendations point to several changes that have either already been implemented or are still in the process of being executed at the Commission. To better explain these changes and how the Commission has implemented the provisions of House Bill 1698, I am also enclosing more detailed comments to be included with the Commission's responses to your audit recommendations.

Please feel free to contact me if you have any additional questions.

Sincerely,

Mitch Weisz
Chairman

Enclosures

Illinois Workers' Compensation Commission

100 W. Randolph, Suite 8-200
Chicago, IL 60601
312-814-6500

Pat Quinn, Governor *Mitch Weisz, Chairman*

Responses

Recommendation 1: The Department of Central Management Services and the Illinois Workers' Compensation Commission should take steps to improve the quality of data contained in their workers' compensation information systems. CMS and the Commission should also consider implementing and/or enhancing its web-based reporting system.

Response: The Commission agrees with this recommendation. The Commission currently relies on a 30-year-old case management mainframe system, which requires case information to be manually entered into this system. The Commission is beginning the process of documenting its workflow and stabilizing this mainframe system so that the Commission can move towards procuring a more modern case management system focused on more accurate means of storing case information, such as the scanning of documents. However, both procuring and implementing a new case management system will take a significant amount of time, financial investment, and may require external resources. A potential source of funding for implementing a new case management system is the fund for capital or system improvements at the Commission created pursuant to a settlement in Illinois State Chamber of Commerce v. Filan.

The Commission has also taken steps towards investigating ways to implement a web-based accident reporting system, either through updating its own current EDI reporting system or by utilizing the staff and technological capabilities of the University of Illinois-Chicago through an intergovernmental agreement. Commission staff will continue to research web-based EDI updates this Spring through the use of the resources of the International Association of Industrial Accident Boards and Commissions (IAIABC), which supports an EDI Committee dedicated to assisting jurisdictions with their electronic reporting efforts. However, mandating the electronic submission of accident report data by employers may possibly require a change to the Workers' Compensation Act.

Recommendation 8: The Illinois Workers' Compensation Commission should require an Application for Adjustment to be filed and a case file established in all cases, prior to the approval of any settlement agreements.

Response: The Commission disagrees with this recommendation. The Commission believes that there are adequate safeguards for the current approval process for settlement contracts. The Arbitrator reviewing the settlement contract verifies that the contract has been presented to the correct venue for approval, based on the location of the accident. In addition, the parties themselves are an important check in this system. As Exhibit 4-1 of this Audit states, a settlement contract represents an agreement by both the employee and the employer, both of whom have consented to the submission of a

settlement contract to an Arbitrator. However, if there were any malfeasance on the part of an Arbitrator in approving a settlement contract, this would be reportable to the Judicial Inquiry Board, the Commission Review Board, or possibly the Attorney Registration & Disciplinary Commission.

Starting March 1, 2011, the Commission requires that each settlement contract presented to an Arbitrator for approval must have a Commission case number. Requiring an Application for Adjustment for settlement contracts would provide both duplicative information and also unnecessarily slow the approval of settlement contracts, a process which provides finality to both injured employees, who desire to obtain compensation for their claim, and employers, who strive to remove the pending liability for outstanding workers' compensation claims.

Recommendation 9: The Commission should take steps to ensure that the data on the call list is correct and updated timely in order to accurately correct the status of pending cases. The Commission should be proactive in removing cases that have been on the call list for more than three years.

Response: The Commission agrees with this recommendation. There are several common reasons why a case remains on the status call after three years. Because of the nature of workers' compensation cases, some cases cannot be tried or settled until an injured worker has reached maximum medical improvement, which may, depending on the nature and extent of the injury, take longer than the three-year period set forth in the Commission's Administrative Rules. The case may have been remanded back to the arbitration level pursuant to an order issued by the Commission on review or even the State circuit or appellate courts. The parties may be waiting for a trial because of a factor external to the Commission or the injured worker, such as approval for a Medicare Set-aside Arrangement (MSA) from the federal Centers for Medicaid and Medicare Services (CMS).

As part of its overall IT improvement plan, the Commission will search for a case management system that will facilitate the removal of settled, tried, or dismissed cases from the status call, a process which is impacted by the logistical challenge of documents originating from the Commission's 16 statewide hearing sites that are then processed in Chicago.

Recommendation 10: The Commission should conduct annual evaluations of Arbitrators and include them in their personnel files.

Response: The Commission agrees with this recommendation. The Commission has revised and started its evaluation of Arbitrators to implement the changes mandated by House Bill 1698. Specifically, House Bill 1698 provides that upon expiration of each Arbitrator's term, the Chairman shall evaluate the performance of the Arbitrator and may recommend that he or she be reappointed to a second or subsequent term by the full Commission. The terms of the first group of appointed Arbitrators are set to expire on July 1, 2012. Thus, the Commission has been in the active process of developing and implementing Arbitrator evaluation procedures since January of 2012. The new evaluation procedure for Arbitrators with expiring terms includes a statistical analysis of case load, an in-person evaluation by Commissioners, and also surveys to be distributed to attorneys who have appeared before that Arbitrator.

Recommendation 14: The Commission should: (1) Make changes to the Application for Adjustment form to identify whether the employer is the State of Illinois; (2) Notify CMS of cases filed by State employees; and (3) Give CMS access to their workers' compensation information system.

Response: The Commission agrees with this recommendation. The Commission's Application for Adjustment form will be updated to include a field to indicate whether the employer is the State of Illinois. However, that field will only yield increased identification of cases where the State of Illinois is the employer if this field is accurately marked by Petitioners. The Commission will provide CMS with an electronic file of new applications filed by State employees on a monthly basis. In addition, the Commission will be releasing a new web-based search of its case management mainframe system for public use. This search should also facilitate the process of CMS identifying State cases that have not been reported by the individual workers' compensation coordinators at State agencies. Before this web search is implemented, the Commission can allow CMS direct access to the Commission's mainframe case management system, which is currently only available on computers physically located at the Commission.

Recommendation 16: The Commission should include trial dates and decision dates in their workers' compensation system to track award decisions to ensure that they are filed in a timely manner.

The Commission agrees with this recommendation. Currently, the Commission internally tracks its trial dates with a program that does not interface with the Commission's case management mainframe system. Any replacement to this system will need to include trial dates and decision dates in order to serve as a means to track whether decisions are filed within the time periods set forth in the Workers' Compensation Act, allow for the compilation of statistical information, and ensure easy access to trial dates by the public to promote transparency.

Recommendation 17: The Commission should develop written guidelines to ensure consistency of Arbitrator awards for certain types of injuries. These guidelines should also discuss how prior awards and settlements for the same type of injury should be taken into account in determining percentage loss for injuries.

The Commission partially agrees with this recommendation. The current "guidelines" that are used by Arbitrators are the Workers' Compensation Act, the Commission's Administrative Rules, and case law from both the Commission and the courts of the State of Illinois. The Commission believes that the most effective way to ensure consistent application of the law is through providing educational and training opportunities for Arbitrators. The Commission has increased the frequency of training seminars for both Arbitrators and Commissioners from annual to semi-annual and increased the number of hours for both sessions. These seminars include training on ethics, substantive workers' compensation law, and also recent appellate cases interpreting the provisions of the Workers' Compensation Act.

Any guidelines that affect the private rights of parties outside of the Commission must be promulgated through the rulemaking process set forth in the Illinois Administrative Procedure Act. 5 ILCS 100/1-70. It is well established case law that administrative rules promulgated by an agency can neither expand nor contract the rulemaking authority set forth in its authorizing statute. Thus, the Commission may not be able to ensure consistency of awards through rules if the law and the facts dictate divergent results.

Recommendation 18: The Commission should revise and clarify their conflict of interest policies to incorporate provisions from the Judicial Code of Conduct and set forth a formal process for recusal of Arbitrators and Commissioners in cases in which their impartiality may be questioned.

Response: The Commission agrees with this recommendation. The Commission is in the process of revising Section 7030.30 of its Administrative Rules in order to both reflect the application of the Code of Judicial Conduct to the Arbitrators and Commissioners, which was set forth in House Bill 1698, and establish a process by which parties can petition for disqualification of an Arbitrator or Commissioner.

Recommendation 19: The Commission should ensure that the Workers' Compensation Review Board meets at least once annually and within 15 days of receipt of complaint against an Arbitrator or Commissioner.

Response: The Commission agrees with this recommendation. The Commission Review Board is scheduled to meet quarterly this year. In addition, the Commission is in the process of reviewing Part 7500 of its Administrative Rules, which governs the procedures of the Commission Review Board. Part of this review is an examination of how the function of the Commission Review Board has been affected by the changes instituted by House Bill 1698 and whether the 15-day meeting requirement is adequate to ensure that the Commission Review Board fulfills its statutory purpose in the most efficient manner.

Recommendation 21: The Commission and the Attorney General should establish policies and procedures regarding referrals for fraud investigations.

Response: The Commission agrees with this recommendation. While the Commission has not established a formal policy for the referral of fraud investigations, the Office of the General Counsel of the Commission actively began referring any party with concerns regarding workers' compensation fraud to the Department of Insurance Fraud Unit starting in Fiscal Year 2011. The Commission also maintains a link on the front page of its website with information regarding workers' compensation fraud. The Commission has provided training to its Information Department staff, which are the Commission team members who answer phone calls from the public, on the changes to the fraud provisions of the Workers' Compensation Act in House Bill 1698.

Illinois Workers' Compensation Commission

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312-814-6500

Pat Quinn, Governor ***Mitch Weisz, Chairman***

Additional Comments

Since the passage of House Bill 1698, the Commission has implemented several new reforms and innovations to improve efficiency of operations at the Commission. While several of these changes were mandated by House Bill 1698, the Commission has also taken the initiative to implement even more policies that capture the spirit of reform set forth by the General Assembly and the Governor in this legislation. Below is a summary of some of these initiatives:

Appointment of New Arbitrators by Governor Quinn House Bill 1698 provided that as of July 1, 2011, the terms of all current Arbitrators at the Commission were ended and the Arbitrators continued to serve until reappointed or a successor was appointed by the Governor, with advice and consent of the Senate. From July through October, the Governor's Office conducted extensive interviews of the Arbitrators and new candidates for these positions. In total, Governor Quinn appointed 30 Arbitrators, which included 12 new Arbitrators. In February 2012, 27 of the Arbitrators appointed by Governor Quinn were confirmed by the Senate. Three Arbitrators still await confirmation by the Senate.

Creation of Downstate Arbitration Zones One of the more significant changes of House Bill 1698 is that it mandated each Commission hearing site be assigned no fewer than three Arbitrators, with no Arbitrator outside of Cook county serving longer than two years at each hearing site. Prior to this mandate, there was only one Arbitrator assigned to each hearing site outside of Cook County. To fulfill this mandate of House Bill 1698, the Commission created six downstate arbitration zones. Each zone has three hearing sites and three Arbitrators assigned to the zone. The Arbitrators rotate through the three hearing sites on 90-day call cycles.

Reassignment of Cases The Arbitrator rotation requirement of House Bill 1698 and also the appointment of new Arbitrators required the reassignment of over 90,000 cases, which are stored on a case management mainframe system that is over 30 years old. Through the dedication and resourcefulness of its staff, the Commission was able to complete this reassignment without interruption to the provision of services.

Increased Training for Arbitrators, Commissioners, and Commission Staff Attorneys House Bill 1698 increased the substantive training requirements for both Commissioners and Arbitrators to include training on ethical standards, workers' compensation fraud, evidence-based medicine, and coal workers' pneumoconiosis. However, the Commission seized this opportunity to not only add this instruction to its existing training program, but also to double the training program to a two-day seminar conducted twice a year. The Commission also broadened the scope of presenters at this training. In its Fall 2011 training, the Commission secured the Executive Director of the Judicial Inquiry Board to provide a presentation on the Judicial Code of Conduct, former Justice Gino DiVito to provide a summary of the newly codified Illinois Rules of Evidence, and Thomas Moriarty of the United States Attorney's office and former member of the Organized Crime Strike Force, to speak on fraud.

Reassignment of Cases through the Chairman's Office Oftentimes, cases will need to be reassigned because of a conflict, recusal, or for the convenience of the parties, such as an injured worker unable to travel long distances. The Commission instituted a procedure mandating a signed reassignment approval form from either the Chairman, General Counsel, or the Secretary of the Commission before a case may be reassigned. This process ensures these cases are reassigned randomly.

Discontinued Use of Social Security Numbers at the Commission Effective November 16, 2011, the Commission no longer accepts documents with Social Security Numbers. Previously, Social Security Numbers had been included on both the Application for Adjustment of Claim and Settlement Contract forms. In addition, the Commission removed the Social Security Number field from its electronic EDI accident reporting systems. This process required coordination with over 15 reporting entities to ensure that the electronic data continued to be transferred to the Commission, but without transferring Social Security Numbers.

Updated Commission Records Retention Policy with the State Record Commission As a State agency, the Commission is required to maintain a current Records Retention Policy to be approved by the State Records Commission. The last policy on file with the Commission dated from 1999 and did not include many Commission records. Commission staff revised this policy in December 2011 and obtained approval of the new policy by the State Records Commission in February 2012. The Commission also designated a Records Officer pursuant to the provisions of the State Records Act, a position that had been previously unfilled. With these changes already underway, the Commission plans on continuing to improve the organization and efficiency of how it stores records.

New Executive Staff at the Commission In the last year, the Executive level positions at the Commission have been filled with new staff:

- In April 2011, Ronald Rascia was appointed as General Counsel. He earned a BA in Economics from DePaul, and both a JD and LLM in Intellectual Property from John Marshall.
- In May 2011, Mark Kimmet was hired as Chief Internal Auditor, a position that had been previously vacant for over ten years. He is a CPA with a BS in Economics from Northern Illinois University and an MBA from the Kellogg Graduate School.
- Also in May 2011, Bob Devereaux was hired in the newly created position of Fraud Prevention and Efficiency Controller. He is a CPA with a BA from Loras College and an MBA from DePaul University.
- In September 2011, Kimberly Janas was named Secretary of the Commission. Ms. Janas is an attorney with a BA in English and a JD from the University of Illinois.
- In January 2012, Mary Wells was hired as Chief Financial Officer. She holds a BA in Political Science from the University of Chicago, an MA in Urban Planning from the University of Illinois at Chicago, and an MBA with a concentration in Finance from DePaul.
- Also in January 2012, Lola Dada-Olley was hired as Deputy General Counsel. She holds a BS in Business from Eastern Illinois University, a JD from Howard University, and an MS in Journalism from the Medill School of Journalism at Northwestern University.

OFFICE OF THE ATTORNEY GENERAL
STATE OF ILLINOIS

Lisa Madigan
ATTORNEY GENERAL

April 9, 2012

Via U.S. Mail and Electronic Mail
The Honorable William G. Holland
Auditor General
State of Illinois
Iles Park Plaza
740 East Ash Street
Springfield, Illinois 62703-3154

Re: Management Audit of the Workers' Compensation Program for State Employees

Dear Auditor General Holland:

I appreciate your office's work in performing the management audit of the Workers' Compensation Program as it applies to employees of the State of Illinois. I have enclosed our office's responses to Recommendations 12, 15 and 21 in the draft report. In addition, I have enclosed a memorandum providing an analysis of the issues impacting the State's defense of these cases and detailing the most significant difficulties that we face and the reforms we believe are necessary.

If you have any questions, please do not hesitate to contact me.

Sincerely,

Lisa Madigan
Attorney General

Enclosure
cc: Michael S. Paoni
Audit Manager

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Recommendation 12, Negotiating Settlement Contracts:

> *The Department of Central Management Services and the Attorney General should ensure that all settlement contract negotiations for cases in which the employee has legal representation are conducted by the Attorney General's Office.*

Response of the Attorney General's Office:

We agree with this recommendation. The office has procedures in place to notify attorneys representing state employees in workers' compensation cases filed with the Workers' Compensation Commission of the entry of our appearance in the cases and, thus, convey the need to communicate only with our office. When we receive notice that a petition has been filed with the Workers' Compensation Commission, we file our appearance and send a letter to the employee's attorney. We will continue the practice of sending that letter at the outset of the case, and we will also emphasize both in that initial letter and in later communications with the state employees' attorneys and in communications with CMS Risk Management Supervisors that all discussions regarding the case should be exclusively with our office.

Recommendation 15, Communication:

> *CMS and the AG should work to improve communications regarding workers' compensation claims and cases.*

Response of the Attorney General's Office:

We agree with this recommendation and, based on it, have taken added steps to improve communications with CMS concerning workers' compensation litigation.

When a state employee files an Application for Adjustment of Claim with the Workers' Compensation Commission, the Commission sends notice of the filing to the employing state agency and our office. The CMS Workers' Compensation Coordinator Manual details the responsibilities of the employing agencies' Coordinators, including "[p]roviding the liability claims adjuster with a copy of all legal notices pertaining to the adjustment of claim." (CMS Bureau of Benefits, Risk Management Division Workers' Compensation Coordinator Manual, Revised: November 2004, Part II, Sec. C, page 15.) Pursuant to this policy, our office understood that the Coordinators were required to provide CMS with a copy of the Commission's notice. When we receive this notice, our office sends a letter to the appropriate Coordinator at the employing agency providing the Coordinator with the name of the assigned Assistant Attorney General, requesting a copy of the Coordinator's entire file regarding the claim, and asking that the Coordinator continue forwarding all additional materials on this claim to our office. Based on the discussion in this audit report indicating that CMS may be unaware of some cases before the Commission, we have, out of an abundance of caution, changed our practice and now copy CMS Risk Management on the letter that we send to the Coordinators to ensure that CMS is aware of the case.

Additionally, on October 12, 2011, we met with CMS management regarding the claims management process and discussed the need to provide annual training for all Coordinators. We committed to participating in any helpful way in this training.

Recommendation 21, Fraud Referral Policies and Procedures:

The Commission and the Attorney General should establish policies and procedures regarding referrals for fraud investigations.

Response of the Attorney General's Office:

We strongly agree that policies and procedures must be in place to require reporting all possible illegal conduct in workers' compensation cases. We have taken a comprehensive approach when establishing such policies that is consistent with this recommendation and has been intended to mandate that Assistant Attorneys General report any conduct that they reasonably believe may constitute a violation of the law. Specifically, the Office of the Attorney General has written policies which require the reporting of all potentially illegal conduct, not only fraud. Based on these policies, this office has reported issues that have arisen in workers' compensation cases to (1) the U.S. Attorney's Office, (2) the Illinois Attorney Registration and Disciplinary Commission (ARDC), (3) the Office of the Executive Inspector General for the Agencies under the Governor, and (4) the Department of Insurance (DOI) Fraud Unit.

First, the Office of the Attorney General has a written policy which requires all Assistant Attorneys General in the Workers' Compensation Bureaus to report to their senior supervisors any conduct by any person that they reasonably believe may constitute a violation of a criminal statute. A fraudulent workers' compensation claim may constitute a violation of Illinois criminal laws.

The Government Representation Litigation Policy Manual, which provides the written policies that attorneys handling workers' compensation cases must follow, specifically requires that an **"Assistant Attorney General and the Bureau Chief shall notify the Division Chief and the Deputy Attorney General, Civil Litigation of any conduct which the assistant reasonably believes may constitute a violation of a criminal statute."** (Government Rep. Division, Litigation Policy Manual, Art. VI.)

Pursuant to this policy, any Assistant Attorney General who suspects that a workers' compensation claimant or any other participant in a workers' compensation case is engaged in fraud must report that suspicion to the Division Chief and the Deputy Attorney General, Civil Litigation. The policy is not limited to reporting fraud because it is intended to cover all possible misconduct that an attorney in our office might suspect is occurring in a case. As a result, the policy does not merely mandate that the Division Chief and Deputy Attorney General, Civil Litigation report the conduct to DOI's Fraud Unit. Given the breadth of possible misconduct that an Assistant Attorney General might come across in a workers' compensation case, it is critical that we have a policy in place to require that attorneys report all suspicions of possible illegal conduct to a senior supervisor and to allow senior supervisors the ability to evaluate the facts to determine the appropriate law enforcement agency for referral. As attorneys, we have an obligation to refer allegations of criminal conduct to the appropriate prosecutorial agency, which, in some instances, may require referral to an agency other than the DOI Fraud Unit.

Second, to ensure that all potentially improper conduct is reported (including conduct that might not necessarily violate a criminal law), the Attorney General's Policy and Procedures Manual includes a broader reporting requirement that provides:

(g) Reporting Violations
(1) An employee who has information which he or she reasonably believes indicates the existence of an activity constituting 1) a possible violation of a rule or regulation of the office; 2) mismanagement, a gross waste of funds, or abuse of authority; or 3) a substantial and specific danger to the public health and safety, shall immediately report such information to his or her supervisor, the Inspector General's Office, the Ethics Officer or any management official of the office. ... (Attorney General's Policy and Procedures Manual, Article 4, Section 4.1.10(g)(1).)

This policy imposes an additional requirement that all employees of the office report all concerns of misconduct.

Third, in instances where an Assistant Attorney General has reason to believe that an attorney involved in a workers' compensation case in any capacity (such as counsel for the claimant, an arbitrator or a Workers' Compensation Commissioner) might be involved in misconduct, the Attorney General's Policy and Procedure Manual and the ethical rules governing the practice of law in Illinois mandate an additional reporting step beyond the requirements described above.

All attorneys in the office must adhere to the Illinois Rules of Professional Conduct and actively cooperate with the ARDC in reporting any violations of the Rules of Professional Conduct. (Attorney General's Policy and Procedures Manual, Sec. 8.1.2 and 8.1.10.) Rules 8.3(a) and 8.4(b) and (c) of the Rules of Professional Conduct require that an attorney inform the ARDC of any knowledge that another attorney has "commit[ted] a criminal act that reflects adversely on the lawyer's honesty, trustworthiness, or fitness as a lawyer in other respects[ ]" or "engage[d] in conduct involving dishonesty, fraud, deceit, or misrepresentation."

Additionally, the Illinois Supreme Court has held that the failure of an attorney to report a violation of Rule 8.4(b) or (c) can be grounds for disciplining the attorney who fails to report. (*See In re Himmel*, 125 Ill. 2d 531 (1988).) Thus, under the office policy and procedures manual and the Rules of Professional Conduct, an Assistant Attorney General is required to report any concerns of attorney misconduct to the ARDC.

Implementation of the Office Policies and Procedures: Every attorney receives these policies and is trained on these policies and procedures when the attorney is hired with the office. Training on the policies and procedures is repeated and reinforced through (1) annual ethics training written by the Inspector General for the Office of the Attorney General, and (2) ethics CLE programs provided to all attorneys in the office by the Ethics Officer and Inspector General. In all of the trainings, attorneys are encouraged to reach out to the Ethics Officer, the Inspector General or a supervisor if they have any concerns or questions about possible illegal or unethical conduct by anyone.

Report Conclusions, Matter for Consideration by the General Assembly:

The General Assembly may wish to consider further changes to the structure and operations of the Workers' Compensation Program as it applies to State employees.

Response of the Attorney General's Office:

The office has provided a memorandum detailing significant issues that impact the defense of workers' compensation claims before the Illinois Workers' Compensation Commission and offering recommendations for reform. This memorandum was originally prepared as a briefing memorandum in Spring, 2011. The office updated this memorandum in Winter 2012.

Illinois Department of Insurance

PAT QUINN
Governor

ANDREW BORON
Director

April 11, 2012

Mr. Michael S. Paoni
Audit Manager
Office of the Auditor General
Iles Park Place
740 East Ash Street
Springfield, Illinois 62703

Dear Mr. Paoni:

The following is the Department's response to recommendation 22 of the Management Audit conducted pursuant to House Resolution 131:

The Workers Compensation Fraud Unit (WCFU) of the Department of Insurance has already made the necessary changes in its data base to be able to track claims for state employees in the future. The Department has also initiated the procurement process for the purchase of predictive modeling software purchase for use by the WCFU.

Should you have additional questions, please feel free to contact Jane Bachman at 217/782-5344.

Sincerely,

Andrew Boron

Andrew Boron
Director

cc: Tim Cena
Jane Bachman

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Appendix F
Agency Responses to
Report Conclusions and
Matter for Consideration by the General Assembly

Department of Central Management Services

Response to

Report Conclusions and

Matter for Consideration by the General Assembly

Report Conclusions: The General Assembly may wish to consider further changes to the structure and operations of the Workers' Compensation Program as it applies to State employees.

Response:

CMS agrees that the Workers' Compensation Program has important challenges regarding technology, structure and operations. Consolidating administrative functions back to CMS in FY2005 provided some opportunities for improved efficiencies and processing. However, the decentralized claims management process continues to negatively impact the program due to lack of technology and especially lack of shared computer systems between CMS and sister agencies. In an effort to leverage expertise and technology that would not otherwise be available in CMS, medical case management, bill review and utilization review were outsourced to a variety of specialized vendors. Additional improvements could be made through enhanced technology and resources to manage the program in the following areas:

- Claims management and administrative technology lag leading industry standards and functionalities, resulting in a highly manual, clerical and paper intensive environment with limited enabling technology. Leading claims administration and management software includes an integrated suite of applications, including web based access, data consolidation and warehousing, ad hoc and standardized reporting, to name a few.
- Highly clerical routine administrative tasks significantly limits adjusters' time to apply critical core skills, further limiting successful claims management for a staff already managing caseloads over 4 times the industry standard.
- Data extraction and technology challenges in the current mainframe system limit the ability to produce timely, accurate and outcome oriented management reports. Ad hoc reporting requests require hard coding by an experience programmer.
- The lack of agency specific financial accountability seriously compromises efforts to motivate departments to control losses. Return to work policies, safety and loss prevention initiatives are inconsistently developed and enforced by agencies.
- Lack of overall resources results in operational issues regarding communication, investigation, documentation and enforcement of policies and procedures.
- Lack of resources has prohibited external continuing education and training in claim management and regulatory matters.

Attorney General

Response to

Report Conclusions and

Matter for Consideration by the General Assembly

Background on Workers' Compensation Claims Filed by State Employees and Reforms Proposed by the Office of the Attorney General
March 2012[1]

The Office of the Attorney General (OAG) represents the State in workers' compensation litigation that State employees file with the Illinois Workers' Compensation Commission (IWCC). In defending against workers' compensation claims, the State is in a position similar to private employers. This document will provide the OAG's perspective on how the current workers' compensation litigation system operates and impacts the State. It will also describe the areas in which further reform is critical to reducing the costs of this system to taxpayers while continuing to compensate employees who are injured while working.

I. The Role of the Office of the Attorney General in Workers' Compensation Litigation

The vast majority of workers' compensation claims by State employees do not result in case filings with the IWCC. There are currently approximately 20,000 to 22,000 open State employee workers' compensation files at the Department of Central Management Services (CMS). As of December 31, 2011, the OAG was handling approximately 5,300 State employee workers' compensation cases which were filed with the IWCC. Thus, the OAG plays no role in approximately 75% of State employee workers' compensation claims.

In addition to handling IWCC cases filed by State employees, the OAG also represents the State in workers' compensation cases where any payment of benefits to the employee must come from one of five State funds. Three of these funds pay benefits to private sector employees under certain circumstances described below: the Injured Workers' Benefit Fund, the Group Workers' Compensation Pool Insolvency Fund and the Self-Insurers Security Fund. The other two funds – the Rate Adjustment Fund and the Second Injury Fund – pay benefits to both private sector and State employees when they qualify for these payments under the Workers' Compensation Act.

(1) The Injured Workers' Benefit Fund (IWBF). The IWBF pays benefits to private sector employees when the responsible employer failed to have the required workers' compensation insurance. The State Treasurer is the *ex-officio* custodian of the IWBF and must be named as a party in the Commission proceedings. The OAG represents the Treasurer and defends the case. To receive benefits from the IWBF, an employee must obtain an award against the employer and the IWBF. The OAG does not have legal authority to settle claims on behalf of the IWBF. Thus, a trial is required in any case in which an employee seeks to collect benefits from the IWBF. Since the creation of the IWBF in 2005, private sector employees have filed 1,912 cases with the IWCC naming the IWBF and over 800 of them have been closed. In over 65% of the IWBF cases, the OAG, on behalf of the Treasurer, is the only party presenting a defense because the private employer has chosen not to appear and defend the case. The OAG does not receive funding from the IWBF to handle these cases.

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1 This memorandum was originally prepared as a briefing memorandum in spring, 2011. The office updated this memorandum in winter, 2012.

(2) The Group Workers' Compensation Pool Insolvency Fund. This fund is set up to provide benefits to employees whose employer belonged to a qualified Group Workers' Compensation Pool (a permitted alternative to workers' compensation insurance), but the pool became insolvent. Unlike the IWBF, this fund generates a very small number of cases. But in these cases, the employer is typically also insolvent or chooses not to participate in the case and, as a result, the OAG is the only party defending against the claim.

(3) The Self-Insurers Security Fund. Under the law, employers may apply and be permitted to be self-insured. If an approved self-insured employer becomes insolvent, the Self-Insurers Advisory Board assumes the workers' compensation obligations of the insolvent employer. The OAG defends the workers' compensation case on behalf of the Board. Because the employer is insolvent, the OAG provides the sole defense in the case. The OAG is currently handling approximately 20 cases involving this fund.

(4) The Rate Adjustment Fund (RAF). The RAF provides supplemental "cost-of-living" payments to both private sector and State employees while they are receiving permanent and total disability or death benefits. In cases filed by private sector employees, the OAG is not involved in the case during the arbitration proceedings or review by the IWCC. Instead, the OAG has become involved when issues have arisen regarding the calculation of RAF payments by the IWCC, the IWCC's termination of payments or the failure to make payments in the first instance. The OAG is currently handling approximately 15 of these cases.

(5) The Second Injury Fund. This fund provides lifetime payments to both private sector and State employees in certain instances when the law deems an injured worker permanently and totally disabled. This occurs when the employee sustains the 100% loss of a body part after having previously suffered a 100% loss of a different body part. In cases involving private sector employees, the employer is often represented by counsel because the employer may be required to pay up to 100% of the injured body part. In some cases, the private employer concludes that it is beneficial to agree that the accident caused a 100% loss of a body part. If that conclusion is not supported by the evidence, the OAG will challenge it on behalf of the Fund.

The OAG expends considerable resources defending the increasing number of workers' compensation cases. To handle the growing number of cases, we have significantly increased the number of attorneys and staff in the office's two Workers' Compensation Bureaus. In 2003, the OAG had 17 attorneys and support staff members in the Workers' Compensation Bureaus. The OAG currently has 36 attorneys and support staff members handling workers' compensation cases (25 attorneys and 11 support staff), with three new attorneys and another support staff member starting in April and May to bring the total to 40.

II. The Workers' Compensation Claims Process for State Employees

When a State employee sustains a work-related injury, the employee is supposed to quickly report the incident to the immediate supervisor, contact the agency's Workers' Compensation Coordinator (WC Coordinator) to obtain a CMS Workers' Compensation packet and return the completed packet to the WC Coordinator. The WC Coordinator forwards the completed forms to CMS Risk Management (CMS).

A. CMS Claims Adjusting Process

CMS currently administers workers' compensation claims for all State agencies. As part of the claims management process, the CMS adjuster initially determines:
(1) whether the claim is compensable under the Workers' Compensation Act;
(2) whether the employee's medical condition is causally related to the work injury;
(3) whether the employee has a medical need to be off work and, therefore, is entitled to receive temporary total disability benefits (TTD benefits);
(4) whether to approve and/or pay for any medical care; and
(5) whether there are any legal defenses to the claim.

The analysis of all these issues is handled exclusively by CMS as part of the usual claims management process. The OAG has no involvement in the claims process. As a result of the determinations by CMS adjusters, workers' compensation benefits are paid from the CMS workers' compensation fund. The payments for TTD benefits, medical care, independent medical exams, vocational rehabilitation and any other benefits under the Act are made at CMS's discretion and payments continue unless and until CMS determines that no further benefits are warranted.

It should be noted that CMS's workers' compensation budget is chronically and severely underfunded. A significant portion of each fiscal year's funding is used to pay medical bills from the previous fiscal year, leaving CMS with insufficient funding for all other aspects of this program, such as retaining independent medical experts when needed to defend a case. (As of March 2012, CMS is currently over 23 months behind in paying medical bills.) And CMS has too few adjusters to handle the claims by State employees. There are approximately 20,000 to 22,000 open State employee workers' compensation claims. At present, there are only 8 CMS Claims Adjuster IIs to handle those claims (a Claims Adjuster I was added in recent months to assist them). Quite simply, the agency does not have sufficient funds or staffing to appropriately handle workers' compensation claims.

Prior to the Blagojevich Administration, some of the largest State agencies – IDOT, IDOC, DHS and ISP – each administered their own workers' compensation claims, using their own funds. As a result, those agencies had a direct financial interest in improving the workplace to avoid or minimize workers' compensation claims, defending against workers' compensation claims and ensuring that injured workers could return to work as soon as possible to reduce the cost of TTD payments. Under the consolidated system for workers' compensation claims, however, the employing agencies do not experience any impact to their budgets when their employees file claims or remain off of work and on TTD for an extended period of time, providing those

agencies with no financial incentive to determine the cause of the increase in claims and take steps to eliminate it. The agencies also have little incentive to accommodate employees whenever possible (including with light duty work) to allow them to return to work quickly.

RECOMMENDATIONS:

- Adequately fund and staff CMS to effectively administer and pay claims or consider retaining a third-party administrator.

- Ensure that CMS has an effective procedure and adequate funding in place to obtain Independent Medical Examinations (IMEs) in all cases in which they might be helpful. CMS recently created standard procedures to be followed in obtaining IMEs. The purpose of these procedures is to make sure that IMEs are done on a timely basis, that pertinent medical, accident and job requirement information is provided to the examining physician and that the assigned Assistant Attorney General (if the case has been sent to the OAG) has been consulted prior to forwarding information to the examining physician.

- Require initial and periodic CMS supervisory approval for all TTD and maintenance benefits.

- Increase CMS's use of vocational rehabilitation counselors. Vocational rehabilitation is critical to ensuring that employees who are unable to return to their current State jobs return to gainful employment as soon as possible. In some cases, a State employee may suffer injuries which result in his physician providing permanent physical restrictions, precluding the employee from performing the duties of his previous State job. In such cases, the State has an obligation to assist the employee in finding alternate employment (most commonly outside of State employment) through vocational rehabilitation services such as resume-building and interviewing skills, job search assistance, job skills training, education and other similar services which are provided by a vocational counselor. During this process, the employee is paid a benefit similar to TTD and referred to as "maintenance" benefits, which, like TTD, amounts to 2/3 of the State employee's salary. If the vocational rehabilitation process is not initiated promptly and closely monitored, this significantly increases the length of time that the employee continues to receive maintenance payments. Additionally, a more comprehensive vocational rehabilitation process would lessen the likelihood that the IWCC will find the employee to be permanently and totally disabled if the case proceeds to trial. This is the case because the IWCC often uses the failure of the employer to provide meaningful vocational rehabilitation services to the employee as justification for finding that the employee is entitled to lifetime permanent and total disability benefits. CMS has recently begun to forward cases in which the petitioners need vocational rehabilitation services and/or job search assistance to the Illinois Department of Human Services. DHS has vocational rehabilitation specialists throughout the State. We are hopeful that this new effort will assist in controlling TTD and maintenance benefit costs paid by CMS and also help to diminish the number of petitioners who are adjudicated to be permanently and totally disabled.

- Ensure that CMS establishes a Preferred Provider Program (PPP) covering all State facilities.

- Ensure that State agencies have an incentive to reduce workers' compensation claims by their employees and have them return to work as soon as possible, including, where appropriate, by accommodating employees who have duty restrictions (such as cases where light duty is required) in order to reduce TTD payments.

B. Issues Relating to State Employees Providing Notice of and Complete Information Concerning Workers' Compensation Claims to the State

The Workers' Compensation Act requires notice of an accident to the employer no later than 45 days after the accident. The Act further provides, however, that this notice may be made to a supervisor either orally or in writing. Under the Act and relevant case law, an employee's failure to provide notice within 45 days is not a bar to the workers' compensation claim unless the employer can prove undue prejudice as a result of the defective notice. Although CMS requires all injured State employees to fill out forms regarding the accident, the Act does not require completion of these forms. As a result, injured State employees often do not complete the CMS forms on advice of their counsel.

The State faces significant difficulty in defending cases on a notice defense particularly in repetitive trauma claims where, as discussed in more detail below, the employee may file the claim long after leaving employment. The IWCC often determines that the notice was defective, but concludes that the employer did not suffer prejudice as a result. To establish that notice has been provided to the employer, the IWCC merely requires testimony that the employee said something to a supervisor at the time of the accident regarding an injury and the fact that it was work-related. In some cases, even the employee's passing mention of an injury or condition of ill-being, however, without specifically informing the supervisor that the injury is work-related, has been deemed sufficient notice by some arbitrators and commissioners. The petitioner is not required to present evidence to corroborate that oral notice was given to a supervisor or to identify, prior to trial, which supervisor received notice.

Under the rules governing workers' compensation cases, the employer is not entitled to pre-trial discovery to determine which supervisor in the chain of command the petitioner alleges received the notice, leaving the employer with difficulty in preparing to present appropriate rebuttal witnesses. If the employer presents a supervisor to rebut the employee's contention that notice was provided, the employee often testifies that a different supervisor was informed about the injury. As a result, unless the employer has present at trial all supervisors/managers who could potentially have received notice to testify that each of them did not receive notice, the employee's testimony is sufficient to establish notice. Another problem arises from the fact that the trial is often held years after the alleged accident. At that time, the employee's supervisor may be called upon to remember and testify that the employee never mentioned anything at all about an accident that may have occurred years ago. Given the passage of years since the alleged accident, such evidence may be impossible to elicit.

RECOMMENDATIONS:

- To ensure that State employees must provide clear notice at the time of an injury, the Workers' Compensation Act should be amended to require that, whenever physically possible, State employees must fully complete the CMS workers' compensation paperwork and to provide that until the paperwork is completed, benefits shall be withheld.

- The Workers' Compensation Act should be amended to require written, signed and verified notice of an accident.

III. Referrals to the Office of the Attorney General for Legal Representation in Litigation

In most State employee workers' compensation claims, CMS agrees to pay TTD and/or medical benefits and the employee does not seek an award for a permanent disability. In these circumstances, the OAG is never involved in the claim. The OAG is only called on to defend the State against a workers' compensation claim if an employee (usually represented by a private attorney) files an Application for Adjustment of Claim (Application) with the IWCC. There are generally two reasons employees file an Application.

(1) When a dispute arises over the non-payment of a benefit which an employee seeks, such as TTD or medical treatment, an Application can be filed with the IWCC.

In the majority of cases that the OAG receives, CMS has previously made a decision that the claim is compensable and paid benefits, but a dispute arose regarding the amount of benefits. In these instances, CMS has reached and determined the threshold issues of compensability and causation. CMS's determinations do not preclude these issues from being raised at trial. Once CMS pays benefits, however, the State cannot recover such payments, even if it is later determined that the employee was not entitled to the benefits. The IWCC cannot order reimbursement of the benefits already paid either to the employee (TTD) or to healthcare providers (medical bills).

(2) If an employee wants to obtain payment for a permanent disability that is claimed to have been suffered as a result of the accident, the case is referred to the OAG and the IWCC must either approve a settlement of permanent partial disability benefits (PPD) or resolve any disputed claim for these benefits through a trial before an Arbitrator.

IV. Litigation of Workers' Compensation Cases

If a dispute concerning an employee's right to a benefit cannot be resolved, the matter is set for hearing before an IWCC Arbitrator. There are two kinds of motions that a State employee can file to obtain a hearing:

(1) A Petition for Immediate Hearing Under Section 19(b) or 19(b-1), or
(2) A Request for Hearing (Trial).

A. Petitions for Immediate Hearing Under Section 19(b) or 19(b-1) – Hearing

Petitions for Immediate Hearing are filed when an employee claims that the State has failed to pay benefits that are required under the Act, such as TTD benefits or medical care. Before an award of any benefits can be made, the Arbitrator must determine whether the employee is entitled to workers' compensation benefits in the first instance. To that end, all threshold issues, such as compensability and causation, must be decided based upon the evidence presented during that hearing. A decision rendered after a section 19(b) or 19(b-1) hearing is considered "final" and the State must seek Commission review of this decision or it cannot later be challenged or re-litigated. 820 ILCS 305/19(b). In contrast with private employees and employers, State employees and the State may not seek judicial review of IWCC decisions.

Under the current IWCC rules, an employee seeking an immediate hearing only needs to provide the employer with 15 days notice prior to the Arbitrator's next monthly status call. As a result, the employer can have as little as 10 business days to prepare for this hearing which conclusively resolves many of the important issues in the case. This time frame is very difficult especially in cases which require the use of an administrative subpoena to obtain the employee's medical records to support any defenses.

RECOMMENDATION:

- The IWCC should change its rules (7020.70(b)(1)(B)) to require that the employer receive notice of at least 20 business days prior to a section 19(b) or 19(b-1) hearing.

B. Requests for Hearing – Trial

If a section 19(b) or 19(b-1) hearing has determined any threshold issues, all that remains to be decided is whether the employee is entitled to any additional TTD or medical benefits (for any time periods after the section 19(b) or 19(b-1) hearing) as well as PPD benefits. If there is no prior section 19(b) or 19(b-1) decision, then all disputed matters are at issue. The primary issues that may be disputed in workers' compensation cases are discussed in detail below.

As an initial matter, however, the current process for petitioners' attorneys to provide notice of a hearing to the employer's counsel creates difficulties in preparing for trial and requires reform. Once a case is on the docket of a workers' compensation arbitrator, there are certain procedures required for the case to proceed to a hearing. For cases that are less than three years old, the petitioner's counsel must send a Request for a Hearing to the employer's counsel 15 days prior to the docket call for a case to proceed to a hearing at that docket call. For cases that are three years old or older, however, the petitioner's counsel is not required to send a Request for Hearing. These older cases are "above the red line" cases which can proceed to a hearing without any notice prior to the docket call.

RECOMMENDATION:

- In cases that are less than three years old, the IWCC should amend its rules to require that the employer receive at least 20 business days notice prior to a trial. And in cases that are

more than three years old, the IWCC should amend its rules to require that the employer receive notice at least 20 business days prior to proceeding to trial.

The common issues are set forth below.

1. Whether there was an "Accident"

An injury is accidental when it is traceable to a definite time, place and cause. An inquiry as to whether an accident occurred takes on particular meaning in the context of repetitive trauma cases. As the Illinois Supreme Court has stated:

> When the accident is a discrete event, the date of the accident is easy to determine: it is, obviously, the date that the employee was injured. When the accident is not a discrete event, this date is harder to specify. An employee who suffers a repetitive-trauma injury still may apply for benefits under the Act, but must meet the same standard of proof as an employee who suffers a sudden injury. That means ... an employee suffering from a repetitive-trauma injury must still point to a date within the limitations period on which both the injury and its causal link to the employee's work became plainly apparent to a reasonable person. *Durand v. IIC*, 224 Ill.2d 53, 64-65 (2006) (citations omitted).

When the Illinois Supreme Court first considered this issue, it determined that "the date of an accidental injury in a repetitive-trauma compensation case is the date on which the injury 'manifests itself.'" *Peoria Co. Bellwood Nursing Home v. IIC*, 115 Ill.2d 524, 531 (1987). The Court held that "' [m]anifests itself' means the date on which both the fact of the injury and the causal relationship of the injury to the claimant's employment would have become plainly apparent to a reasonable person." *Peoria Co. Belwood Nursing Home*, 115 Ill.2d at 531.

In 2006, however, the Illinois Supreme Court modified its approach to determining the manifestation date in a repetitive-trauma injury, finding that the fact that the employee believed she had carpal tunnel syndrome and believed that it was work-related did not establish the manifestation date of her injury. *Durand*, 224 Ill.2d at 68-69. The Court held that "the date on which the employee notices a repetitive-trauma injury is not necessarily the manifestation date. Instead, the date on which the employee became unable to work, due to physical collapse or medical treatment, helps determine the manifestation date." *Durand*, 224 Ill.2d at 68-69. In its analysis, the Court explained that "courts considering various factors have typically set the manifestation date on either the date on which the employee requires medical treatment or the date on which the employee can no longer perform work activities." *Durand*, 224 Ill.2d at 72. Under this approach to determining the manifestation date, an employee can know he has suffered a work injury, continue to work for years without treatment while his condition worsens to the point of physical breakdown, and only then have an obligation to report an "accident" to his employer. In *Durand*, the Court specifically "decline[d] to penalize an employee who diligently worked through progressive pain until it affected her ability to work and required medical treatment." *Durand*, 224 Ill.2d at 74.

Given this expansive definition, the manifestation date for a repetitive-trauma injury can be difficult to identify and can even be long after the employer-employee relationship has ended –

essentially preventing the employer from learning about the employee's condition and its possible connection to work activities and taking timely action to ensure that the employee's condition does not become worse. Ultimately, identifying the manifestation date is a fact determination for the IWCC. *Durand*, 224 Ill.2d at 65. The IWCC and the courts typically choose the latest date possible to avoid the employee's claim being barred by the statute of limitations or a notice defense. This approach makes it extremely difficult for the employer to challenge the timing of the employee's notice and filing of the claim.

An example of this is a March 2010 Arbitrator decision in the case of a former correctional officer at Menard. *Vasquez v. Menard Correctional Center*, 10 IWCC 0826 (2010). The petitioner worked as a Menard correctional officer from 1997 to 2007. She began to notice numbness, pain and discomfort in her arms in 2006. Over a year after she left State employment, she saw her regular physician and "complained about weakness, tingling and numbness in her bilateral arms which had been present over the 'last couple of years.'" Her regular physician referred her to another doctor in April 2009 and his notes reflected that he asked her, "Where did this happen?" She responded, "About 3 years ago, at work, turning locks, felt discomfort and felt like I had no strength ...." Nonetheless, the Arbitrator concluded that her injury did not manifest itself until May 2009, "the first day she was told by Dr. Brown [the surgeon] that her condition was caused by her work activities for [the State]." According to the Arbitrator, "the law allows Petitioner to select a manifestation date that coincides with her discovery of injury and its relation to work after medical consultation." As a result, the Arbitrator found, and the IWCC affirmed, that the petitioner provided timely notice of the accident to the State.

RECOMMENDATION:

- The legislature should amend the Act to provide a clear method for determining the date upon which a repetitive-trauma injury manifests itself for purposes of the Act's notice requirements and the statute of limitations.

2. Compensability – Whether the accident arose out of and in the course of employment

For a claim to be compensable, the accident or injury must arise out of and in the course of employment. For an accident to "arise out of" employment, it must have its origin in some risk connected with or incidental to the employment. In other words, the employment must subject the employee to some increased risk beyond that faced by the general public. The issue of whether an accident arises "in the course of" employment typically involves whether the accident occurred at a time, a place and under circumstances related to the employment.

The IWCC and courts have taken a very broad approach to determining whether an injury "arises out of" the petitioner's employment. For example, in a case involving a State employee who slipped off of a curb in a parking lot and was injured, the IWCC reversed the Arbitrator's denial of benefits and found that the employee sustained injuries arising out of and in the course of his employment. *Rossi v. State of Illinois, Secretary of State*, 06 IWCC 0492 (2006). The employee in this case had arrived at work and parked in the employee designated parking garage as he had for many years. As he was walking into the building, he "stepped off the edge of a curb," his

foot twisted and he fell. In reversing the decision of the Arbitrator, the IWCC found that the sidewalk in the parking garage "was a hazard in that it was raised several inches above the surface level of the parking garage floor" and, as a result, the employee was subject to a risk "beyond that which the general public would be subjected." In dissent, one Commissioner noted: "[t] here is no evidence that the sidewalk/curb was either hazardous or defective. Petitioner's foot simply went off the edge. Therefore, Petitioner was not subjected to a greater degree of risks than the general public because of his employment."

In 2009, the Second District Appellate Court reinstated benefits to an employee who was injured when he threw himself up against a vending machine in an attempt to dislodge a bag of Fritos that had become stuck after a co-worker attempted to purchase them. *Circuit City Stores, Inc. v. IIC*, 391 Ill. App. 3d 913 (2d Dist. 2009). The IWCC had awarded benefits to the employee by finding that the personal comfort doctrine applied and that because the employee's use of physical force to shake the machine to dislodge a bag of chips was neither unusual nor outrageous, the employer was liable for workers' compensation benefits.[2] The Circuit Court reversed, finding that the personal comfort doctrine did not apply. The Appellate Court then reversed and reinstated the benefits.

While acknowledging that the personal comfort doctrine did not apply, the Appellate Court found the claim was nevertheless compensable under the "Good Samaritan" doctrine. The Appellate Court noted that prior cases applying the Good Samaritan doctrine involved an employee providing aide to someone in urgent need (such as rescuing someone who fell into a lake, protecting a young child from physical harm or providing transportation to a stranded motorist and her children). The Appellate Court, however, extended the doctrine to cover an injured worker's attempt to rescue a co-worker's stranded bag of chips because the Court found that it was reasonably foreseeable to the employer that this may occur. In addressing the "arising out of" employment analysis, the Appellate Court concluded that a reasonable trier of fact could find that the "injury originated in a risk incidental to [the employee's] employment" because (1) the employer provided the vending machine for the convenience of its employees, (2) the machine was defective and (3) the defect "creat[ed] a need for action to dislodge the bag of Fritos." *Circuit City Stores, Inc.* 391 Ill. App. 3d at 990-91.

The Illinois Supreme Court has made it clear that Illinois employers are not liable for accidents or injuries solely because they occur at work. The IWCC and the lower courts, however, have increasingly applied an expansive approach to determining whether an accident or injury arose out of and in the course of employment. These decisions have created significant challenges for employers in defending claims on the issue of compensability.

3. Compensability – Whether the accident arose out of and in the course of employment and the "traveling employee" doctrine

The IWCC and the courts also have significantly expanded the concept of compensability through the "traveling employee" doctrine, a theory of compensability that is not found in the

2 The IWCC awarded 12 4/7 weeks of temporary total disability benefits, $60,306.83 in medical benefits and 35% loss of use of the right leg, resulting in a total award of $74,107.74.

Workers' Compensation Act. Historically, the doctrine was intended to broaden the scope of compensability for those employees whose work required that they travel. The reasoning behind this approach was that such employees would be exposed to unfamiliar surroundings which, in and of themselves, increased an employee's risk of injury. In such cases, if the employee was injured in circumstances that were not normally compensable (such as when engaging in recreational activities, slipping and falling when no defect was identified, or suffering an injury in the hotel where the employee was staying), the accident would be considered compensable under the traveling employee doctrine as long as the employee's conduct was "reasonably foreseeable" to the employer. The IWCC and the courts, however, have expanded this doctrine in two significant ways.

First, the IWCC and the courts have applied the doctrine to employees who are not traveling to areas that are unfamiliar and who are only engaged in incidental "travel" as a part of their job duties. In *Metropolitan Water Reclamation Dist. of Greater Chicago v. IIC*, 407 Ill. App. 3d 1010 (1st Dist. 2011), for example, a clerical worker was taking a short walk to the local bank to make a deposit for her employer and tripped on a "dip" in a driveway – a risk to which the general public was also exposed. In awarding benefits to the employee, the Appellate Court found that the "street risk" doctrine (the functional equivalent of the traveling employee doctrine) applied to make the accident compensable.

Second, the IWCC has chosen not to apply the traditional compensability analysis (whether the accident arose out of and in the course of employment) in cases where the employee can be considered a "traveling" employee. Specifically, in these cases, the IWCC has replaced the traditional compensability analysis with the expansive notion of "foreseeability." As a result, the IWCC essentially applies a form of strict liability to provide the "traveling" employee with portal-to-portal coverage for accidents which would normally not be considered work accidents under the Act.

For example, in *Leung v. United Airlines*, 08 IWCC 0535 (2008), a flight attendant with a long history of right shoulder dislocations was in an airline lounge for a three-hour layover. When she was preparing to head to the plane to start boarding the next flight, the flight attendant dislocated her shoulder while putting on her coat. The IWCC found that because she was traveling, the "Petitioner need not show that the injury is connected or incidental to her employment or that she is exposed to a greater risk than the general public." Likewise, in *Smith v. Downers Grove Fire Department*, 07 IWCC 1339 (2007), two firefighters were out of town for a seminar. While in their hotel room, they were engaged in what would normally be characterized as "horseplay" ("wrestling, like a couple of over-sized kids"), when the Petitioner injured his knee. In awarding benefits, the IWCC determined that whether the conduct was considered horseplay (and therefore not compensable under a traditional compensability analysis) was not relevant because the Petitioner was considered a traveling employee and therefore "the standards for determining whether an injury arose out of and in the course of employment are governed by the employer's foreseeability of the employee's conduct and the reasonableness of the employee's conduct." Finally, in *Cortey v. Sara Lee*, 11 IWCC 1197 (2011), the employee traveled out of state to take some of the employer's customers to a coffee plant. While riding in a rented limousine with the customers, the employee (who had a history of knee problems) stood up to move from one seat to another. At that point, he felt a sharp pain in

his knee and felt something pop. The IWCC found the injury compensable and agreed with the Arbitrator's holding that "it [is] important to note Petitioner was a 'traveling employee' for the Respondent[.] Case law is well-settled when an employee[']s work duties require travel, injuries sustained by that employee will be found to arise out of and in the course of his employment so longs[sic.] as the employee's conduct was reasonable and the risk of injury was foreseeable."

By broadening the concept of the traveling employee and holding that the traditional compensability analysis (whether the accident or injury arose out of or in the course of employment) does not apply to a traveling employee, the IWCC has greatly expanded the workers' compensation liability of employers without legislative involvement.

RECOMMENDATION:

- The legislature should enact reforms to clarify the accidents that are covered by the Workers' Compensation Act, including by adding a definition of "traveling employee" to the Act and detailing the scope of the Act's coverage to such employees.

4. Causation – Whether the employee's condition is causally connected to a work injury

The Workers' Compensation Act provides for a "no-fault" system for the compensation of injuries due to work-related accidents. As a result, assumption of the risk and comparative negligence principles do not – and should not – play a role in determining whether the employee has a ***compensable*** claim under the Act. Separate from the issue of compensability, however, is the issue of whether the condition of ill-being claimed by the employee is causally related to a work accident as opposed to being related to a pre-existing condition, or a condition which later develops, but is not a result of the work accident. An employee's condition must be causally connected to an accidental work injury for him to obtain benefits under the Act.

The issue of causation in a workers' compensation case is considered a question of fact to be resolved by the IWCC. Under current Illinois law, the work accident need not be the sole proximate cause or even a primary cause of the employee's injury. *Sisbro, Inc. v. IIC*, 207 Ill.2d 193, 205 (2003). "[E]ven though an employee has a preexisting condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. ... Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it was *a* causative factor in the resulting condition of ill-being." *Sisbro, Inc.*, 207 Ill.2d at 205. Thus, if a work accident aggravates or accelerates (even slightly) a pre-existing condition, the employer is liable for workers' compensation benefits. And once the employee establishes causation, the employer is liable for the costs of ***all*** resulting care and disability even for the pre-existing condition.

A few examples illustrate the extraordinary difficulty employers face in defending cases based on this causation standard.

a. Degenerative Condition Cases

Workers' compensation cases involving a degenerative condition of a body part (such as the body parts that naturally degenerate through aging – back, neck and knees) are increasingly common and extremely difficult to defeat before the IWCC. For example, if an employee with a pre-existing diagnosis of a severe degenerative condition of the lumbar spine picks something up at work and experiences pain, or an increase in pre-existing pain, he can claim that he suffered a work accident entitling him to workers' compensation benefits and the employer's defense to this claim is limited. It is not a defense to show that the employee had a pre-existing severe degenerative disc disease. If the employee's physician states that the condition was aggravated by work, even only slightly, then the employer is liable for ***all*** medical care the employee will need for his back regardless of the fact that the employee's work did not cause the development of degenerative disc disease. Additionally, the IWCC does not require that the aggravation of a pre-existing injury be supported by objective medical evidence that the employee's condition has worsened (such as a comparison of a pre- and post-accident MRI demonstrating an objectively verifiable aggravation of the condition). The IWCC accepts the employee's subjective complaints about an increase in pain as sufficient.

The same scenario is becoming more prevalent in workers' compensation cases involving knees. An employee with a documented pre-existing degenerative knee condition (which has progressed to the point of a doctor recommending knee replacement in the near future) can have a minor incident at work which causes knee pain, or an increase in pain, which sends the employee back to the doctor for the knee replacement that the employee would nevertheless have had in the near future. If the employee makes a claim that the work "accident" *accelerated* the need for a knee replacement, the employer is required to pay for the knee replacement, all related time off work, and 45-50% loss of use of the leg in PPD benefits. The employee can establish this claim simply by testifying that there were no symptoms or minor symptoms before the work accident, but the employee became symptomatic, or more symptomatic, after the accident.[3]

b. Repetitive-Trauma Cases

In repetitive-trauma cases, as in cases involving pre-existing degenerative conditions, the fact that the employee had pre-existing carpal tunnel (wrist) or cubital tunnel (elbow) syndrome is not a defense under Illinois law. Additionally, because the work injury need only be ***a*** causative factor in the development of the carpal or cubital tunnel syndrome, the presence of one or more other known risk factors for these conditions (such as diabetes, obesity and arthritis) is ***not*** a defense that will prevent the IWCC from finding the claim compensable and ordering the employer to pay all benefits.

If an employee asserts that there was a worsening or aggravation of the ***symptoms*** (not even of the condition itself) as a result of her work activities, the employer will be liable for all of the medical care and for the time the employee needs to remain off work while recovering from

3 This current causation standard applied by the IWCC essentially amounts to a reversal of the burden of proof in cases involving pre-existing degenerative conditions or repetitive trauma. In these cases, to be successful, the employer is basically required to prove that the employee's work could not have caused any aggravation of his pre-existing condition.

surgery on one wrist or elbow and then another (as these conditions often occur bilaterally). Many employees have one or more risk factors, but if they testify that the pain in their wrists or hands got worse while doing their duties at work, and their physicians agree that the work ***could*** have caused or aggravated this condition, the IWCC will award compensation. In the cases involving Menard Correctional Center, for example, correctional officers have obtained workers' compensation benefits simply by presenting evidence that work could have caused or aggravated their carpal or cubital tunnel syndrome. The State cannot succeed in defending against these cases unless it can present independent medical testimony stating that it is ***not possible*** that the correctional officer's work even slightly aggravated his pre-existing condition.[4] It is extremely difficult, if not impossible, for the State to obtain credible, independent medical testimony concluding that a correctional officer's work at Menard Correctional Center could not have even slightly aggravated the carpal or cubital tunnel syndrome. Moreover, many cases demonstrate that even when the State obtains independent medical testimony challenging the causal connection opinion offered by the employee's physician, Arbitrators tend to place little value in the opinion of a State expert who never treated the employee and offered his opinion years after the work accident at issue. Finally, although repetitive trauma to the wrist and the elbow are the most common repetitive-stress injuries, we are increasingly seeing cases involving repetitive trauma to the shoulders, knee and neck.

RECOMMENDATIONS:

- To protect taxpayer dollars, the legislature must address and change the causation standard that is currently applied by the IWCC and the courts. Senate Bill 2521 addresses the causation standard and provides an opportunity to discuss the appropriate language to make this needed change.

- The legislature should consider defining repetitive-trauma claims which will be considered compensable under the Act. For example, the legislature could define compensable repetitive-trauma claims to include only those injuries in which the

4 The following Arbitrator decision demonstrates the significant difficulty employers face in defending against repetitive trauma claims. In this particular case, the State employee asserted that in 2001 she began experiencing pain and swelling in her non-dominant hand. She stated that she never provided any written notice of her work accident, but did mention to her supervisor in July 2001, that her hand was bothering her and she was going to see a doctor. In February 2002, she completed a SERS Disability Form specifying that her condition was ***not*** work-related. Despite these facts, the IWCC Arbitrator determined that a work accident occurred and that proper notice was provided to the employer. With regard to causation, none of the employee's treating physicians stated that her condition was work-related. In January 2009, over seven years after the alleged date of accident, the employee was seen by a specific doctor at her attorney's request. This physician opined that her condition was causally related to her work. In his deposition, the physician acknowledged other risk factors for carpal tunnel syndrome such as arthritis, diabetes and being overweight but stated that he had ruled out these risk factors because the employee did not have them. In contrast, the Arbitrator noted that the Petitioner was overweight, and said that the physician "is clearly wrong. Her medical records are replete with notations that she suffers from high blood pressure and diabetes. She also has arthritis in other parts of her body." The Arbitrator also noted that the physician did not review any job description or any evidence of the employee's work activities and, instead, relied solely upon the employee's description of what she did. After identifying the physician's faulty factual conclusions, the Arbitrator nonetheless credited the physician's opinion on causal connection and awarded the employee 15% loss of use of her non-dominant hand and 20 weeks of TTD benefits ($11,067.90). *Frieson v. DHS*, 03 WC 26709. Our office sought review of this case, and the IWCC affirmed the Arbitrator's decision. *Frieson v. DHS*, 12 IWCC 0323.

employee's job duties were the "primary" cause or a "major" cause of the condition of ill-being and excluding those conditions which are primarily caused by the natural degenerative process which occurs during aging.

5. Partial Permanent Disability

In addition to TTD benefits and medical benefits, an employee is entitled to a partial permanent disability benefit (PPD) if the employee has suffered any permanent functional loss of use of a body part (or of the "person as a whole") as a result of the work injury.[5] The IWCC has sole discretion in determining whether an employee is entitled to PPD benefits and, if so, the permanency value of the injury. In assessing the level of permanent disability, the IWCC considers a number of factors, including age, occupation, whether the injury was to a dominant body part, disability from engaging in specific types of employment or physical activities, skill, training, experience, pain, stiffness, weakness, atrophy, limitation of motion, and interference with or absence of normal bodily structures or organs. Prior to the recent amendments to the Act, the IWCC routinely awarded partial permanent disability benefits without requiring any medical evidence establishing that the employee had suffered a loss of use of a body part.

For example, in *McGovern v. US Steel*, 07 IL.W.C. 19395, 10 IWCC 0354 (2010), the petitioner underwent surgery for carpal tunnel syndrome in his right hand. After the surgery, his physician released him to return to work without any restrictions. With regard to permanent disability, the petitioner testified "that he has a little ache in his hand and a little grip problem but he was doing okay. He said he wears a glove on his hand when he uses the hammer at work. He is able to do all aspects of his job. He does not take any prescription medicine for his hand and he has not been to the doctor for his hand since [his surgeon] released him." Nonetheless, the Arbitrator found that "[a]s a result of his work injury Petitioner has sustained the loss of 20% of the right hand." The IWCC affirmed that decision.

As a result of the recent amendments, however, section 8.1b of the Act now requires that for injuries occurring after September 1, 2011, the Arbitrator must consider (i) the level of impairment as reported in an AMA Impairment Rating if introduced into evidence by a party; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. Under the law, no single factor is determinative of disability and the Arbitrator must explain the weight given to each factor in the decision.

Along with this critical change to the Act, the IWCC should require that an Arbitrator's award of permanency benefits must be made on a case-by-case basis as supported by the evidence of permanent disability. Permanency benefits should not be awarded based on a pre-conceived notion that certain categories of injuries automatically result in a certain level of permanent disability. In addition, regular advances in medical technology must be considered when

5 In cases involving severe injuries where the employee cannot return to work, other benefits may be available to her such as vocational rehabilitation, wage differential (to offset any loss of earnings due to her inability to return to her usual occupation), or even permanent and total disability benefits should her condition render her unemployable.

determining an employee's level of permanent disability.[6] A clear example of why this is important comes from the IWCC's treatment of carpal tunnel cases in recent years.

Advances in medical technology have made carpal tunnel surgery less invasive and with fewer complications. Most carpal tunnel surgeries now result in the complete relief of symptoms with no residual problems. Yet, prior to the recent amendments to the Act placing a cap on the permanency value of a carpal tunnel claim, the value of an operated carpal tunnel case continued to increase. Ten years ago, an employee who underwent carpal tunnel surgery on her dominant hand could expect a permanency award of about 15% loss of use of the dominant hand. In recent years, that same case has been valued in the Chicago area IWCC dockets at 17.5% loss of use of the hand and in the downstate IWCC dockets at 22.5% loss of use of the hand. And these numbers were just the starting point for carpal tunnel cases – they represented the ***minimum*** amount of permanency awarded even with the complete relief of symptoms, no residual effects and the treating physician's determination that the employee could return to her previous job without any restrictions. If there were any complications in a particular case, the value increased. Critically, the recent amendment to section 8(e)(9) of the Act caps carpal tunnel injuries at 15% (up to 30% with clear and convincing evidence of disability). Even with this change in the law, it is important that arbitrators analyze the evidence of permanent disability on a case-by-case basis and not simply award 15% loss of use of the hand in all carpal tunnel cases.

The IWCC's routine approach to awarding partial permanent disability benefits is not, however, limited to carpal tunnel cases. Cubital tunnel syndrome (typically repetitive trauma to the elbow), an injury which involves a surgical procedure to reduce the compression of the nerve running through the cubital tunnel at the elbow, typically commands an automatic 15 - 17.5% loss of use of the affected arm in the Chicago area dockets and 20 - 25% in the downstate dockets, without any requirement that the petitioner demonstrate actual permanent disability. Given that the same problem exists in awards for both carpal tunnel and cubital tunnel claims, the legislature should consider placing a statutory cap on cubital tunnel claims similar to the one it placed on carpal tunnel claims.

An additional issue relating to permanency findings arises when an employee has a subsequent injury to a body part for which the employee had a previous workers' compensation claim. In these instances in recent years, the arbitrators and the IWCC have focused on ensuring that the employee receives additional money for the subsequent injury, regardless of whether the medical evidence and resulting work restrictions, if any, justify an additional permanency award. For example, consider an employee who had a claim for carpal tunnel syndrome for the right hand and received an award of 15% loss of use of that hand and subsequently injures that same hand

6 The repetitive trauma cases arising out of Menard Correctional Center have illustrated the problem with the IWCC's approach to PPD benefits prior to the recent amendments to the Act. These cases primarily involve carpal or cubital tunnel syndrome or both. For example, a correctional officer who is diagnosed with bi-lateral carpal tunnel syndrome has a minimally invasive, very brief surgery on each hand. The correctional officer's physician allows him to return to work without any restrictions on his ability to perform his job. Despite the fact that the surgery has alleviated the condition and his physician has not placed any restrictions on his ability to do his job, the correctional officer seeks PPD benefits. Then, the IWCC Arbitrator determines, without any medical evidence, that the correctional officer's ability to use his hands has permanently diminished by as much as 22.5%. As a result, the correctional officer receives over $50,000 for bi-lateral carpal tunnel syndrome (and in the many cases where the employee has both bi-lateral carpal and bi-lateral cubital tunnel syndrome, he receives over $100,000).

(either through repeat carpal tunnel syndrome or other injury) and seeks another permanency award. In considering the permanency award for the subsequent injury, the arbitrators and IWCC should focus on the resulting level of disability that the employee has experienced and then make an award accordingly, off-setting the portion of the disability payment that the employee has already received from any new payment. Instead, the arbitrators and IWCC too often focus on awarding additional money to the employee for the subsequent injury. As a result, the employee in this example would often receive a second award for 15% loss of use of the hand, with the employer having paid for a total of 30% loss of use of the hand despite the fact that the employee's actual physical disability has not changed due to the second hand injury.

A recent Appellate Court decision raises another issue relating to permanency awards. The Third District Appellate Court, Workers' Compensation Commission Division, recently held that a shoulder injury should be treated as an injury to the "person as a whole" rather than as an arm injury. *Will County Forest Preserve District v. IWCC*, No. 10-MR-673 (Ill. App. 3rd, Feb. 17, 2012). This decision, which is contrary to well-established precedent, is likely to result in a significant increase in costs for employers for two reasons. First, PPD benefits are calculated based on a number of benefit weeks, and the number of weeks awarded varies by the body part affected. The Act provides a schedule of benefits for the loss of use of certain body parts. Under the Act, "[a]n employee who suffers the physical loss of an arm or the permanent and complete loss of use of an arm is compensated at 253 benefit weeks." *Will County Forest Preserve District*, at para. 13 (citing 820 ILCS 305/8(e)(10) (West 2008)). If the employee's injury results in a partial loss of use, then the number of weeks awarded is based on the percentage loss of use of the arm. So, a 25% loss of use of an arm would result in an award of 63.25 benefit weeks. If an injury is treated as an injury to the person as a whole, the benefits are awarded based on a percentage of 500 weeks, in contrast to the 253 weeks used in arm injury cases. As a result, the petitioner in the *Will County Forest Preserve District* case, who experienced a 25% loss of use of his shoulder, was awarded 125 benefit weeks – **nearly double** what he would have received under the longstanding precedent that treated shoulders as part of the arm. The State currently has a number of cases involving shoulder injuries similar to the injury in this recent decision.

Second, in cases where an employee experiences a subsequent injury to a body part, such as an arm, the employer can set-off any previous permanency award in paying a permanency award for the subsequent injury. The *Will County Forest Preserve District* case provides an example of this issue. Several years before the petitioner's shoulder injury, he sustained an injury that required surgery to his right elbow and a right carpal tunnel release. He settled with his employer for 15% loss of use of his right hand and 15% loss of his right arm. If the court had treated his shoulder injury as an arm injury, the employer could have set-off the previous arm award against this new award. Under the current law, however, an employer cannot set-off a previous award for a body part against a "person as a whole" permanency award in any subsequent case.

RECOMMENDATIONS:

- Given that the petitioners usually return to work with no restrictions after carpal tunnel treatment or surgery, the legislature should consider specifying a lower level of permanent partial disability to be awarded in carpal tunnel claims.

- The legislature also should adopt a statutory cap on permanency benefits for cubital tunnel claims, similar to the cap adopted for carpal tunnel claims.

- In training arbitrators and reviewing cases, the IWCC should ensure there is no significant difference in permanency awards in similar cases based solely on the location of the dockets, eliminating significant differences in the amount of permanency awards between the Chicago and downstate dockets.

- The legislature should require that in cases involving a subsequent injury to a body part for which the employee has already been compensated, the permanency award must be based on evidence of the employee's resulting permanent disability, regardless of whether that will result in the employee receiving more money for the loss of use of that body part.

- The legislature should allow set-offs for "person as a whole" awards if the employee's subsequent injury is to the same body part as the prior injury.

6. Wage Differential and Permanent and Total Disability Awards

If an injury affects the ability to pursue the employee's usual and customary line of employment and a decrease in earning capacity results, the employee is entitled to receive a wage differential. The wage differential is calculated as 2/3 of the difference between what the employee would be earning if returned to work and what the post-accident earning capacity is determined to be. Until recently, a wage differential award was a lifetime benefit. In 2011, the General Assembly made a critical change and amended the Act to limit wage differential awards to a period of five years or until the employee reaches age 67, whichever is greater.

The recent amendments to the Act, however, did not address a separate, significant issue relating to wage differential awards. If an employee receives a wage differential award, but later obtains new employment making more than the employee's previous job, this increase in earnings will not affect the wage differential award. The wage differential award cannot be reduced by showing that the employee's earning capacity has in fact returned to its pre-accident level or even increased. Rather, the employer can only succeed in a request to reduce the wage differential award by demonstrating that the employee's physical disability has decreased, regardless of his actual income.

If an injury prevents an employee from returning to any gainful employment, the employee is entitled to a permanent and total disability award (PTD benefits). This lifetime award continues to be paid while the employee is receiving retirement or Social Security benefits. An employee is determined to be permanently and totally disabled when, due to the injury, the employee cannot perform any services except those so limited in nature that there is no reasonably stable labor market for them. As an expansion of the permanent disability concept, the IWCC and courts have created a separate class of cases referred to as "odd-lot" permanent and total disability cases. In these odd-lot cases, if the employee has significant restrictions and can show that the injuries in conjunction with other personal limitations (such as education or language barriers) have prevented the return to gainful employment, the IWCC will award him permanent

and total disability benefits for life. The odd-lot category is not in the Workers' Compensation Act, yet the IWCC is entering an increasing number of permanent and total disability awards based on this theory.

It also should be noted that State employees who are found by the IWCC to be permanently and totally disabled have the potential to earn more in disability related payments than they would have earned if they remained employed until retirement. These employees receive 66 2/3% of their wages for life, along with annual increases from the Rate Adjustment Fund. Additionally, they can receive 8 1/3% of their wages in disability payments from the state retirement system. When they reach retirement age, the retirement system switches them from disability benefits to pension benefits. Because none of these payments are taxed under Illinois law, once these employees reach retirement age, they may receive more income than they would have received if they had continued to be employed and then retired.

RECOMMENDATIONS:

To save taxpayer dollars, the legislature should make significant changes to the current provisions for these awards:

- If the employer can demonstrate that the employee's earning capacity has returned to its pre-accident level (regardless of whether the level of physical disability has remained constant), the employer should be entitled to a modification of the wage differential award.

- The legislature should specifically define the odd-lot theory of permanent and total disability in the Act to prevent abuse or the expansion of this approach without legislative approval.

- The legislature should provide that workers' compensation benefits paid to State employees must be off-set by the amount the employee is receiving in State pension payments. This would avoid a situation where a State employee who is receiving PTD benefits is earning more in retirement than the employee earned while working for the State.

7. Penalties and Attorneys' Fees

The IWCC may award penalties under Sections 19(k) and (l) of the Act and attorneys' fees under Section 16.

Under Section 19(k), the IWCC has the discretion to award penalties against an employer, including the State, for an unreasonable or vexatious delay in paying compensation, including medical expenses. The amount of the penalty is equal to 50% of the amount payable. For example, if there is $60,000 in unpaid medical expenses, and the IWCC Arbitrator determines that the non-payment was unreasonable or vexatious, another $30,000 is awarded in Section 19(k) penalties. The penalty goes to the employee and the attorney, not to the medical provider whose bill was unpaid. When Section 19(k) penalties are awarded, Section 16 allows the IWCC

to award attorneys' fees to the employee. (The IWCC cannot award attorneys' fees under Section 16 unless it also awards Section 19(k) penalties.) When awarded, attorneys' fees are usually 20% of the 19(k) penalties.

Section 19(l) allows the IWCC to award a per diem penalty against the employer, *including the State*, for an unreasonable delay in paying benefits, including medical expenses and TTD. Section 19(l) provides for a penalty of $30 per day, not to exceed $10,000, if the employer "shall without good and just cause fail, neglect, refuse or unreasonably delay the payment of benefits." Under this Section, a "delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay." Section 19(l) penalties are interpreted as essentially a late fee and are considered mandatory if the employer cannot show an adequate justification for its delay.

Due to chronic underfunding of the CMS budget for workers' compensation and the State's fiscal crisis, CMS is routinely nearly two years behind in paying medical expenses. Currently, CMS has a 22 to 24 month delay in paying medical bills. The IWCC Arbitrators in the downstate dockets have awarded Section 19(l) penalties against the State for failure to pay medical expenses in a timely manner, although in an April 2011 decision, the IWCC denied a State employee's petition for penalties and attorneys' fees, finding that the State's inability to pay was adequate justification for the delay. *Spiller v. Menard Correctional Center*, 08 WC 31092.

RECOMMENDATION:

- The Act currently provides for 1% per month interest payable to the provider for any medical bills that are unpaid after 30 days (820 ILCS 305/8.2(d)(3)). With this provision in place to provide for interest to medical providers, the legislature should amend the Act to expressly prohibit the IWCC from awarding any additional penalties or attorneys' fees against the State when the cause for the delay is the underfunding of the workers' compensation budget.

8. Medical Expenses

The unpaid medical expenses are most often awarded to the employee. Often, the employee's attorney will negotiate with the medical providers to reduce their bills, resulting in the employee keeping the difference between the amount awarded for medical expenses by the IWCC and the amount paid to medical providers.

RECOMMENDATION:

- The legislature should amend the Act to provide that the award of medical expenses is limited to the State satisfying the bills of the medical providers, prohibiting the payment of any portion of the medical award to the employee or the employee's attorney.

V. Settlement of Workers' Compensation Cases

In defending a State employee's workers' compensation case, it may be financially advantageous to the State to consider settlement if there is a chance the State might be required to pay for future medical care related to the work injury. If a workers' compensation case goes to trial and the IWCC enters an award for the State employee, the State remains liable for any and all medical care related to the work injury that the employee may need in the future (this is commonly referred to as "open medical"). The vast majority of settlement agreements, however, specifically end the employee's right to future medical benefits, relieving the State of any further liability for medical expenses.

In cases where a State employee has reached maximum medical improvement and the claim is otherwise uncontested (when, based on the facts and the law, there are no viable legal defenses to the claim), the parties may explore settlement of the employee's claim for PPD benefits. In negotiating any settlement of a claim, the OAG must first receive a specific amount of funds in settlement authority from the CMS Risk Management Supervisor assigned to the case and must operate within the limits provided by CMS. The OAG considers many factors in determining an appropriate settlement amount, including but not limited to:

(1) the diagnosis based upon objective medical evidence;
(2) the amount and level of treatment rendered to address the employee's condition;
(3) the employee's age and occupation;
(4) any resulting inability to perform certain types of employment or physical activities;
(5) ongoing residual physical problems (pain, stiffness, weakness, limitation of motion etc.);
(6) the level of any interference with or absence of normal bodily functions;
(7) the costs involved to secure evidence to support defense(s) (i.e., IME's, FCE's, JSA's) and the likelihood that any such defense(s) would be successful;
(8) the potential liability should the matter go to trial;
(9) the effects a particular settlement would have on the defense of other State workers' compensation claims;
(10) the potential costs of future medical expenses; and
(11) the potential for future workers' compensation claims by the same employee.

The permanency value of a given case is also driven by the IWCC's decisions in previous cases of a similar nature. As a result, these previous decisions necessarily dictate the settlement value of a case. For example, the OAG is usually unable to settle a cubital tunnel case for much less than what the IWCC will award if the case goes to trial. A petitioner's attorney will not accept a settlement offer of 5 - 7% loss of use of the arm when he knows that the Arbitrator will award 17.5 - 20% loss of use of the arm after a trial.

VI. Conclusion and Summary of Recommendations

Following the critical reforms enacted last year, the legislature and the Illinois Workers' Compensation Commission can take a number of additional steps to improve the system and protect taxpayer dollars while also ensuring that State employees who are injured while working are appropriately compensated. These reform proposals would require changes to the

administration of State employees' workers' compensation claims, changes to the IWCC's procedures in workers' compensation litigation and further amendments to the law.

- Reforms to the Administration of State Employees' Workers' Compensation Claims: The State should undertake reforms to ensure that the workers' compensation claims process is administered effectively and that all state agencies take action to reduce workplace injuries and return employees to work as quickly as possible. The most critical of these reforms include:
    - Adequately fund and staff CMS to effectively administer and pay claims or consider retaining a third-party administrator;
    - Ensure CMS has adequate funding to retain Independent Medical Examinations (IMEs) in all cases in which they might be appropriate and that CMS has an effective procedure in place to obtain IMEs in all appropriate cases;
    - Require initial and periodic CMS supervisory approval for all TTD and maintenance benefits;
    - Increase CMS's use of vocational rehabilitation counselors and ensure that CMS has an effective procedure in place to provide vocational rehabilitation to employees in all appropriate cases;
    - Ensure that CMS establishes a Preferred Provider Program covering all State facilities; and
    - Ensure that State agencies have an incentive to reduce work injuries and workers' compensation claims by employees on their budgets.

- Reforms to the Rules of the IWCC Governing Procedures in Workers' Compensation Litigation:
    - By amending its rules to require that the employer receive at least 20 business days notice prior to a section 19(b) or 19(b-1) hearing or a trial, the IWCC can ensure that employers, including the State, have adequate time to prepare to defend against a claim; and
    - Through training of arbitrators and review of arbitrator decisions, the IWCC should eliminate geographic disparities in awards, ensuring that similar injuries are treated similarly in dockets in the Chicago area and downstate.

- Further Reforms to the Illinois Workers' Compensation Act: Through additional amendments to the Act, the legislature can build on the important reforms enacted last year to provide a fair process for both employees and employers and protect taxpayer dollars. The legislature should consider the following amendments to the Act:
    - To ensure adequate notice of an accident or injury, require that State employees must complete all CMS workers' compensation claim forms prior to receiving benefits and require written, signed and verified notice of an accident;
    - Provide a clear method for determining the date upon which a repetitive-trauma injury manifests itself for purposes of the Act's notice requirements and statute of limitations;
    - Clarify the accidents that are covered by the Act, including by adding a definition of "traveling employee" and detailing the scope of the Act's coverage for such employees;

- Address and change the causation standard that is currently applied by the IWCC and the courts;
- Define repetitive-trauma claims which will be considered compensable under the Act;
- Lower the cap on the level of permanent partial disability to be awarded in carpal tunnel claims;
- Adopt a cap on permanency benefits for cubital tunnel claims;
- Require that in cases involving a subsequent injury to a body part for which the employee has already been compensated, the permanency award must be based on evidence of the employee's resulting permanent disability, regardless of whether that will result in the employee receiving more money for the loss of use of that body part;
- Allow set-offs for "person as a whole" awards if the employee's subsequent injury is to the same body part as the prior injury;
- Provide that if the employer can demonstrate that the employee's earning capacity has returned to its pre-accident level (regardless of whether the level of physical disability has remained constant), the employer should be entitled to a modification of the wage differential award;
- Define the odd-lot theory of permanent and total disability in the Act to prevent abuse or the expansion of this approach without legislative approval;
- Provide that workers' compensation benefits paid to State employees must be off-set by the amount the employee is receiving in State pension payments to avoid a situation where an employee receiving PTD benefits is earning more in retirement than the employee earned while working for the State;
- Prohibit the IWCC from awarding penalties or attorneys' fees against the State when the cause for the delay is the underfunding of the workers' compensation budget; and
- Provide that the award of medical expenses is limited to the State satisfying the bills of medical providers, prohibiting the payment of any portion of the medical award to the employee or the employee's attorney.