WCLA MCLE 6-7-18

- Electronic Case Notices
- June 7, 2018
- 12:00 noon to 1 pm
- James R. Thompson Center Auditorium, Chicago, IL
- 1 hour general MCLE credit

Legislative Update
www.ilga.gov

- **SB 904 (Medical Bills): Passed both Houses 5-31-18**
  - Explanation of benefits
  - Cause of action for provider in Circuit Court for 1% per month interest
  - Electronic billing by 1-1-19
- **SB 1737 (Insurance): Passed both Houses 5-31-18**
  - Pre-filing of rates (file & use vs. use & file)
  - Premium increase notice
    - >5% above recommended rate
    - Amount & reason

Electronic Notices
A Couple of Cases Already

- Oquendo v. Resurrection, 17 IWCC 0556: IWCC dismisses Petition for Review not timely filed; "Pursuant to Commission procedure, decisions are e-mailed with a delivery receipt and read receipt requested. The delivery receipt is generated automatically when the e-mail is successfully transmitted to the recipient's e-mail address. The read receipt is generated when thee-mail is opened but we note that it is possible for this receipt to be manually prevented by the receiving party. Commission records indicate that Respondent's attorney sent a read receipt on February 3rd, but Petitioner's attorney did not send a read receipt until March 24th."
- Dotson v. White County Coal, 17 IWCC 0829: IWCC does not dismiss POR; "While the Respondent's concerns are well founded, the Commission notes a lack of proof that the claimant's counsel in fact received the originally sent April 14, 2016 e-mail. Moreover, the Claimant's attorney asserts receipt on May 24, 2016, supported by his signature on the filing. There does not appear to be any bad faith, malfeasance or abuse of the process being demonstrated. The Commission accepts the May 24, 2016 date fior purposes of the receipt of the Decision; as such, jurisdiction before the Commission is extant."

Electronic Case Notices

- See attached memo from Chairman Joann Fratianni
- Pursuant to IWCC Rules
- Parties will receive case activity notices electronically starting 7-2-18
- Required to maintain designated electronic email for receipt
- E-mail Registration Form
  - On line
  - In Person
- Exception: Respondents at time App filed

Rep. Jay Hoffman

Filed: 5/28/2018

10000SB0904ham003 LRB100 06276 HEP 40951 a

AMENDMENT TO SENATE BILL 904

AMENDMENT NO. _____. Amend Senate Bill 904, AS AMENDED, with reference to page and line numbers of House Amendment No. 2, on page 9, line 21, by changing "2% ~~1%~~" to "1%".

after September 1, 2011, the maximum allowable payment shall be 70% of the fee schedule amounts, which shall be adjusted yearly by the Consumer Price Index-U, as described in subsection (a) of this Section.

(a-3) Prescriptions filled and dispensed outside of a licensed pharmacy shall be subject to a fee schedule that shall not exceed the Average Wholesale Price (AWP) plus a dispensing fee of $4.18. AWP or its equivalent as registered by the National Drug Code shall be set forth for that drug on that date as published in Medispan.

(b) Notwithstanding the provisions of subsection (a), if the Commission finds that there is a significant limitation on access to quality health care in either a specific field of health care services or a specific geographic limitation on access to health care, it may change the Consumer Price Index-U

increase or decrease for that specific field or specific geographic limitation on access to health care to address that limitation.

(c) The Commission shall establish by rule a process to review those medical cases or outliers that involve extra-ordinary treatment to determine whether to make an additional adjustment to the maximum payment within a fee schedule for a procedure, treatment, or service.

(d) When a patient notifies a provider that the treatment, procedure, or service being sought is for a work-related illness or injury and furnishes the provider the name and address of the responsible employer, the provider shall bill the employer or its designee directly. The employer or its designee shall make payment for treatment in accordance with the provisions of this Section directly to the provider, except that, if a provider has designated a third-party billing entity to bill on its behalf, payment shall be made directly to the billing entity. Providers ~~and providers~~ shall submit bills and records in accordance with the provisions of this Section.

(1) All payments to providers for treatment provided

pursuant to this Act shall be made within 30 days of receipt of the bills as long as the bill ~~claim~~ contains substantially all the required data elements necessary to adjudicate the bill ~~bills~~.

(2) If the bill ~~claim~~ does not contain substantially all the required data elements necessary to adjudicate the

bill, or the claim is denied for any other reason, in whole or in part, the employer or insurer shall provide written notification to the provider in the form of an explanation of benefits ~~,~~ explaining the basis for the denial and describing any additional necessary data elements~~, to the provider~~ within 30 days of receipt of the bill. The Commission, with assistance from the Medical Fee Advisory Board, shall adopt rules detailing the requirements for the explanation of benefits required under this subsection.

(3) In the case (i) of nonpayment to a provider within 30 days of receipt of the bill which contained substantially all of the required data elements necessary to adjudicate the bill, (ii) of ~~or~~ nonpayment to a provider of a portion of such a bill, or (iii) where the provider has not been issued an explanation of benefits for a bill ~~up to the lesser of the actual charge or the payment level set by the Commission in the fee schedule established in this Section~~, the bill, or portion of the bill up to the lesser of the actual charge or the payment level set by the Commission in the fee scheduled established in this Section, shall incur interest at a rate of 2% ~~1%~~ per month payable by the employer to the provider. Any required interest payments shall be made by the employer or its insurer to the provider not later than ~~within~~ 30 days after payment of the bill.

(4) If the employer or its insurer fails to pay

interest required pursuant to this subsection (d), the provider may bring an action in circuit court to enforce the provisions of this subsection (d) against the employer or its insurer responsible for insuring the employer's liability pursuant to item (3) of subsection (a) of Section 4. Interest under this subsection (d) is only payable to the provider. An employee is not responsible for the payment of interest under this Section. The right to interest under this subsection (d) shall not delay, diminish, restrict, or alter in any way the benefits to which the employee or his or her dependents are entitled under this Act.

The changes made to this subsection (d) by this amendatory Act of the 100th General Assembly apply to procedures, treatments, and services rendered on and after the effective date of this amendatory Act of the 100th General Assembly.

(e) Except as provided in subsections (e-5), (e-10), and (e-15), a provider shall not hold an employee liable for costs related to a non-disputed procedure, treatment, or service rendered in connection with a compensable injury. The provisions of subsections (e-5), (e-10), (e-15), and (e-20) shall not apply if an employee provides information to the provider regarding participation in a group health plan. If the employee participates in a group health plan, the provider may submit a claim for services to the group health plan. If the claim for service is covered by the group health plan, the

employee's responsibility shall be limited to applicable deductibles, co-payments, or co-insurance. Except as provided under subsections (e-5), (e-10), (e-15), and (e-20), a provider shall not bill or otherwise attempt to recover from the employee the difference between the provider's charge and the amount paid by the employer or the insurer on a compensable injury, or for medical services or treatment determined by the Commission to be excessive or unnecessary.

(f) Nothing in this Act shall prohibit an employer or insurer from contracting with a health care provider or group of health care providers for reimbursement levels for benefits under this Act different from those provided in this Section.

(g) On or before January 1, 2010 the Commission shall provide to the Governor and General Assembly a report regarding the implementation of the medical fee schedule and the index used for annual adjustment to that schedule as described in this Section.

(Source: P.A. 97-18, eff. 6-28-11.)

(820 ILCS 305/8.2a)

Sec. 8.2a. Electronic claims.

(a) The Director of Insurance shall adopt rules to do all of the following:

(1) Ensure that all health care providers and facilities submit medical bills for payment on standardized forms.

(2) Require acceptance by employers and insurers of electronic claims for payment of medical services.

(3) Ensure confidentiality of medical information submitted on electronic claims for payment of medical services.

(4) Ensure that health care providers have an opportunity to comply with requests for records by employers and insurers for the authorization of the payment

of workers' compensation claims.

(5) Ensure that health care providers are responsible for supplying only those medical records pertaining to the provider's own claims that are minimally necessary under the federal Health Insurance Portability and

Accountability Act of 1996.

(6) Provide that any electronically submitted bill determined to be complete but not paid or objected to within 30 days shall be subject to interest pursuant to item (3) of subsection (d) of Section 8.2.

(7) Provide that the Department of Insurance shall impose an administrative fine if it determines that an employer or insurer has failed to comply with the electronic claims acceptance and response process. The amount of the administrative fine shall be no greater than $1,000 per each violation, but shall not exceed $10,000 for identical violations during a calendar year.

(b) To the extent feasible, standards adopted pursuant to subdivision (a) shall be consistent with existing standards under the federal Health Insurance Portability and Accountability Act of 1996 and standards adopted under the Illinois Health Information Exchange and Technology Act.

(c) The rules requiring employers and insurers to accept electronic claims for payment of medical services shall be proposed on or before January 1, 2012, and shall require all employers and insurers to accept electronic claims for payment

of medical services on or before June 30, 2012. The Director of Insurance shall adopt rules by January 1, 2019 to implement the changes to this Section made by this amendatory Act of this 100th General Assembly. The Commission, with assistance from the Department and the Medical Fee Advisory Board, shall publish on it its Internet website a companion guide to assist with compliance with electronic claims rules. The Medical Fee Advisory Board shall periodically review the companion guide.

(d) The Director of Insurance shall by rule establish criteria for granting exceptions to employers, insurance carriers, and health care providers who are unable to submit or accept medical bills electronically.

(Source: P.A. 97-18, eff. 6-28-11.)

Sec. 456. Making of rates. (1) All rates shall be made in accordance with the following provisions:

(a) Due consideration shall be given to past and prospective loss experience within and outside this state, to

catastrophe hazards, if any, to a reasonable margin for profit and contingencies, to dividends, savings or unabsorbed premium deposits allowed or returned by companies to their policyholders, members or subscribers, to past and prospective expenses both countrywide and those specially applicable to this state, to underwriting practice and judgment and to all other relevant factors within and outside this state;

(b) The systems of expense provisions included in the rates for use by any company or group of companies may differ from those of other companies or groups of companies to reflect the requirements of the operating methods of any such company or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof for which subdivision or combination separate expense provisions are applicable;

(c) Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which measure variation in hazards or expense provisions, or both. Such rating plans may measure any differences among risks that have a probable effect upon losses or expenses;

(d) Rates shall not be excessive, inadequate or unfairly discriminatory.

A rate ~~in a competitive market is not excessive. A rate in a noncompetitive market~~ is excessive if it is likely to produce a ~~long-run~~ profit that is unreasonably high for the insurance

provided or if expenses are unreasonably high in relation to

the services rendered.

A rate is not inadequate unless such rate is clearly insufficient to sustain projected losses and expenses in the class of business to which it applies and the use of such rate has or, if continued, will have the effect of substantially lessening competition or the tendency to create monopoly in any market.

Unfair discrimination exists if, after allowing for practical limitations, price differentials fail to reflect equitably the differences in expected losses and expenses. A rate is not unfairly discriminatory because different premiums result for policyholders with like exposures but different expenses, or like expenses but different loss exposures, so long as the rate reflects the differences with reasonable accuracy.

(e) The rating plan shall contain a mandatory offer of a deductible applicable only to the medical benefit under the Workers' Compensation Act. Such deductible offer shall be in a minimum amount of at least $1,000 per accident.

(f) Any rating plan or program shall include a rule permitting 2 or more employers with similar risk characteristics, who participate in a loss prevention program or safety group, to pool their premium and loss experience in determining their rate or premium for such participation in the program.

(2) Except to the extent necessary to meet the provisions of subdivision (d) of subsection (1) of this Section, uniformity among companies in any matters within the scope of this Section is neither required nor prohibited.

(Source: P.A. 82-939.)

(215 ILCS 5/457) (from Ch. 73, par. 1065.4)

Sec. 457. Rate filings. (1) Every ~~Beginning January 1, 1983, every~~ company shall prefile ~~file~~ with the Director every manual of classifications, every manual of rules and rates,

every rating plan and every modification of the foregoing which it intends to use. Such filings shall be made at least ~~not later than~~ 30 days before ~~after~~ they become effective. A company may satisfy its obligation to make such filings by adopting the filing of a licensed rating organization of which it is a member or subscriber, filed pursuant to subsection (2) of this Section, in total or, with the approval of the Director, ~~by notifying the Director in what respects it intends to~~ deviate from such filing. If a company intends to deviate from the filing of a licensed rating organization of which it is a member, the company shall provide the Director with supporting information that specifies the basis for the requested deviation and provides justification for the deviation. Any company adopting a pure premium filed by a rating organization pursuant to subsection (2) must file with the Director the modification factor it is using for expenses

and profit so that the final rates in use by such company can be determined.

(2) Each ~~Beginning January 1, 1983, each~~ licensed rating organization must prefile ~~file~~ with the Director every manual of classification, every manual of rules and advisory rates, every pure premium which has been fully adjusted and fully developed, every rating plan and every modification of any of the foregoing which it intends to recommend for use to its members and subscribers, at least ~~not later than~~ 30 days before ~~after~~ such manual, premium, plan or modification thereof takes effect. Every licensed rating organization shall also file with the Director the rate classification system, all rating rules, rating plans, policy forms, underwriting rules or similar materials, and each modification of any of the foregoing which it requires its members and subscribers to adhere to not later than 30 days before such filings or modifications thereof are to take effect. Every such filing shall state the proposed effective date thereof and shall indicate the character and extent of the coverage contemplated.

(3) A filing and any supporting information made pursuant to this Section shall be open to public inspection as soon as filed ~~after the filing becomes effective~~.

(4) A filing shall not be effective nor used until approved by the Director. A filing shall be deemed approved and legally effective if the Director fails to disapprove within 30 days after the filing.

(Source: P.A. 82-939.)

(215 ILCS 5/458) (from Ch. 73, par. 1065.5)

Sec. 458. Disapproval of filings. (1) If within 30 ~~thirty~~ days of any filing the Director finds that such filing does not meet the requirements of this Article, he shall send to the company or rating organization which made such filing a written notice of disapproval of such filing, specifying therein in what respects he finds that such filing fails to meet the requirements of this Article ~~and stating when, within a reasonable period thereafter, such filing shall be deemed no longer effective~~. A company or rating organization whose filing has been disapproved shall be given a hearing upon a written request made within 30 days after the disapproval order. ~~If the company or rating organization making the filing shall, prior to the expiration of the period prescribed in the notice, request a hearing, such filings shall be effective until the expiration of a reasonable period specified in any order entered thereon. If the rate resulting from such filing be unfairly discriminatory or materially inadequate, and the difference between such rate and the approved rate equals or exceeds the cost of making an adjustment, the Director shall in such notice or order direct an adjustment of the premium to be made with the policyholder either by refund or collection of additional premium. If the policyholder does not accept the increased rate, cancellation shall be made on a pro rata basis.~~

~~Any policy issued pursuant to this subsection shall contain a provision that the premium thereon shall be subject to adjustment upon the basis of the filing finally approved.~~

(2) If at any time subsequent to the applicable review period provided for in subsection (1) of this Section, the Director finds that a filing does not meet the requirements of this Article, he shall, after a hearing held upon not less than ten days written notice, specifying the matters to be considered at such hearing, to every company and rating organization which made such filing, issue an order specifying in what respects he finds that such filing fails to meet the requirements of this Article, and stating when, within a reasonable period thereafter, such filings shall be deemed no longer effective. Copies of said order shall be sent to every such company and rating organization. Said order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in said order.

(3) Any person or organization aggrieved with respect to any filing which is in effect may make written application to the Director for a hearing thereon, provided, however, that the company or rating organization that made the filing shall not be authorized to proceed under this subsection. Such application shall specify the grounds to be relied upon by the applicant. If the Director shall find that the application is made in good faith, that the applicant would be so aggrieved if his grounds are established, and that such grounds otherwise

justify holding such a hearing, he shall, within thirty days after receipt of such application, hold a hearing upon not less than ten days written notice to the applicant and to every company and rating organization which made such filing.

If, after such hearing, the Director finds that the filing does not meet the requirements of this Article, he shall issue an order specifying in what respects he finds that such filing

fails to meet the requirements of this Article, and stating when, within a reasonable period thereafter, such filing shall be deemed no longer effective. Copies of said order shall be sent to the applicant and to every such company and rating organization. Said order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in said order.

(4) Whenever an insurer has no legally effective rates as a result of the Director's disapproval of rates or other act, the Director shall on request of the insurer specify interim rates for the insurer that are high enough to protect the interests of all parties and may order that a specified portion of the premiums be placed in an escrow account approved by him or her. When new rates become legally effective, the Director shall order the escrowed funds or any overcharge in the interim rates to be distributed appropriately, except that refunds to policyholders that are de minimis shall not be required.

(Source: P.A. 82-939.)

(215 ILCS 5/462a new)

Sec. 462a. Premium increase notice. A policy of workers' compensation insurance issued, delivered, amended, or renewed on or after January 1, 2019 shall remain in full force and effect subject to the same terms and conditions, loss cost multipliers, and classification of the employer with regard to the payment of dividends, unless written notice is mailed or delivered by the insurer to the employer, at the address shown on the policy, and to the employer's authorized agent or broker, indicating the insurer's intention to condition renewal upon issuance of a policy that supersedes the policy previously issued and that will result in a premium in excess of 5% above the rate recommendation filed with the Department, exclusive of any premium increase generated as a result of increased loss costs or increased exposure units or as a result of experience rating, contractor credit adjustment program,

large deductible, retrospective rating, or audit. The notice shall be delivered at least 30 days in advance of the expiration date of the policy, and shall set forth: (1) the amount of the premium increase or, if the amount cannot reasonably be determined as of the time the notice is provided, a reasonable estimate of the premium increase based upon the information available to the insurer at that time; and (2) the reason for the increased premium in excess of the rate recommendation filed with the Department. Nothing in this Section requires the insurer to provide notice when the

employer, an agent or broker authorized by the employer, or another insurer of the employer has delivered written notice that the policy has been replaced or is no longer desired.

(215 ILCS 5/123C-4 rep.)

(215 ILCS 5/460 rep.)

Section 95. The Illinois Insurance Code is amended by repealing Sections 123C-4 and 460.

Section 99. Effective date. This Act takes effect upon becoming law, except that the provisions changing Sections 456, 457, and 458 of the Illinois Insurance Code and the provisions repealing Section 460 of the Illinois Insurance Code take effect February 1, 2019.".

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARIA OQUENDO,

Petitioner,

vs.

NO: 11 WC 36858

RESURRECTION HEALTH CARE,

17IWCC0556

Respondent,

DECISION AND OPINION ON REVIEW

Petitioner filed a Petition for Review on the issues of causation, temporary total disability, medical expenses, and nature and extent. However, we find that Petitioner's Petition was not filed timely and we no longer have jurisdiction.

At the hearing, the parties agreed to waive receipt of the Arbitrator's decision by certified mail and consented to receive the decision by electronic mail. (T.9, 11). Both parties agreed that their e-mail addresses are listed on the Request for Hearing form. (Id.) The decision was filed on February 2, 2016 and sent to both parties via e-mail on February 3rd. Petitioner did not file a Petition for Review until March 31, 2016, well beyond the 30-day time limit required under §19(b) of the Act. On the Petition, Petitioner indicated that the decision was filed on February 2, 2016, but that it was received on March 23, 2016.

Pursuant to Commission procedure, decisions are e-mailed with a delivery receipt and read receipt requested. The delivery receipt is generated automatically when the e-mail is successfully transmitted to the recipient's e-mail address. The read receipt is generated when the e-mail is opened but we note that it is possible for this receipt to be manually prevented by the receiving party. Commission records indicate that Respondent's attorney sent a read receipt on February 3rd, but Petitioner's attorney did not send a read receipt until March 24th.

Petitioner's brief indicates that the decision was e-mailed to an attorney who subsequently left the firm and that this e-mail address was not being monitored by the office manager. Without citing anything in support, Petitioner claims that, "It has been the understanding of the undersigned that the decision is not considered to be received until receipt

is acknowledged by the opening of the e-mail." (P-brief at 1). The Commission does not know what the basis of this alleged "understanding" could have been but it is not accurate.

This situation is similar to a party receiving a certified letter via USPS but choosing not to read it. We find that Petitioner's attorney's law firm had an affirmative duty to review all of the e-mails sent to the former attorney's e-mail address and/or inform the Arbitrator of a change in e-mail address. Therefore, we find that Petitioner's Petition for Review was not timely filed and that the "date of receipt" of the decision is the date that the decision is e-mailed unless the party proves that it was not received, such as when the decision was sent to an e-mail address that is different than the one specified on the Request for Hearing form. To find otherwise would allow too much opportunity for the 30-day deadline to be subverted by simply waiting indefinitely to read any e-mails from the Commission.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition for Review is hereby dismissed for lack of jurisdiction.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 7 - 2017

Charles J. DeVriendt

SE/
O: 7/26/17
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Kevin W. Lamborn

Joshua D. Luskin

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gregory Dotson,
Petitioner,

vs. NO: 10 WC 21807

White County Coal Co.,
Respondent.

17IWCC0829

DECISION AND OPINION ON REVIEW

A Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission first addresses the timeliness of the filing of the Petition for Review and the Commission's jurisdiction to review the Decision of the Arbitrator filed April 14, 2016.

The parties agreed to receive the Decision of the Arbitrator via electronic mail (email). Commission records show the email to the parties with the Decision of the Arbitrator attached was originally sent at 4:30 PM on April 14, 2016, the day the Decision was filed at the Commission. The claimant, through counsel, filed a Petition for Review on June 1, 2016, with a mailing date of May 25, 2016. The respondent objects to further proceedings on review based on a lack of subject matter jurisdiction pursuant to Section 19(b) of the Act, as the review was filed more than 30 days following receipt of the Decision.

The respondent received the email on April 15, 2016; the petitioner's counsel, in his Petition for Review, alleges receipt of the Decision on May 24, 2016. The Commission's April 14, 2016 email shows it was sent to the address kirk.caponi@wcflaw.com for the claimant; a follow-up email, apparently sent at the claimant's attorney's request, was sent on May 24, 2016 at 2:56 PM to the email address culleyandwissore@myfrontiermail.com. The Commission further observes Mr. Caponi had, on the trial stipulation sheet, provided an email address of culleyandwissore@frontier.com.

17IWCC0829

If the claimant's attorney did receive the April 14, 2016 email either that day or the next morning (April 15, 2016 was a Friday) then clearly the Petition for Review would be untimely and therefore void. Claimant's counsel avers receipt of the Decision on or about May 24, 2016; based on that date of receipt, the Petition for Review would clearly have been timely filed.

While the respondent's concerns are well founded, the Commission notes a lack of proof that the claimant's counsel in fact received the originally sent April 14, 2016 email. Moreover, the claimant's attorney asserts receipt on May 24, 2016, supported by his signature on the filing. There does not appear to be any bad faith, malfeasance or abuse of the process being demonstrated. The Commission accepts the May 24, 2016 date for purposes of the receipt of the Decision; as such, jurisdiction before the Commission is extant.

Finding jurisdiction to have been properly established, after considering the issues of occupational disease, causal connection, and permanent partial disability, and being advised of the facts and law, the Commission affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 14, 2016 is hereby affirmed and adopted.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: DEC 26 2017

Joshua D. Luskin

o-12/05/17
jdl/ac
68

Charles J. DeVriendt

L. Elizabeth Coppoletti

Chairman Joann Fratianni is pleased to announce another step forward in the IWCC's modernization and technological upgrade of operations. Pursuant to the IWCC's Rules, as found in Section 50 of the Illinois Administrative Code, parties will receive case activity notices electronically beginning on July 2, 2018. **The IWCC will no longer send case notices via U.S. Mail as of this date.*** All parties (law firms on behalf of clients and *pro se* litigants) will be required to maintain a designated electronic mail ("e-mail") address for receiving case notices, just as they are now required to maintain a physical address to receive them by U.S. Mail. You only need to fill out the "E-Mail Registration Form" once (just like providing us your physical address), so that we can update our system. **PLEASE NOTE** that it does not matter if you already have an e-mail on file or in use with us – we are populating the system with new and updated information. So, please submit a law firm/*pro se* e-mail address to us again.

> **** The only exception to electronic notices is respondent parties at the time a case is initially filed, whom will be notified that a case has been filed against them by U.S. Mail at the address provided by the petitioner. This is the current practice.***

Attorneys – Our system links cases before the IWCC to the law firm, not the individual practitioner. So, please provide us your firm's e-mail address for receipt of electronic notices. If one of your attorneys "updates" your firm e-mail address with their own, all firm notices will go to the most updated address.

INSTRUCTIONS (for law firms and *pro se* litigants)

There are two ways to provide the IWCC an e-mail address:

1. Go on our website to: https://www2.illinois.gov/sites/iwcc/resources/Pages/Request-for-Attorney-Code-Number-.aspx (our website, followed by "forms").

   Fill out the "E-Mail Registration Form" and click "submit."

2. Fill out the "E-Mail Registration Form" in person at the IWCC's Chicago office located at:

   Illinois Workers' Compensation Commission
   100 W. Randolph St.
   Suite 8-200
   Chicago, IL 60601

   You will receive a confirmation e-mail to the address provided in three to five business days. If you are concerned that you failed to receive an e-mail from us, please contact Greg Ettling at (312) 814-6639.