Testimony of Medical Witnesses

The Petitioner and Respondent's Perspective

Petitioner:

Francis J. Lynch
Wolter, Beeman & Lynch
1001 South 6th Street
Springfield, IL 62703
217-753-4220
flynch@wbllawyers.com

Respondent:

Elaine T. Newquist
Ganan & Shapiro, P.C.
210 West Illinois
Chicago, IL 60654
312-822-0040
Elaine.Newquist@ganan-shapiro.com

© 2015, 2016 by Francis J. Lynch and Elaine T. Newquist. All rights reserved.

Testimony of Medical Witnesses

Introduction. Workers' compensation laws exist to address the benefits due a person injured in the workplace. An injury typically results in medical care. Thus, central to the practice of workers' compensation law is "dealing with" medical issues and the expressed opinions from medical providers on them—the accident histories, descriptions of job duties and development of symptoms that lead to causation opinions, the subjective complaints, examinations and objective findings that lead to diagnoses, the opinions on work capabilities and prescriptions for treatment, the conclusions on a maximum medical status reached, the opinions on permanent restrictions, future treatment needs, and impairment ratings that go into permanent disability determinations.

Just as no two lawyers may ever agree on anything, no one party may simply agree to allow a record, report, bill or opinion to be admitted into evidence, whether that medical evidence has been provided by a treating provider or an "expert" brought in by one side or the other to address any medical issue. Thus, the taking of testimony, whether at a trial setting or in a deposition, may become necessary in order to successfully introduce that evidence into the record.

The following is an overview of the taking medical witness testimony, from the perspective of a Petitioner and a Respondent.

1. Treatment, Causation

A. General Admissibility of Treating Records, Reports and Bills Under Section 16

Section 16 of the Act addresses the admissibility of treating records into evidence. In general, medical records, reports and bills kept by a treating doctor, hospital or other healthcare provider are admissible into evidence, when certified as "true and correct" by that provider. There is a rebuttable presumption the records are "true and correct" when submitted in response to a Commission issued subpoena.

Section 16 specifically provides that certified treating records are admissible to establish the treatment has been rendered, without further proof. However, the section specifically provides this is not "conclusive proof of such matters."

The section also expressly does not apply to an "automatic" admission of "reports prepared by treating providers for use in litigation."

Issues and Commentary:

Are all treating records admissible into evidence over any hearsay objection, thus negating the need to take any medical testimony?

Petitioner's Perspective: Records which are kept by a treating hospital, physician, or healthcare provider and which are certified to be true and correct "Shall be admissible without any further proof as evidence of the medical and physical matters stated therein, but shall not be conclusive proof of such matters. There shall be a rebuttable presumption that any such records, reports, and bills received in response to a Commission Subpoena are certified to be true and correct." (820 ILCS 305/16) The Petitioner should be prepared to offer an appropriate certification or proof that the records and bills were produced in response to a Subpoena or are complete, true, and correct.

Section 16 of the Act also states: "This provision does not apply to reports prepared by treating providers for use in litigation." It is the Petitioner's position that office notes are generally admissible, and opinions contained therein are admissible as part of that note. The fact that an office note addresses issues of causal connection, permanency, or disability does not necessarily suggest that it was "prepared by treating providers for use in litigation." The fact that a physician answers a question which may be posed in litigation does not mean that his record is a "report prepared" for litigation.

As a caveat, however, the fact that one **can** do something does not mean that someone **should** do something. Certified medical records may be admissible under 16 but must be carefully evaluated to determine whether they adequately address the issues presented in the case and must be evaluated to determine if they are sufficient without additional deposition testimony. The burden of proof is with Petitioner; take a deposition if you aren't sure.

Respondent's Perspective: A qualified yes. A certified record signed by the "keeper" of the medical records who can be identified as such, along with verification of the number of pages being tendered, will usually allow me to confirm that everything that exists from this provider is being tendered by my opponent and thus that a deposition to clarify "nothing else is out there" is not needed. I have usually subpoenaed my own set of treating records and will compare what my opponent plans to tender into evidence with what he or she plans to tender. There are also a number of medical facilities I see frequently on files, recognize and can acknowledge provide a full set of medical records, and thus I am less likely to have any objection to their tendered records into evidence on sufficiency grounds. Conversely there are facilities I would question and may therefore insist upon some further confirmation of sufficiency and/or a deposition.

What other reasons would cause a Respondent to object to the tender of treating records into evidence, thus necessitating the securing of medical testimony?

Petitioner's Perspective: The Petitioner should anticipate objections from Respondent to medical record contents which address causation, permanency, and disability. The fact that a physician addresses the etiology or causation does not mean that note was prepared for litigation. Evaluate the content of the records in light of the complete context of the doctor/patient relationship.

Respondent's Perspective: Any commentary which veers into the "prepared for use in litigation" territory, including causation opinions or generic findings a condition is "related to

work." Also, anything contained the medical records which goes beyond the typical recitation of complaints, exam, diagnosis and treatment plan. This can include commentary that cannot be substantiated, changes in medical history during the course of care including, and in particular, a "new" appearance of a work accident history or "different" history of accident than originally reflected, reference to diagnoses or medical care that cannot be located or substantiated elsewhere, and basically any time the doctor appears to become more of an advocate for his patient rather than a treating medical provider. More rarely, when a history of accident and medical condition are related by the provider but simply make no sense or need to be more fully explained.

Are medical providers required to tender "any and all" medical records, unless privileged or otherwise limited, in response to a Commission issued subpoena?

Petitioner's perspective: It depends. Clearly, certain medical conditions and certain medical treatment are subject to other statutory limitations and are strictly privileged. The Petitioner should maintain the position that records of post-accident care **in general** should be subject to disclosure. However, if the patient's post-accident care involves treatment or conditions which are the subject of a statutory privilege, or involves other clearly irrelevant material, the Petitioner should take the position that they are not subject to disclosure or publication of any kind.

Ask for your client's medical records yourself and review them for confidential, prejudicial, or privileged content. If some of those records should not be disclosed, advise the provider and the Respondent of your position and try to work it out. If you can't, let an Arbitrator ultimately decide if they should be admitted into evidence.

With respect to records that relate to a reasonable inquiry into post-occurrence healthcare, the better practice is to cooperate. I have never had a Respondent's attorney insist on the production of clearly irrelevant or privileged records of unrelated care or treatment. The essential issue is whether the care or treatment was related or unrelated to a compensable injury. As with most issues arising under the Workers' Compensation Act, a reasonable accommodation with Respondent's attorney can usually result in an appropriate resolution but if the parties cannot agree that some records must remain confidential, ask for a ruling by the Arbitrator. There is nothing in the rules that prevents a patient from notifying his provider that he objects to the disclosure of his records or prevents a Petitioner from asking the Arbitrator to quash a Subpoena.

Respondent's perspective: Yes. When putting forth a claim for a medical condition, which a Petitioner seeks to relate to his work duties or an accidental injury, the Petitioner opens up his or her prior medical history to scrutiny. Section 8(a) specifically provides that every medical provider "shall upon written request furnish full and complete reports thereof, and permit their records to be copied . . ." ***without any statutory limitation to strictly post accident medical care.***

This has not prevented certain providers from refusing to release any pre accident medical records without a separate authorization signed by the Petitioner. These providers frequently cite to 45 CFR 164.512, which addresses the uses and disclosures for which an authorization is not required. The section provides that a medical provider may disclose protected health information without the written authorization of the individual:

- to an employer;
- if the medical provider "provides health care to the individual at the request of the employer;"
- about an individual who is a member of the workforce of the employer;
- to "evaluate whether the individual has a work related illness or injury;"
- the protected health information that is disclosed consists of findings concerning the work related illness or injury;

Without having to litigate with a provider over release of records I have been able to get those authorizations signed and the records released, however, a strict reading of Section 8(a) would appear to suggest that upon proper service to the medical provider, the Commission has the authority to demand release of **all** non privileged medical records purely with proper issuance of a subpoena.

Medical records for mental health and AIDS/HIV care are protected and thus require a special authorization signed by the Petitioner, which I have also had no difficulty securing from my opponents when this type of care may likewise be germane to the case at hand. A ruling could also be secured from an arbitrator to compel signatures on any such authorizations, if needed, with the parties providing the arbitrator the bases of their request and any objections thereto.

The Commission has addressed the issues raised by the subpoenas for treating records, the sufficiency of what is tendered by the providers, and whether the parties can ask for more than just post accident medical records in a number of cases, including Estrada v. Complete Temporary Labor, 08 WC 31145, 09 IWCC 862. At trial, the Petitioner sought to introduce into evidence the medical records from the Spine Institute of Waukegan. Respondent's counsel objected to the tender as she perceived a difference between the set she had received and the set her opponent sought to tender. Included only with Respondent's counsel's set of the medical records was a multi page history form, which had been completed by Petitioner in writing in Spanish. Respondent's counsel took issue with the failure to include the form, and also that tender of it in Spanish deprived the arbitrator and Commission of the ability to read it. Respondent's counsel sought a continuance of the arbitration hearing, presumably to seek from the medical provider what their full record for Petitioner consisted of.

The arbitrator allowed the hearing to proceed. Petitioner testified with use of a translator, and the arbitrator then had him translate the form into English, on the record. Both parties then introduced the Spanish version of the form, along with all other medical records tendered in

response to the subpoena, as Petitioner's Exhibit No. 2 and again as Respondent's Exhibit No. 4. The arbitrator closed proofs.

Petitioner prevailed in his claim for benefits and Respondent filed a review, arguing in part that Petitioner willfully or otherwise failed to provide all relevant medical records pursuant to Section 8(a), and that denial of a continuance and requiring Respondent to proceed to trial without being able to verify the sufficiency of the medical record from this provider in some way prejudiced the Respondent. The Commission disagreed, noting first and foremost that there is nothing to obligate the Petitioner to tender all of his medical records. By listing the Spine Institute as one of his providers on the 19b petition he filed, he clearly made Respondent aware of a source of medical care.

The Respondent in turn had the ability then to subpoena those medical records and did so, actually receiving more documentation than had been received by Petitioner, apparently, and the Commission noted the Respondent had the ability to tender what it received into evidence.

Additionally, and somewhat parenthetically to the issues being raised by Respondent in its review, the Commission also noted that Respondent had had the ability to request "any and all" medical records from this provider but had chosen not to do so. There had been references in the records it had received that in fact Petitioner had been under active medical care for the same parts of the body claimed injured in this incident, that not only could (should?) Respondent have asked for all such records but also that Respondent's counsel could have asked about the prior care during cross examination but did not do so. The Commission specifically noted: "Respondent was afforded an opportunity to explore, via subpoena and cross examination, any relevant treatment that Petitioner underwent before the June 20, 2008 accident. Respondent's election to limit that exploration was a trial strategy." And apparently not a good one.

Thus, I take the position I am entitled to everything.

B. Treating Physician Testimony

In an instance where the Petitioner wishes to secure the testimony of a treating medical provider, in lieu of or in addition to tender of treating records from that provider, or the Respondent raises a hearsay objection to the records of a treating provider, that provider's testimony may be secured via deposition set by agreement of the parties, deposition, or live before the arbitrator. Due to provider, to say nothing of attorney, schedules, most testimony of treating medical providers is taken by deposition.

As will be discussed in greater detail below, the Section 12 requirement of tender of the report from a treating physician at least 48 hours before the "time the case is set for hearing" to the Respondent (its carrier or, if represented, its attorney) has been held to apply to the opinions of treating physicians; Ghere v. Industrial Commission, 278 Ill.App.3d 840, 663 N.E.2d 1046 (1996).

Issues and Commentary:

Petitioner's perspective: The most important consideration for Petitioner's attorney is whether or not the medical records contain adequate evidence to meet your burden of proof. Do they address causal connection? Do they address permanency? Do they address the issue of the reasonableness and necessity of medical care? Do they talk about disability or permanency? Do they address the Petitioner's work status?

Depositions are expensive. The unfortunate reality is that the decision about whether or not to obtain a doctor's deposition must be weighed against the potential value of the case. A strain/sprain injury seldom justifies the expenditure of $1,500.00 to depose an orthopedic surgeon.

Remember the rule in Darling v. Industrial Commission, 176 Ill.App.3d 186, 530 N.E.2d 1135 (1988):

> "A causal connection between work duties and a condition may be established by a chain of events including Petitioner's ability to perform the duties before the date of accident, and inability to perform the same duties following that date (citing Pulliam Masonry v. Industrial Commission, (1979) 77 Ill.2d 469). Here, a causal connection is shown from the events which reveal a prior state of good health; a good work record; a definite accident date; a resulting disability; and Petitioner's inability to work, or even to use his left arm or hand at all after that date."

A Petitioner will more likely need a physician's testimony in complicated cases involving serious sequela, aggravation of pre-existing degenerative conditions, ongoing future deterioration, or the need for future medical care. In such cases, take the doctor's deposition.

It is important to note that the Petitioner should approach the issue of whether or not a doctor's deposition should be taken after carefully determining the contents of the records. Again, certified records are admissible into evidence over Respondent's objections (820 ILCS 305/16). The decision to depose a doctor is not up to the Respondent – it is up to you. Do you need a deposition to meet your burden of proof?

Respondent's perspective: As discussed above, I will consider raising a hearsay objection and demanding the testimony of a medical provider for a number of reasons including that there is suspected incompleteness in the record, discrepancies in the histories, changes in the histories, complaints, or treatment that cannot or needs to be explained. A causation opinion I wish to challenge because it is not supported will require testimony and the opportunity to cross examine the provider. I may have other records, histories or information I wish to provide the medical provider which I suspect he or she is not aware of and which may change the proffered opinion.

For example, some years ago I had the free time to read through hundreds of pages of physical therapy records while preparing for the deposition of a treating doctor who had unequivocally

stated that a lengthy period of treatment and disability was clearly related to the work injury originally reported to him. Not only did I have evidence of some pre-accident, similar complaints, but I also found in the physical therapy records a history of an intervening accident. After confronting the treating doctor with evidence of both, on cross examination, he changed his testimony and now stated not only did he believe that the Petitioner had sustained an intervening accident which had ended our liability, but that he now had reason to question anything the Petitioner had ever told him and thus could no longer opine that there had been any work related injury that was the cause of the medical condition. A major exposure case was reduced to a zero, in one deposition.

My basic rule of thumb is: if I can accomplish something by insisting on the provider's deposition, I will insist it be taken. If I cannot likely do so, and really only stand the chance of giving the provider the opportunity to further embellish and strengthen his opinions, I will simply raise no objection to the medical records going in.

C. Preferred Panel Physician Testimony

With the implementation of Section 8.1a of the Act, for injuries sustained on or after June 28, 2011 an employer was given the ability to create a preferred panel of physicians in Illinois. Employers can designate a panel of medical providers for their employees to choose from to treat with. That election to treat with a panel provider becomes a "first choice" of two allowed under Section 8a of the Act. An election to not treat with a panel provider became a "waiver" of one of two choices of physician under the Act. The Act was silent as to the admissibility of the records, reports or bills of any panel physician, beyond the general admissibility provisions already present in Section 16.

As of December, 2015 there are currently nine approved preferred provider program administrators listed on the Illinois Department of Insurance website, with a further 26 provisionally approved/pending approval. Of those who have been approved or who have sought approval, none appear to be individual employers, rather, the type agencies which have provided other types of "medical management care" like nurse case managers or bundled prescription purchasing, along with a handful of insurance carriers.

Issues and Commentary:

Clearly any Respondent whose injured worker was treating with "their choice" of medical provider should have no cause to take issue with any resulting care or opinions from that provider. But what if a Respondent came to disagree with some aspect of that medical care and wished to secure a provider's testimony? More likely, a Petitioner might perceive his "mandated" choice of panel provider to be biased in some way against him or her and might, then, wish to challenge a treatment recommendation or opinion expressed, albeit from his or her "treating" physician.

Petitioner's perspective: Section 8(4)(b) of the Act provides as follows:

> Subsequent to the report of an injury by an employee, the employee may choose in writing at any time to decline the preferred provider program, in which case that would constitute one of the two choices of medical providers to which the employee is entitled under Section (a)(2) or (a)(3).

It is essential to read Section 8(a) carefully. Pay particular attention to Section 8(a)(2), (3), and (4).

Generally, depositions in the workers' compensation arena are arranged by agreement of parties. If the parties cannot agree on a deposition, an Arbitrator or the Commission may be asked to order the deposition pursuant to a Dedimus Potestatem.

The issue of allowing depositions is best resolved by negotiation and cooperation through the parties. Simply put, there is seldom a good reason to require the other side to ask the Arbitrator for a Dedimus. Similarly, there is no reason for the Respondent to rely on a procedural trap to limit testimony.

Panel physicians and "second choice" physicians are subject to the same rules respecting depositions. The real question is "do we need the testimony rather than the records?"

Respondent's perspective: One would assume if the employer has chosen the panel carefully, we would have no issue with the treatment, opinions, and sufficiency of records of our providers. That having been said, I have no Respondent's to date who have referred files where the Petitioner actually treated with, let alone we might have issue with, a panel provider. Perhaps time will tell and will further elucidate the Commission and courts' ultimate conclusion as to the impact of our "choice" here. However, the language of the section would not make any such provider our "agent," and thus, we should be able to raise objection and demand testimony from these providers as well. However, one can envision some potential cross examination from my opponent along the lines of, "so, you're part of the panel the Respondent selected to treat their injured workers? And they thought you were good enough for that? But now, you're not so good enough that they want to abide by your treatment plan or opinions?"

D. Petitioner's Examining Physician Testimony

While not specifically governed by Section 12, which expressly deals with an Employer requested medical examination, there is nothing in the Act prohibiting a Petitioner from obtaining an examining physician's report and thus, nothing preventing a Petitioner's attorney from deciding to take that doctor's testimony or preventing a Respondent's attorney from having a hearsay objection to that report and demanding that testimony be taken. Ghere tender requirements also apply.

Issues and Commentary:

Petitioner's perspective: The Petitioner has the option of obtaining a report or an opinion from an examining physician. There is nothing in the Act that prevents a Petitioner from obtaining such a report. The real problem rests with the credibility and probative value of such a report.

It is counteproductive for the Petitioner to use an examining physician's report to contradict the opinions of a treating physician. One must expect an Arbitrator and the Commission to see through that practice.

An examining physician may be extremely helpful, however, in complicated cases or cases which require physicians to coordinate and explain complex and broad-based treatment. It is often helpful in complicated cases involving complicated injuries to seek the opinions and insight of an expert to map out and explain past and future care requirements. Oftentimes such a physician may actually be insightful in coordinating and planning the care of treating physicians much like a hospitalist or a PCP. Not only can they provide good evidence; they can help secure good care.

Respondent's perspective: I would consider demanding the testimony of an examining physician more closely than that of a treating physician for a number of reasons, most obvious that I would perceive my opponent clearly felt something lacking in the treating records and opinions he or she felt needed to be "created" by the examining doctor in order to prevail on the case. I would also look closely at who the opinions were requested from. Is the doctor one of the "frequent flyers" always used by my opponents and always linking up work related conditions or finding more care needed? I would also look closely at exactly what was provided the doctor in rendering those opinions. Did my opponent provide the doctor everything, or just a "rosy picture" without the "bad and the ugly" that I may need to bring to the doctor's attention? Again, my evaluation has to include whether taking the testimony will simply give the doctor the platform to further expound on theories and bases of liability, further sinking my defenses. If the report is sketchy, or I can counter it in other ways, I may just let it in.

E. Respondent's Examining Physician Testimony - Section 12

An employer may require an examination of a Petitioner pursuant to Section 12 of the Act. The examination shall be conducted by a "duly qualified medical practitioner" or surgeon. The examination shall be at a time and place "reasonably convenient" to the Petitioner. The examination shall be secured for purposes of determining the "nature, extent and probable duration of the injury," and/or for determining the amount of compensation as may be due that Petitioner.

Any resulting report addressing the Petitioner's condition, its relationship to a claimed accident or work duties, needed treatment, ability to work or any other issue leading to a compensation determination is subject to a hearsay objection and thus to the securing of that provider's testimony. <u>Ghere</u> tender requirements apply.

Issues and Commentary:

Petitioner's perspective: Read the Respondent's IME report carefully and then make a judgment about whether or not you actually can accomplish anything by cross-examining the Section 12 doctor. The report may provide you with a sound basis to challenge the doctor's opinions but in the long run you must judge whether you will be doing more harm than good by insisting on the IME doctor's deposition. At the end of the deposition, the IME doctor still will maintain the opinions which favor the Respondent – if the IME doctor didn't dispute your client's compensable injury, you wouldn't be at trial, right? So, ask yourself if making the Respondent depose the IME doctor isn't just going to give them more of an opportunity to expand on those opinions. The real question is: Does the IME report bring up any basis for further inquiry of the treating physician? Now that you have seen the IME report, do you think you need to take the treating doctor's deposition?

Respondent's perspective: If my opponent does not raise a hearsay objection, which would obviously necessitate my taking of the doctor's testimony, I will likely do so anyway if I feel really strongly about my doctor's credentials over the treating physician's, the extent to which my doctor may have reviewed prior medical or treating medical, the degree to which he or she has or can expound upon the opinions and bases. As with all such evaluations, it is really a consideration of how strong my report is versus how strong I think my doctor's added testimony on what is in the report will be.

Further, and on rare occasions because it is usually difficult if not impossible to bring a doctor in live to testify, I will do so. I have had arbitrators tell me they got so much out of hearing the doctor explain the findings and conclusions, over reading a "cold" report or deposition transcript, and there is nothing to prevent an arbitrator from asking his or her own questions, and clearly up any inconsistencies, right then and there.

F. Records' Reviews

In instances where a single or limited series of issues may need to be addressed, or treatment may have already been obtained and thus an examination might not be needed or possible to address a medical concern, a party may elect to secure a medical records' review. While not specifically addressed by the Act, any resulting opinion is subject to the same hearsay objection and thus to the securing of testimony from the medical provider.

Further, the appellate court has held that Ghere tender requirements apply to the opinion report resulting from a records review; Mulligan v. Illinois Workers' Compensation Commission, 408 Ill.App.3d 206, 946 N.E.2d 421 (2011).

Issues and Commentary:

Petitioner's perspective: Records reviews are of limited probative value or evidentiary weight. As a Petitioner, you must be cautious, however, of record reviews that attempt to introduce into evidence otherwise inadmissible material. A physician, for example, can rely on learned texts or treatises to support their opinions but they can't recite the contents of texts or opinions into evidence on direct examination. Make sure that a records reviewer doesn't try to sneak inadmissible evidence in by citing or quoting what otherwise would be hearsay.

Respondent's perspective: I have really used a records' review over a Section 12 examination in only very limited circumstances, say, where there is a limited issue or medical question I need to have addressed. For example, I have a claimant who has bounced through three orthopedic physicians and three pain management doctors, none of whom can find anything wrong with him and all of whom then refer him back to the opposite practice for further care. I finally had an orthopedic physician with extensive background in pain management review the entire medical file for a hoped for honest answer as to what was wrong, whether or not it might be work related, and if so, what if any further medical care was needed. The resulting report isolated the condition, recommended some further diagnostic testing to confirm and, when that came back negative, was finally able to conclude there simply is no medical condition which can explain the symptom cluster presented. Should the case continue to be litigated, I will have no hesitation securing that doctor's testimony, perhaps even live, to explain to the arbitrator the bases of his conclusions.

G. Commission Ordered Exam Under Section 19(c)

In instances where a 19(e) or 19(h) hearing is pending, the Commission may on its own order an "impartial physical or mental examination of a Petitioner whose mental or physical condition is in issue," for purposes of adding the Commission in a "just determination of the case." Section 19(e) is the general provision of the Act governing hearings before the Commission on review, and expressly prohibits *either party* from introducing additional evidence on review where the arbitration hearing commenced after December 1, 1989, basically exempting out ALL reviews currently and for some time pending before the Commission.

Section 19(h) allows for either party to pursue an increase or decrease in the amount of disability being paid to a Petitioner, subject to certain filing limitations from final award.

Issues and Commentary:

Petitioner's perspective: The occurrence of the Commission ordering an exam under Section 19(c) is so rare that inquiries amongst practitioners in Central Illinois has failed to reveal a single occurrence. As a practical matter, if the treating physicians that your clients are seeing are inherently not credible or cannot provide a reasonable treatment plan, talk to your client about exercising his choice of physician option to pick a better treating physician. Also, more experienced defense counsel and insurance representatives are interested in moving the case forward medically as well as legally. Talk to them and work with them toward the end of having them send the Petitioner to a doctor that everybody trusts. If your case has come to the point

where the Commission has to order an examination, something has gone badly wrong with the handling of the case by both parties.

Respondent's perspective: In my 29 years of practice at the Commission I can think of only one instance when this was "threatened" by a Commissioner, when he felt the medical being provided by either party was not particularly helpful as to the Petitioner's current condition, the end result of which was the parties backed down from their respective positions and settled out the case, and NEVER an instance when this was ever used. It is also my "general" understanding that the Commission has for some time lacked the funding to pay for its own exams. That having been said, any such opinion would likewise be subject to a hearsay objection and thus testimony.

2. <u>Frequency, Duration and Type of Care</u>

A. Utilization Reviews Under Section 8.7

With implementation of the amendments in 2005 the Act for the first time allowed for the concept of utilization review in Illinois. The expressed legislative purpose was to control medical costs. The section, as it originally existed, sought to impose nationally recognized standards in the evaluation of the necessity, type and duration of medical care. The section set forth the necessary qualifications for one providing a utilization review, the manner in which any resulting review was to be conveyed to the medical provider proposing or providing the medical care, and the appeals process for that provider in addressing the utilization review. However, the section specifically provided that the utilization review was to be considered with "all other evidence" including treating records and opinions, Section 12 examinations and opinions.

No significant medical savings were achieved and in fact medical costs continued to increase in Illinois at a rate greater than the national median (State of Illinois, Illinois Workers' Compensation Commission, *Annual Report 2010,* Springfield, 2011.)

Effective in 2011, the section was further amended to provide some "teeth" to the utilization review section. The treatment or bills of a medical provider who failed to provide clinical information to support the request might have the treatment or services found not "compensable nor collectible by the provider or claimant from the employer . . ."

When treatment or payment was denied by a utilization review the burden shifted from the Respondent to the Petitioner to "show by a preponderance of the evidence that a variance from the standards of care used . . . (by the utilization review) is reasonably required to cure or relieve the effects of his or her injury."

Further the amended section set forth that the medical professional responsible for signing off on the utilization review "must be available in this State for interview or deposition; or must be available for deposition by telephone, video conference or other remote electronic means," and if

outside of the State of Illinois, in person or similarly via telephone, video conferencing or other electronic means.

Issues and Commentary:

Petitioner's Perspective: Recall that the real substantive change in the purpose and effect of utilization review under the 2011 amendments is found in Subsection 4 of Section (i) (820 ILCS 305/8.7(i)(4). That Section states that when services are denied pursuant to utilization review, the burden shifts to the employee to show evidence that a variance from the standard of care used by the entity performing the review is required.

Your best ally in responding to utilization review is the treating physician. Subsection 1 of Section (i) states that

> If the provider fails to make such reasonable efforts (to provide timely and complete reports to the utilization review service), the charges for the treatment or service may not be compensable nor collectible by the provider or claimant from the employer, the employer's agent, or the employee.

This means that it is in the doctor's interest, both for the good of his patient and for the good of his billing service, to cooperate with the utilization review and provide additional information that they need. Also, make sure the treating physician follows the appeal procedures.

In practical experience, if the treating physician exchanges information with the utilization review service, one of two thins usually happens. The first option is that the treating physician amends his care protocol to comply with the utilization review. That happens about half the time and ultimately seems to move the patient forward in a treatment protocol.

The second option is that the utilization review service actually revises its report and authorizes care and treatment.

Either way, in the long run that works best. When you get the results of the utilization review report, send that report to the treating physician and ask them to contact the utilization review service to either obtain their approval, review their recommendations, or discuss a revision to the Petitioner's care plan.

Regarding depositions, the Act specifically requires the utilization review professional to be available for deposition by telephone. If you are going to depose a utilization review provider, read Subsection (a) of the 2011 amendments carefully. That Section of the Act outlines specific requirements for a utilization review and provides the basis to cross examine the utilization review provider regarding the standards relied upon in reaching their conclusions.

Most importantly, if a deposition of a utilization review provider is required, make sure that it is conducted after you have requested the treating physician to respond to utilization review with an appropriate inquiry and appeal. If possible, talk to the treating physician; if the doctor wasn't able to reach an agreement with the utilization review provider, find out why and focus your cross-examination on that issue.

Respondent's Perspective: On the cases I have had involving utilization reviews, a majority of my opponents allowed the report to go into evidence without testimony. I suspect they believed their doctors' testimony outweighed any utilization review. Despite the theory that relying upon some sort of "nationally recognized" standard should outweigh a treating doctor stating, in effect, "I provided the care because I thought it was needed," in most instances it was the treating provider's opinions the arbitrator went with. There seems to be a trend in favor of what a doctor decides in treating his or her individual patient, over a period of time, over what a national standard of care dictates. My other frustration is that most of the doctors my clients have used are out of state, frequently in California. They take forever to set up a deposition and then it's on west coast time. They are not available to discuss beforehand. They limit the time for taking the deposition, usually to no more than two hours, which would seem enough time but may not be. And they are frequently very expensive, in many cases more than half of the amount of the disputed medical charge.

B. New or Novel Scientific Methodology

Unlike the utilization review statutes in many other states, Illinois made a specific point of not adopting one national standard. Rather, Section 8.7 provides the evaluation shall be based on "standards of care of nationally recognized peer review guidelines as well as nationally recognized treatment guidelines and evidence based medicine . . ."

Where the medical expert is basing the opinion on a new or novel scientific methodology or principle, the proponent of that opinion has the burden of showing the method or principle is "sufficiently established to have gained general acceptance" in the field, per Rule 702 of the *Illinois Rules of Evidence.* Thus, the expert must provide added testimony establishing some "general acceptance" in the field from which he or she comes.

By requiring simply evidence of "general acceptance" Illinois has adopted the Frye standard over the Daubert standard.

The Frye standard, as set forth by the District of Columbia Court of Appeals in 1923, is basically a "general acceptance" test. The case stands for the proposition that the opinion of an expert or skilled witness is admissible into evidence where the "matter of inquiry is such that inexperienced persons are unlikely to prove capable of forming a correct judgment . . . (and/or) when the question involved does not lie within the range of common experience . . . but requires special knowledge . . ." If the expert is able to testify to a general accepted principle upon which his or her opinion is based, that opinion becomes admissible.

The Daubert standard as adopted by the Court of Appeals for the Ninth Circuit in 1994 and applicable in all federal cases goes further, requiring the trier of fact to "ensure that any and all scientific testimony or evidence admitted is not only relevant, but reliable." Thus, the judge must determine whether the methodology giving rise to the expert opinion is tested, including whether there are standards controlling the testing, whether the theory or technique has been submitted

for peer review or publication, whether there is a known or reliable rate of error, and whether the theory or practice has been generally accepted by the proper scientific community. Only with satisfactory answers to each of these will the evidence be deemed admissible.

The Illinois Supreme Court expressly declined to apply the Daubert standard, and reiterated the Frye standard, in Donaldson v. Central Illinois Pub. Serv. Co., 199 Ill.2d 63, 767 N.E.2d 314 (2002), and more recently in People v. New, 2014 IL 116306, 21 N.E.3d 406 (2014).

The Appellate Court, Fifth District reiterated that a Frye "general acceptance" test is not even needed if the testimony does not involve a new or novel technique; Watson v. Plocher Contruction Co., (a 2012 Rule 23 unpublished decision).

Finally, the Appellate Court, Third District, has expressly applied Frye in Illinois Workers' Compensation cases in Bernardoni v. Industrial Commission, 362 Ill.App.3d 582, 840 N.E.2d 300 (2005). Bernardoni pursued a claim for respiratory illness and chemical sensitivity after alleged exposure to a cleaning agent at work. Several doctors offered opinions, some relating her condition to chemical exposure at work, some to a pre existing condition temporarily aggravated by chemical exposure at work, and some to a multi year history of smoking. One doctor went so far as to suggest she had developed "multiple chemical sensitivity" (MCS) initiated with the exposure at work and then manifesting at any time Bernardoni was exposed to any chemicals, at or outside of the work place. This doctor conceded that MCS was a "controversial" diagnosis not accepted by pulmonologists or taught in medical school, but found in some peer journals. The employer obtained another expert opinion to challenge this opinion, citing no well controlled studies proving the existence or cause of the condition.

The arbitrator adopted the MCS diagnosis and opinion the condition was work related, finding Bernardoni permanently and totally disabled. The Commission reversed and rejected that doctor's testimony, finding that as MCS was not sufficiently established to have gained general acceptance the doctor's testimony should not have been admitted.

The Appellate Court affirmed the Commission decision, finding no evidence to meet the Frye standard to allow for admission of the doctor's testimony. In so holding the Appellate Court noted the Frye standard requires evidence an opinion be "sufficiently established to have gained general acceptance in the particular field in which it belongs." General acceptance does not mean universal acceptance or something that is accepted unanimously or even by a majority of experts. Rather, "it is sufficient that the underlying method used to generate an expert's opinion is reasonably relied upon by experts in the relevant field."

Where proposed testimony concerns a syndrome "that has not been admitted in Illinois, then the trial court should conduct a Frye hearing to determine the scientific validity or invalidity of the syndrome." In an Illinois workers' compensation case, rather than requiring a separate Frye hearing with live witnesses, the arbitrator and Commission can consider the expert deposition testimony. The proponent of the expert's testimony has the burden of demonstrating that the proffered opinion is worthy of admission into evidence. Where, as in the instant case, the claimant made no such offer, the doctor herself testified MCS is controversial and has not been

accepted by the mainstream medical community, and she only testified about others who had accepted as opposed to disagreed with the condition, while the employer offered evidence that the larger medical community does not accept MCS, the Commission had satisfied its Frye obligation in adopting the employer's expert and disregarding Bernardoni's.

Thus, most expert testimony will be admissible into evidence, weighed against all other expert testimony offered, an opinion adopted by the Commission and final unless clearly not support by the manifest weight of all evidence introduced. Where a new or novel theory is espoused, the Commission must satisfy the Frye standard by showing the evidence is generally accepted in the field, even if not relied upon or accepted by all.

Issues and Commentary:

Petitioner's Perspective: Illinois, in general, and the Workers' Compensation Commission, in particular, remains a Frye state. As noted above, even a Frye test isn't necessary if the testimony does not involve new or novel techniques. In common practice before the Commission, experts almost always are addressing medical issues like causation, reasonableness and necessity, and disability. Frye issues can generally be avoided if in conducting the examination of physicians and other experts the practitioner focuses on reasonable foundational elements for expert opinion testimony.

Respondent's Perspective: Having your expert testify about recent studies or innovative treatments, as the basis for the position you have taken, can shine a light on the otherwise dulling process of medical depositions. Arbitrators are eager to learn new things and being able to produce something new for them can be a persuasive tool toward having him or her adopt your position.

3. AMA Impairment Ratings Under Section 8.1b

With implementation of Section 8.1b the Act now includes consideration of an AMA impairment rating as one of five factors to be considered in the determination of permanent partial disability, for injuries sustained on or after September 1, 2011. An impairment rating shall be done by a licensed physician. Any rating is subject to a hearsay objection and thus to a deposition.

No case has specifically applied the Ghere tender rule to AMA impairment ratings. However, following the appellate court logic in Mulligan and its extension to reports generated in records reviews, not specifically contemplated by Section 12, an argument may be made that Ghere will likewise apply to an AMA impairment rating.

Issues and Commentary:

Petitioner's Perspective: The first thing the Petitioner has to remember is that the 2011 amendments to the Act allowing use of AMA guideline impairment ratings do not **require** a claimant to submit an impairment rating but instead they require the Commission to consider any

submitted report complying with the statutory requirements regardless of which party submitted it (Continental Tire of America v. Illinois Workers' Compensation Commission, 215 Ill.App.5th 140445WC (5th Dist. 2015)).

Recall that the Commission and its Arbitrators have widely recognized that impairment is not the same as disability and an impairment rating is only one factor to be considered by the Commission. In light of these facts, there are probably few occasions when a Petitioner would obtain his own impairment rating and then obtain the deposition of the rating physician.

If the Respondent obtains an impairment rating, review the AMA report carefully. If a deposition would provide fruitful, then indicate your intent to object to the report and request Respondent's attorney to set the deposition.

If you are going to depose an AMA impairment physician, make sure to get a copy of a Guide to Evaluation of Permanent Impairment (6th Edition) and review the enclosed charts carefully. Frankly, the deposition may give you an opportunity to ask the impairment physician to confirm his use and reliance on the text and explain its application and limitations.

A deposition of an AMA Impairment Physician may be necessary in complex cases or cases involving catastrophic injuries. In general, however, the impairment rating is just one of a pre-determined set of factors to be considered. The practitioner may do better focusing on presenting testimony relating to the other factors than in cross examining an impairment physician, particularly if the report appears to comply with the 6th Edition of the Impairment Rating Guidelines.

Respondent's Perspective: The purpose of an AMA impairment rating, and indeed, the goal in adopting AMA impairment ratings as a factor to be considered in assessing permanency, was that there was to be a consistent standard in setting impairment. However, as has been established, impairment is not the same as disability, and an impairment rating is only one factor of five to be considered in setting permanent partial disability. My decision in insisting upon securing the testimony of a Petitioner's impairment rating provider, or in taking the testimony of mine, would be limited to instances in which I thought Petitioner's had somehow been done incorrectly and/or mine had been done correctly. I cannot envision many instances in which the time and expense of securing such testimony would be "worth" it.

4. Billing

A. Fee Schedule Under Section 8.2

Section 8.2 sets forth the medical fee schedule for medical bills incurred for treatment in the State of Illinois. The presumption is that anyone running the CPT codes through the fee schedule should be able to come to the same figure.

Issues and Commentary:

Petitioner's Perspective: Rely on the Respondent. If the case is compensable, it is in the Respondent's interest to work with you to make sure that bills and billing documentation is appropriately received and that bills are paid in accordance with the Fee Schedule.

If compensability is contested, the general practice of Commission Arbitrators has been to consider the bills along with testimony regarding their compensability and to award the bills as introduced with the caveat that they are to be paid by the Respondent in accordance with the Fee Schedule.

Respondent's Perspective: I have for the most part relied upon the outside vender used by my client to correctly run the fee schedule and further, determine the sorts of charges that are duplicative or otherwise should be eliminated. On rare occasions I have had an opponent take issue with fee schedule reductions, and have had to bring in representative of the vender to testify as to how he or she reached her conclusions. I did insist upon someone who was completely familiar with the process including what should and should not be charged, and not just someone who knew how to run the computer program. Fortunately, at least in my cases, the national venders who provide this service were willing to bring someone in, in my two cases from out of state, at no added cost to my clients given the vender, and not my client, had chosen someone outside of Illinois.

B. Out of State Providers/Bases for Their Billing

Section 8.2 also governs the amount to be charged for out of state services, pursuant to that state's fee schedule or the amount as would have been due had the services been rendered in the county in which the Petitioner resides.

Issues and Commentary:

Petitioner's Perspective: I have had lots of cases involving out-of-state treaters, particularly treaters in the Metropolitan St. Louis area. However, I have never had an occurrence where the Respondent objected to payment of the out-of-state physician's charges in compensable cases and have never had a case in which the out-of-state physician was unable to reach an agreement with the insurance company regarding the applicable charge for services either under the Missouri Fee Schedule or the Illinois Fee Schedule.

Respondent's Perspective: While I have not yet had to take the testimony of an out of state provider on the issue of medical bill charges, it would be no different than taking the testimony of an out of state treating physician in terms of the added time and expense borne by my client. I would familiarize myself with that state's fee schedule beforehand. Typically, I am assuming this situation would only occur as part of a deposition of a treating physician addressing other issues, as well, or where the charges were egregious.

5. Medicare Set Asides/Future Medical Allocations

In instances where Medicare's interests need to be protected with a future medical allocation or Medicare Set Aside, a future medical projection is prepared, typically by Respondent. This may include a lump sum or annuity payment proposal. Where the Medicare Set Aside is subject to CMS review and approval, and thus the funding will be based on what CMS approves, there would seem no need for either party to quibble over amounts set as CMS will be the final arbiter of what is included. However, if not reviewable by CMS, one could envision an instance in which one side disagreed with and wished testimony to establish the basis of a future medical projection.

<u>*Issues and Commentary:*</u>

Petitioner's Perspective: The Petitioner's interest in obtaining appropriate terms for a Medicare set-aside agreement are identical to those of the Respondent. A report prepared by an appropriate vendor and subsequently approved by CMS addresses both party's interests. There is nothing to be gained in challenging the Respondent's set-aside vendor or the Respondent's effort to obtain CMS approval. Once a set-aside report is approved, both party's interests are satisfied and future risks are covered.

Respondent's Perspective: I can honestly say I have never had a party take issue with a future medical projection or the basis upon which my vender has set forth future medical costs. Theoretically that provider could offer testimony as to the basis of their conclusions, subject to cross examination. However, as future medical allocations are usually part of settlement negotiations and not in preparation for trial, this issue is simply one of negotiation between the parties toward settlement, and no testimony would ever be secured.

6. <u>Other Healthcare Providers</u>

   A. Physical Therapists/Functional Capacity Evaluations

   B. Spiritual and Other Treatment Modalities-Section 8(a)(4), 19(d)

7. <u>Objections/Other Issues</u>

   A. Dedimus Motions Under Section 16

Section 16 provides that the Commission *may*, upon application of either party, issue a dediumus potestatem to someone authorized to administer oaths (commissioner, notary public, justice of the peace, court reporter) to take the deposition of a witness "as may be necessary in the judgment of the applicant." The statute and Commission Rules are very specific as to what must be set forth in the dedimus petition. The opposing party may file objections.

The courts have held that the power to issue a dedimus is discretionary with the arbitrator or Commission; <u>Rosenbaum v. Industrial Commission</u>, 93 Ill.2d 381, 444 N.E.2d 122 (1983).

Here, the pro se Petitioner was noted to have had the opportunity to bring in treating physicians to testify at the arbitration hearing, but chose not to do so due to concerns of time and expense.

Issues and Commentary:

Petitioner's Perspective: If you are in front of the Arbitrator on a Petition for a Dedimus, someone has done something wrong. Work with the opposing party to schedule depositions. Accommodate one another's schedules and try to reach an agreement.

If it is necessary for you to petition the Arbitrator to issue a Dedimus, make sure that you can clearly and specifically explain how you have tried to cooperate and have given the opposing party options to set a date for the deposition but the opposing party has simply refused to cooperate with you. If you can't make that showing, you are not doing it right.

Respondent's Perspective: **fill in**

B. Ghere and its application

Section 12 of the Act specifically requires that in cases where a "surgeon engaged by the employer" has examined the Petitioner, he shall tender the resulting report to the Petitioner or his attorney no less than "48 hours before the time the case is set for hearing." In Ghere, the Petitioner argued that 48 hour rule did not apply to the report of a treating physician. The appellate court disagreed, finding "the purpose of Section 12 would be frustrated if we read Section 12 to only apply to examining physicians . . . (when) the purpose (of the section) is to prevent . . . springing surprise medical testimony . . ."

Issues arise where a treating doctor's deposition is taken, and he or she then testifies to opinions not expressly laid out in the medical records. In dispute is whether that testimony offers sufficient "surprise" to require that said opinions have been tendered at least 48 hours before the taking of the testimony. The courts in Illinois have gone with a "should have known" approach. In Ghere, where prior disclosure was deemed required, a doctor had been asked to opine as to work related cause for a heart attack when he had never treated the Petitioner for heart related problems. The appellate court noted "the physician's causation opinion would have gone beyond the contents of his medical records," thus, "there was nothing in the records to put the employer on notice that the physician had an opinion regarding causation."

A contrary result was had where the treating doctor had treated the Petitioner for the allegedly work related problem, thus, the appellate court deemed the Respondent should have been on notice that the doctor would be asked questions about the medical condition and its possible work related cause; Homebright v. Industrial Commission, 351 Ill.App.3d 333, 814 N.E.2d 126 (2004).

The non application of a Ghere tender has also been extended in instances where the doctor testifies to something that "logically flows" from the opinions expressed; Certified

Testing v. Industrial Commission, 367 Ill.App.3d 938, ____________ (2006). The treating physician had opined in his written report regarding the medical condition and severity of it, with certain resulting activity restrictions, but without providing an opinion on permanent restrictions. His testimony to such met with a Ghere objection. The appellate court upheld the admission of that testimony, holding that it was "a natural continuation of the opinion in his narrative report"

The appellate court has expressly extended the 48 hour rule to records reviews, in Mulligan.

In Mulligan the appellate court has also defined "the time the case is set for hearing." Previously this had been construed variously as the date of first evidence deposition, the date of first trial setting, or the date of first actual taking of "live" testimony before the arbitrator. In Mulligan the appellate court concluded the Section 12 means the "proponent of medical testimony provide the other party with the required medical reports 48 hours before evidence is presented on the first day of arbitration hearing."

Petitioner's Perspective: The best way to address potential Ghere objections is by making sure that the Respondent has all of the medical information that you have. If the Respondent has the treating physician's records and reports of care and treatment, then disclosure should not be an issue.

The definitive word on this issue appears to be Kishwaukee Community Hospital v. Industrial Commission, 356 Ill.App.3d 915 (March 14, 2015). According to Kishwaukee, if the treating physician's records contain information and details about that doctor's treatment of the claimant's condition, then the doctor is competent to testify as to causation. Citing the Homebrite case noted above, "the records put the employer on notice that the (treating) doctor might testify as to causal relationship." (Kishwaukee, 356 Ill.App.3d at 923).

Respondent's Perspective: **fill in**

C. Timing of Taking of Depositions – local rules

D. Witness' Fees Under Section 16

Section 16 provides that the Commission shall set the "fee of compensation for any person, including . . . physicians, surgeons and hospitals . . . for any service performed in the performed in connection with this Act, or for which payment is . . . rendered in securing any right under this Act."

E. Attorney Conduct During Depositions

Illinois Supreme Court Rule 206(c)(3) provides that objections during depositions shall be "concise, stating the exact legal nature of the objection."

Rule 206(e) allows for a party to ask the court to end or limit the scope of a deposition "being conducted in bad faith or in any manner that unreasonably annoys, embarrasses, or oppresses the deponent or party."