Illinois Workers' Compensation Commission

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Bruce Rauner, Governor ***Joann M. Fratianni, Chairman***

November 9, 2016

On October 19, 2016, the Illinois Workers' Compensation Commission voted unanimously to adopt amendments to and new parts for its Administrative Rules. The IWCC wishes to express its sincere appreciation to the 28 attorneys who assisted in drafting and amending the rules.

Although every effort was made to reproduce the rules accurately in this document, the official version is maintained on the General Assembly's website available HERE.

This document contains the following Parts of Titles 2 and 50 of the Illinois Administrative Code:

TITLE 2: GOVERNMENTAL ORGANIZATION
CHAPTER XXII: WORKERS' COMPENSATION COMMISSION

TITLE 50: INSURANCE
CHAPTER VI: WORKERS' COMPENSATION COMMISSION

SUBTITLE E

TITLE 2: GOVERNMENTAL ORGANIZATION
SUBTITLE E: MISCELLANEOUS STATE AGENCIES
CHAPTER XXII: WORKERS' COMPENSATION COMMISSION

PART 2026
ACCESS TO RECORDS OF THE WORKERS' COMPENSATION COMMISSION

SUBPART A: INTRODUCTION

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SUBPART B: CLASSIFICATION OF RECORDS

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SUBPART E: PROCEDURES FOR PROVIDING RECORDS TO REQUESTERS

Section

AUTHORITY: Implementing and authorized by Section 3(h) of the Freedom of Information Act [5 ILCS 140/3(h)] and Section 5-15 of the Illinois Administrative Procedure Act [5 ILCS 100/5-15].

SOURCE: Adopted at 8 Ill. Reg. 15451, effective August 10, 1984; former Part repealed at 40 Ill. Reg. _____ and new Part adopted at 40 Ill. Reg. _____, effective _____.

Section 2026.105 Summary and Purpose

a) This Part states the policy of the Workers' Compensation Commission (Commission) for making its records available for reasonable public inspection while, at the same time, protecting legitimate interests in confidentiality.

b) This Part:

1) Establishes the following classifications for records in the Commission's possession:

A) Records that shall be disclosed; and

B) Records that shall be withheld from disclosure;

2) Contains the procedures by which requesters may obtain records in the Commission's possession; and

3) Contains the procedures for claiming and determining that records submitted to the Commission are exempt from disclosure.

Section 2026.115 Definitions

Terms not defined in this Section shall have the same meaning as in the Freedom of Information Act [5 ILCS 140]. The following definitions are applicable for purposes of this Part:

"Act" means the Illinois Workers' Compensation Act [820 ILCS 305].

"Chairman" means the Chairman of the Commission.

"Commercial purpose" means the use of any part of a record or records, or information derived from records, in any form for sale, resale, or solicitation or advertisement for sales or services. For purposes of this definition, requests made by news media and non-profit, scientific, or academic organizations shall not be considered to be made for a "commercial purpose" when the principal purpose of the request is:

to access and disseminate information concerning news and current or passing events;

for articles or opinion or features of interest to the public; or

for the purpose of academic, scientific, or public research or education. (Section 2(c-10) of FOIA)

"Commission" means the Workers' Compensation Commission as established by the Act and WODA.

"Copying" means the reproduction of any record by means of any photographic, electronic, mechanical, or other process, device or means now known or hereafter developed and available to the Commission. (Section 2(d) of FOIA)

"FOIA" means the Freedom of Information Act [5 ILCS 140].

"Freedom of Information Officer" or "FOI Officer" means an individual or individuals responsible for receiving and responding to requests for public records.

"News media" means a newspaper or other periodical issued at regular intervals, news service in paper or electronic form, radio station, television station, television network, community antenna television service, or person or

corporation engaged in making news reels or other motion picture news for public showing. (Section 2(f) of FOIA)

"Person" means any individual, corporation, partnership, firm, organization or association, acting individually or as a group. (Section 2(b) of FOIA)

"Private information" means unique identifiers, including a person's Social Security number, driver's license number, employee identification number, biometric identifiers, personal financial information, passwords or other access codes, medical records, home or personal telephone numbers, and personal email addresses. Private information also includes home address and personal license plates, except as otherwise provided by law or when compiled without possibility of attribution to any person. (Section 2(c-5) of FOIA)

"Public Access Counselor" means an individual appointed to that office by the Attorney General under Section 7 of the Attorney General Act [15 ILCS 205].

"Public body" means all legislative, executive, administrative, or advisory bodies of the State, State universities and colleges, counties, townships, cities, villages, incorporated towns, school districts and all other municipal corporations, boards, bureaus, committees or commissions of this State, any subsidiary bodies of any of the foregoing, including but not limited to committees and subcommittees thereof, and a School Finance Authority created under Article 1E of the School Code [105 ILCS 5]. (Section 2(a) of FOIA)

"Records" means all records, reports, forms, writings, letters, memoranda, books, papers, maps, photographs, microfilms, cards, tapes, recordings, electronic data processing records, electronic communications, recorded information and all other documentary materials pertaining to the transaction of public business, regardless of physical form or characteristics, having been prepared by or for, or having been or being used by, received by, in the possession of or under the control of the Commission. (Section 2(c) of FOIA)

"Recurrent requester" means a person that, in the 12 months immediately preceding the request, has submitted to the same public body a minimum of 50 requests for records, a minimum of 15 requests for records within a 30-day period, or a minimum of 7 requests for records within a 7 day period. For the purposes of this definition, requests made by news media and non-profit, scientific, or academic organizations shall not be considered in calculating the number of requests made in the time periods, in this definition when the principal purpose of the requests is to access and disseminate information concerning news and current or passing events, for articles of opinion or features of interest to the

public, or for the purpose of academic, scientific, or public research or education. For the purposes of this definition, "request" means a written document (or oral request, if the public body chooses to honor oral requests) that is submitted to a public body via personal delivery, mail, telefax, electronic mail, or other means available to the public body and that identifies the particular public record the requester seeks. One request may identify multiple records to be inspected or copied. (Section 2(g) of FOIA)

"Requester" is any person who has submitted to the Commission a written request, electronically or on paper, for records.

"Unwarranted invasion of personal privacy" means the disclosure of information that is highly personal or objectionable to a reasonable person and in which the subject's right to privacy outweighs any legitimate public interest in obtaining the information. (Section 7(1)(c) of FOIA)

"WODA" means the Illinois Workers' Occupational Diseases Act [820 ILCS 310].

Section 2026.205 Records that Will Be Disclosed

Upon request meeting the requirements of this Part, the Commission shall disclose to the requester all records requested except that it shall not disclose certain records as provided in Section 2026.215 or 2026.225. Records covered under this Section shall include, but are not limited to:

a) *Records of funds. All records relating to the obligation, receipt and use of public funds of the Commission are records subject to inspection and copying by the public.* (Section 2.5 of FOIA)

b) *Payrolls. Certified payroll records submitted to the Commission under Section 5(a)(2) of the Prevailing Wage Act* [820 ILCS 130] *are records subject to inspection and copying in accordance with the provisions of FOIA; except that contractors' and employees' addresses, telephone numbers, and Social Security numbers will be redacted by the Commission prior to disclosure.* (Section 2.10 of FOIA)

c) *Settlement and severance agreements. All settlement and severance agreements entered into by or on behalf of the Commission are records subject to inspection and copying by the public, provided that information exempt from disclosure under* Section 2026.215 or 2026.225 *may be redacted.* (Section 2.20 of FOIA)

Section 2026.215 Records that Will Be Withheld from Disclosure

a) For exemptions from FOIA that are stated in FOIA, see Section 7(1) of the Act.

b) *A record that is not in the possession of the Commission but is in the possession of a party with whom the Commission has contracted to perform a governmental function on behalf of the Commission, and that directly relates to the governmental function and is not otherwise exempt under FOIA, shall be considered a record of the Commission for purposes of* Subpart C. (Section 7(2) of FOIA)

Section 2026.225 Statutory Exemptions

For exemptions from FOIA that are stated in other statutes, see Section 7.5 of the Act.

Section 2026.235 Records Maintained Online

a) *Notwithstanding any provision of FOIA to the contrary, the Commission is not required to copy a public record that is published on the Commission's website. The Commission shall notify the requestor that the public record is available online and direct the requestor to the website where the record can be reasonably accessed.*

b) *If the person requesting the public record is unable to reasonably access the record online after being directed to the website pursuant to subsection (a), the requester may resubmit his or her request for the record, stating his or her inability to reasonably access the record on line, and the public body shall make the requested record available for inspection or copying.* (Section 8.5 of FOIA)

Section 2026.305 Submittal of Requests for Records

a) Any request for public records should be submitted in writing to the FOI Officer of the Commission.

b) The Commission has one FOI Officer, located in the Chicago office.

c) Contact information for each FOI Officer can be found online at www. Illinois.gov/Pages/FOIAContacts.

d) FOIA requests may be submitted via mail, e-mail, fax, or hand delivery. Requests should be mailed or hand delivered to:

Workers' Compensation Commission
100 West Randolph Street, Suite 8-200
Chicago, Illinois 60601
Attn: FOI Officer

e) E-mailed requests should be sent to wcc.FOIA@illinois.gov, contain the request in the body of the e-mail, and indicate in the subject line of the e-mail that it contains a FOIA request. Faxed FOIA requests should be faxed to 312/814-3520, Attn: FOI Officer.

Section 2026.315 Information To Be Provided in Requests for Records

A request for records should include:

a) The complete name, mailing address and telephone number of the requester;

b) As specific a description as possible of the records sought. Requests that the Commission considers unduly burdensome or categorical may be denied. (See Section 3(g) of FOIA and Section 2026.415 of this Part.);

c) A statement as to the requested medium and format for the Commission to use in providing the records sought: for example, paper, specific types of digital or magnetic media, or videotape;

d) A statement as to the requested manner for the Commission to use in providing the records sought: for example, inspection at Commission headquarters or providing paper or electronic copies;

e) A statement as to whether the requester needs certified copies of all or any portion of the records, including reference to the specific documents that require certification; and

f) A statement as to whether the request is for a commercial purpose.

Section 2026.325 Requests for Records for Commercial Purposes

a) *It is a violation of FOIA for a person to knowingly obtain a record for a commercial purpose without disclosing that it is for a commercial purpose if requested to do so by the Commission.* (Section 3.1(c) of FOIA)

b) *The Commission shall respond to a request for records to be used for a commercial purpose within 21 working days after receipt. The response shall:*

1) *Provide to the requester an estimate of the time required by the Commission to provide the records requested and an estimate of the fees to be charged, which the Commission may require the person to pay in full before copying the requested documents;*

2) *Deny the request pursuant to one or more of the exemptions set out in* Section 2026.215 or 2026.225;

3) *Notify the requester that the request is unduly burdensome and extend an opportunity to the requester to attempt to reduce the request to manageable proportions; or*

4) *Provide the records requested.* (Section 3.1(a) of FOIA)

c) *Unless the records are exempt from disclosure, the Commission shall comply with a request within a reasonable period considering the size and complexity of the request, and giving priority to records requested for non-commercial purposes.* (Section 3.1(b) of FOIA)

Section 2026.405 Timeline for Commission Response

a) Except as stated in subsection (b) or (c), the Commission will respond to any written *request for records within 5 business days after its receipt of the request. Failure to comply with a written request, extend the time for response, or deny a request within 5 business days after its receipt shall be considered a denial of the request. If the Commission fails to respond to a request within the requisite periods in this* subsection (a) *but thereafter provides the requester with copies of the requested records, it will not impose a fee for* those *copies. If the Commission fails to respond to a request received, it will not treat the request as unduly burdensome as provided under* Section 2026.415. (Section 3(d) of FOIA) A written request from the Commission to provide additional information shall be considered a response to the FOIA request.

b) *The time limits prescribed in* subsection (a) *may be extended for not more than 5 business days from the original due date for any of the following reasons:*

1) *The requested records are stored in whole or in part at locations other than the office having charge of the requested records;*

2) *The request requires the collection of a substantial number of specified records;*

3) *The request is couched in categorical terms and requires an extensive search for the records responsive to it;*

4) *The requested records have not been located in the course of routine search and additional efforts are being made to locate them;*

5) *The requested records require examination and evaluation by personnel having the necessary competence and discretion to determine if they are exempt from disclosure under Section 7 or 7.5 of FOIA or should be revealed only with appropriate deletions*;

6) *The request for records cannot be complied with by the Commission within the time limits prescribed by* subsection (a) *without unduly burdening or interfering with the operations of the Commission; or*

7) *There is a need for consultation, which shall be conducted with all practicable speed, with another public body or among two or more components of a public body having a substantial interest in the*

determination or in the subject matter of the request. (Section 3(e) of FOIA)

c) *The person making a request and the Commission may agree in writing to extend the time for compliance for a period to be determined by the parties. If the requester and the Commission agree to extend the period for compliance, a failure by the Commission to comply with any previous deadlines shall not be treated as a denial of the request for the records.* (Section 3(e) of FOIA)

d) *When additional time is required for any of the reasons* set forth in subsection (b), *the Commission will, within 5 business days after receipt of the request, notify the person making the request of the reasons for the extension and the date by which the response will be forthcoming. Failure to respond within the time permitted for extension shall be considered a denial of the request. If the Commission fails to respond to a request within the time permitted for extension but thereafter provides the requester with copies of the requested public records, it may not impose a fee for those copies. If the Commission issues an extension and subsequently fails to respond to the request, it will not treat the request as unduly burdensome under* Section 2026.415. (Section 3(f) of FOIA)

Section 2026.415 Requests for Records that the Commission Considers Unduly Burdensome

a) *The Commission will fulfill requests calling for all records falling within a category unless compliance with the request would unduly burden the Commission, there is no way to narrow the request, and the burden on the Commission outweighs the public interest in the information. Before invoking this exemption, the Commission will extend to the requester an opportunity to confer with it in an attempt to reduce the request to manageable proportions.* (Section 3(g) of FOIA) The amended request must be in writing.

b) If the Commission determines that a request is unduly burdensome, *it shall do so in writing, specifying the reasons why it would be unduly burdensome and the extent to which compliance will so burden the operations of the Commission.* The *response shall be treated as a denial of the request for information.* (Section 3(g) of FOIA)

c) *Repeated requests from the same person for records that are unchanged or identical to records previously provided or properly denied under* this Part *shall be deemed unduly burdensome.* (Section 3(g) of FOIA)

Section 2026.425 Recurrent Requesters

a) *Notwithstanding any provision of this* Part *to the contrary, the Commission will respond to a request from a recurrent requester, as defined in* Section 2026.115, *within 21 business days after receipt. The response shall*:

1) *provide to the requester an estimate of the time required by the Commission to provide the records requested and an estimate of the fees to be charged, which the Commission may require the person to pay in full before copying the requested documents*;

2) *deny the request pursuant to one or more of the exemptions set out in this* Part;

3) *notify the requester that the request is unduly burdensome and extend an opportunity to the requester to attempt to reduce the request to manageable proportions; or*

4) *provide the records requested.*

b) *Within 5 business days after receiving a request from a recurrent requester, the Commission will notify the requester that the Commission is treating the request as a recurrent request, of the reasons why the Commission is treating the request as a recurrent request, and that the Commission will send an initial response within 21 business days after receipt in accordance with subsection (a). The Commission will also notify the requester of the proposed responses that can be asserted pursuant to subsection (a).*

c) *Unless the records are exempt from disclosure, the Commission will comply with a request within a reasonable period considering the size and complexity of the request.* (Section 3.2 of FOIA)

Section 2026.435 Requests for Records that Require Electronic Retrieval

a) A request for records that requires electronic retrieval will be treated the same as any other request for records, with the same timeline and extensions as allowed for other records.

b) The Commission will retrieve and provide electronic records only in a format and medium that is available to the Commission.

Section 2026.445 Denials of Requests for Records

a) The Commission will deny requests for records when:

1) Compliance with the request would unduly burden the Commission, as determined pursuant to Section 2026.415, and the requester has not reduced the request to manageable proportions; or

2) The records are exempt from disclosure pursuant to Section 7 or 7.5 of FOIA or Section 2026.215 or 2026.225 of this Part.

b) The denial of a request for records must be in writing.

1) The notification shall include a description of the records denied; *the reason for the denial, including a detailed factual basis for the application of any exemption claimed; and the names and titles or positions of each person responsible for the denial* (Section 9(a) of FOIA);

2) *Each notice of denial shall also inform* the *person of the right to review by the Public Access Counselor and provide the address and phone number for the Public Access Counselor* (Section 9(a) of FOIA); and

3) *When a request for records is denied on the grounds that the records are exempt under Section 7* or 7.5 *of FOIA, the notice of denial shall specify the exemption claimed to authorize the denial and the specific reasons for the denial, including a detailed factual basis and a citation to the supporting legal authority* (Section 9(b) of FOIA).

c) A requester may treat the Commission's failure to respond to a request for records within 5 business days after receipt of the written request as a denial for purposes of the right to review by the Public Access Counselor.

d) If the Commission has given written notice pursuant to Section 2026.405(d), failure to respond to a written request within the time permitted for extension may be treated as a denial for purposes of the right to review by the Public Access Counselor.

e) *Any person making a request for records shall be deemed to have exhausted his or her administrative remedies with respect to that request if the Commission fails to act within the time periods provided in* Section 2026.405. (Section 9(c) of FOIA)

Section 2026.455 Requests for Review of Denials − Public Access Counselor

a) *A person whose request to inspect or copy a record is denied by the Commission may file a request for review with the Public Access Counselor established in the Office of the Attorney General not later than 60 days after the date of the final denial. The request for review shall be in writing, be signed by the requester, and include a copy of the request for access to records and any response from the Commission.* (Section 9.5(a) of FOIA)

b) *A person whose request to inspect or copy a record is made for a commercial purpose may not file a request for review with the Public Access Counselor. A person whose request to inspect or copy a record was treated by the Commission as a request for a commercial purpose may file a request for review with the Public Access Counselor for the limited purpose of reviewing whether the Commission properly determined that the request was made for a commercial purpose*. (Section 9.5(b) of FOIA)

c) *Within 7 business days after the Commission receives a request for review from the Public Access Counselor, the Commission shall provide copies of records requested and shall otherwise fully cooperate with the Public Access Counselor.* (Section 9.5(c) of FOIA)

d) *Within 7 business days after it receives a copy of a request for review and request for production of records from the Public Access Counselor, the Commission may, but is not required to, answer the allegations of the request for review. The answer may take the form of a letter, brief, or memorandum. The Public Access Counselor shall forward a copy of the answer to the person submitting the request for review, with any alleged confidential information to which the request pertains redacted from the copy.* (Section 9.5(d) of FOIA)

e) *The requester may, but is not required to, respond in writing to the answer within 7 business days and shall provide a copy of the response to the Commission.* (Section 9.5(d) of FOIA)

f) *In addition to the request for review, and the answer and response to the request, if any, a requester or the Commission may furnish affidavits or records concerning any matter germane to the review.* (Section 9.5(e) of FOIA)

g) *A binding opinion from the Attorney General shall be binding upon both the requester and the Commission, subject to administrative review under* Section 2026.475. (Section 9.5(f) of FOIA)

h) *If the Attorney General decides to exercise his or her discretion to resolve a request for review by mediation or by a means other than issuance of a binding opinion, the decision not to issue a binding opinion shall not be reviewable.* (Section 9.5(f) of FOIA)

i) *Upon receipt of a binding opinion concluding that a violation of FOIA has occurred, the Commission will either take necessary action immediately to comply with the directive of the opinion or shall initiate administrative review under* Section 2026.475. *If the opinion concludes that no violation of FOIA has occurred, the requester may initiate administrative review under* Section 2026.475. (Section 9.5(f) of FOIA)

j) *If the Commission discloses records in accordance with an opinion of the Attorney General, the Commission is immune from all liabilities by reason thereof and shall not be liable for penalties under FOIA.* (Section 9.5(f) of FOIA)

k) *If the requester files suit under* Section 2026.465 *with respect to the same denial that is the subject of a pending request for review, the requester shall notify the Public Access Counselor.* (Section 9.5(g) of FOIA)

l) *The Attorney General may also issue advisory opinions to the Commission regarding compliance with FOIA. A review may be initiated upon receipt of a written request from the* Chairman of the Commission or the Commission's Chief Legal Counsel, *which shall contain sufficient accurate facts from which a determination can be made. The Public Access Counselor may request additional information from the Commission in order to assist in the review. If the Commission relies in good faith on an advisory opinion of the Attorney General in responding to a request, the Commission is not liable for penalties under FOIA, so long as the facts upon which the opinion is based have been fully and fairly disclosed to the Public Access Counselor.* (Section 9.5(h) of FOIA)

Section 2026.465 Circuit Court Review

A requester also has the right to file suit for injunctive or declaratory relief in the Circuit Court for Sangamon County or for the county in which the requester resides, in accordance with the procedures set forth in Section 11 of FOIA.

Section 2026.475 Administrative Review

A binding opinion issued by the Attorney General shall be considered a final decision of an administrative agency, for purposes of administrative review under the Administrative Review Law [735 ILCS 5/Art. III]. An action for administrative review of a binding opinion of the Attorney General shall be commenced in Cook County or Sangamon County. An advisory opinion issued to the Commission shall not be considered a final decision of the Attorney General for purposes of this Section. (Section 11.5 of FOIA)

Section 2026.505 Inspection and Copying of Records

a) The Commission may make available records for personal inspection at the Commission's headquarters office located at 100 West Randolph Street, Chicago, or at another location agreed to by both the Commission and the requester. No original record shall be removed from State-controlled premises except under constant supervision of the agency responsible for maintaining the record. The Commission may provide records in duplicate forms, including, but not limited to, paper copies, data processing printouts, videotape, microfilm, audio tape, reel to reel microfilm, photographs, computer disks and diazo.

b) *When a person requests a copy of a record maintained in an electronic format, the Commission shall furnish it in the electronic format specified by the requester, if feasible. If it is not feasible to furnish the records in the specified electronic format, then the Commission shall furnish it in the format in which it is maintained by the Commission, or in paper format at the option of the requester.* (Section 6(a) of FOIA)

c) A requester may inspect records by appointment only, scheduled subject to space availability. The Commission will schedule inspection appointments to take place during normal business hours, which are 8:30 a.m. to 5:00 p.m. Monday through Friday, exclusive of State holidays. If the requester must cancel the viewing appointment, the requester shall so inform the Commission as soon as possible before the appointment.

d) In order to maintain routine Commission operations, the requester may be asked to leave the inspection area for a specified period of time.

e) The requester will have access only to the designated inspection area.

f) Requesters shall not be permitted to take briefcases, folders or similar materials into the room where the inspection takes place. An Commission employee may be present during the inspection.

g) The requester shall segregate and identify the documents to be copied during the course of the inspection.

Section 2026.515 Fees for Records

a) In accordance with Section 2026.525, unless a fee is otherwise fixed by statute, the Commission will provide copies of records and certifications of records in accordance with the fee schedule set forth in Appendix A.

b) *In calculating its actual cost for reproducing records or for the use of the equipment of the Commission to reproduce records, the Commission will not include the costs of any search for and review of the records or other personnel costs associated with reproducing the records.* (Section 6(b) of FOIA)

c) In order to expedite the copying of records that the Commission cannot copy, due to the volume of the request or the operational needs of the Commission, in the timelines established in Section 2026.405, the requester may provide, at the requester's expense, the copy machine, all necessary materials, and the labor to copy the public records at the Commission headquarters in Section 2026.501, or at another location agreed to by both the Commission and the requester. No original record shall be removed from State-controlled premises except under constant supervision of the agency responsible for maintaining the record.

d) Copies of records will be provided to the requester only upon payment of any fees due. *The Commission may charge the requester for the actual cost of purchasing the recording medium, whether disc, diskette, tape, or other medium, but the Commission will not charge the requester for the costs of any search for and review of the records or other personnel costs associated with reproducing the records.* (Section 6(a) of FOIA) Payment must be by check or money order sent to the Commission, payable to "Illinois Workers' Compensation Commission".

e) If a contractor is used to inspect or copy records, the following procedures shall apply:

1) The requester, rather than the Commission, must contract with the contractor;

2) The requester is responsible for all fees charged by the contractor;

3) The requester must notify the Commission of the contractor to be used prior to the scheduled on-site inspection or copying;

4) Only Commission personnel may provide records to the contractor;

5) The Commission must have verification that the requester has paid the Commission, if payment is due, for the copying of the records before providing the records to the contractor; and

6) The requester must provide to the Commission the contractor's written agreement to hold the records secure and to copy the records only for the purpose stated by the requester.

f) *The Commission may charge up to $10 for each hour spent by personnel in searching for and retrieving a requested record. No fees shall be charged for the first 8 hours spent by personnel in searching for or retrieving a requested record. The Commission may charge the actual cost of retrieving and transporting public records from an off-site storage facility when the public records are maintained by a third-party storage company under contract with the Commission. If the Commission imposes a fee pursuant to this subsection (f), it must provide the requester with an accounting of all fees, costs, and personnel hours in connection with the request for public records. The provisions of this subsection (f) apply only to commercial requests.* (Section 6(f) of FOIA)

Section 2026.525 Reduction and Waiver of Fees

a) *Fees may be reduced or waived by the Commission if the requester states the specific purpose for the request and indicates that a waiver or reduction of the fee is in the public interest. In making this determination, the Commission will consider the following:*

1) *Whether the principal purpose of the request is to disseminate information regarding the health, safety, welfare or legal rights of the general public; and*

2) *Whether the principal purpose of the request is personal or commercial benefit. For purposes of this subsection* (a)*, "commercial benefit" shall not apply to requests made by news media when the principal purpose of the request is to access and disseminate information regarding the health, safety, welfare or legal rights of the general public.* (Section 6(c) of FOIA)

b) *In setting the amount of the waiver or reduction, the Commission will take into consideration the amount of materials requested and the cost of copying them.* (Section 6(c) of FOIA)

c) The Commission will provide copies of records without charge to federal, State and municipal agencies, Constitutional officers and members of the General Assembly, and not-for-profit organizations providing evidence of good standing with the Secretary of State's Office.

d) *Except to the extent that the General Assembly expressly provides, statutory fees applicable to copies of records when furnished in a paper format will not be applicable to those records when furnished to a requester in an electronic format.* (Section 6(a) of FOIA)

Section 2026.APPENDIX A Fee Schedule for Duplication and Certification of Records

TYPE OF DUPLICATION	FEE (PER COPY)
Paper copy from original, up to and including 50 copies of black and white, letter or legal sized copies	No charge
Paper copy from original, in excess of 50 copies of black and white, letter or legal sized copies	$.15/page
Paper copy from microfilm original	$.15/page
Microfilm diazo from original	$.50/diazo
VHS video copy of tape	Actual cost of the reproduction
Audio tape copy of tape	Actual cost of the reproduction
CD ROM disk	Actual cost of the reproduction
Photograph from negative	Actual cost of the reproduction
Blueprints/oversized prints	Actual cost of the reproduction
Paper copies in color or in a size other than letter or legal	Actual cost of the reproduction
Certification fee	$1.00/record

NOTE: Expense for delivery other than by First Class U.S. Mail must be borne by the requester.

TITLE 50: INSURANCE
CHAPTER VI: WORKERS' COMPENSATION COMMISSION

PART 9010
ACCIDENT REPORTING

Section
9010.10 Time Limitations

AUTHORITY: Implementing Section 6(b) of the Workers' Compensation Act [820 ILCS 305/6(b)] and authorized by Section 6 of the Workers' Occupational Diseases Act [820 ILCS 310/6].

SOURCE: Filed and effective March 1, 1977; amended at 4 Ill. Reg. 26, p. 159, effective July 1, 1980; emergency rule at 6 Ill. Reg. 5820, effective May 1, 1982 for a maximum of 150 days; amended at 6 Ill. Reg. 8040, effective July 1, 1982; amended at 6 Ill. Reg. 11909, effective September 20, 1982; codified at 7 Ill. Reg. 1241; emergency amendment at 10 Ill. Reg. 4011, effective February 14, 1986, for a maximum of 150 days; adopted at 10 Ill. Reg. 12958, effective July 22, 1986; recodified from 50 Ill. Adm. Code 7010 to 50 Ill. Adm. Code 9010 at 39 Ill. Reg. 9602.

Section 9010.10 Time Limitations

Every employer within the provisions of the Workers' Compensation Act [820 ILCS 305/6(b)] and the Workers' Occupational Diseases Act [820 ILCS 310/6] shall report all fatal accidental injuries to the Workers' Compensation Commission immediately; and, between the 15th and 25th day of the month shall report to the Workers' Compensation Commission all non-fatal accidental injuries resulting in the loss of more than three scheduled work days. All reports are to be filed on forms furnished by the Commission.

(Source: Amended at 10 Ill. Reg. 12958, effective July 22, 1986)

TITLE 50: INSURANCE
CHAPTER VI: WORKERS' COMPENSATION COMMISSION

PART 9015
ELECTRONIC FILING

Section

AUTHORITY: Implementing the Electronic Commerce Security Act [5 ILCS 175] and authorized by Section 13 of the Illinois Workers' Compensation Act [820 ILCS 305/13].

SOURCE: Adopted at 40 Ill. Reg. 15700, effective November 9, 2016.

Section 9015.10 Overview of Electronic Filing

a) The Electronic Commerce Security Act [5 ILCS 175] (ECSA) authorizes State agencies to send and receive electronic records and electronic signatures to and from other persons and otherwise create, use, store and rely upon electronic records and electronic signatures. The purpose of the ECSA is to facilitate electronic communication by means of reliable electronic records, and to facilitate electronic filing of documents with State agencies. By virtue of the ECSA, and with guidance from Supreme Court Rules, the Illinois Workers' Compensation Commission adopts this Part.

b) Pursuant to Section 13 of the Illinois Workers' Compensation Act (Act), the Chairman will set forth administrative guidelines for the implementation of a system by which documents filed under this Part may be formatted and filed electronically. The Chairman shall set forth administrative procedures by which pro se nonattorney litigants may gain access to and file documents using the electronic filing system.

c) Prior to filing any document electronically with the Commission, users are required to register with the Commission and provide all information as required by the Commission's registration procedure. Users shall promptly update the required information. The Commission shall provide an identifier to all registered participants and a means to confirm that the filing was approved by an authorized user. The Attorney Registration and Disciplinary Commission number may be used as the identifier for attorneys to ensure that the attorney is licensed and in good standing.

d) The e-filing system will allow the Commission to verify whether an attorney who registers as a user is authorized to practice in Illinois.

e) Information, records and signatures shall not be denied legal effect, validity or enforceability solely on the grounds that they are in electronic form. Further, if statute, regulation or case law requires information to be "written" or "in writing", or provides for certain consequences if it is not, an electronic record satisfies that requirement.

Section 9015.20 Format

a) Documents must be submitted in the format prescribed by the Commission or in PDF format directly from the program creating the document, rather than the scanned image of a paper document. All electronically filed documents shall include the case caption and nature of filing. Each document shall include the typed name, e-mail address and telephone number of the attorney filing the document.

b) All electronically filed documents shall, to the extent possible, be formatted in accordance with this Part.

c) Electronic documents containing links to material either within the filed document or external to the document are for convenience purposes only. The external material behind the link is not considered part of the filing or basic record.

d) Bulk filing of multiple cases or multiple documents combined into one PDF document will not be accepted. Documents with different workers' compensation numbers must be filed individually.

e) Documents not complying with ECSA or this Part may be rejected.

Section 9015.30 Filing

a) The e-filing provider is an agent of the Commission for purpose of e-filing and receipt of electronic documents. Upon submission of the e-filed document, the e-filing provider will e-mail the registered user a transaction confirmation that includes the transaction number, a list of the documents submitted, and the date and time of submittal. The transaction number shall serve as proof of submittal.

b) Filings may include pleadings, petitions, motions, proofs of service, exhibits or any other Commission authorized document. Communication between attorneys or attorneys and their clients shall not be filed electronically, unless part of a pleading, petition, motion or a Commission authorized document.

c) A person who files a document electronically shall have the same responsibility as a person filing a document in the conventional manner for ensuring that the document is complete, readable and properly filed.

d) A document shall be considered timely filed if e-filed at any time before midnight on or before the date on which the document is due. If the date required for filing falls on a Saturday, Sunday or holiday, the time for filing shall be the next date that is not a Saturday, Sunday or holiday. A document submitted at or after midnight or on a day that is not a Commission business day (see 50 Ill. Adm. Code 9020.10(c)) shall be considered filed the next Commission business day.

e) The transmission date and time of transfer shall govern the electronic file mark. Each document reviewed and accepted for filing by the Commission will receive an electronic file stamp.

f) If an e-filed document is untimely filed due to a technical failure or a system outage, the registered user may seek appropriate relief from the Commission.

g) Proposed Decisions are to be submitted via e-mail directly to the Arbitrator in Microsoft Word format. For Proposed Decisions, only the proof of service must be e-filed.

h) In any proceeding before the Commission, nothing in the application of the rules of evidence shall be applied in a manner that denies the admissibility of an electronic record or electronic signature. Information in the electronic record will be given due evidentiary weight by the Commission.

i) Any electronic document or record submitted to the Commission will be deemed filed if not rejected by the Commission. The transmission date and time shall govern the electronic file mark.

j) An e-filed document must not contain viruses or malware. The e-filing of a document constitutes a certification by the registered user that the document has been checked for viruses and malware.

k) All filed documents that are required to be maintained and preserved must be kept for one year after the appellate process period has been completed.

Section 9015.40 Signatures

a) When a signature is required, or when certain consequences are provided if a document is not signed, an electronic signature will suffice.

b) Any document electronically filed with a subscriber identifier is deemed to have been signed by the holder of the user identification and password.

c) The original signed document that has been electronically filed shall be maintained and preserved by the party filing the document and presented to the Commission upon its request.

d) Documents containing signatures of third parties may be filed electronically and shall bear a facsimile or typographical signature. If a document requires the signature of one or more persons not a party to the case or not registered for electronic filing, the subscriber must confirm all persons required to sign the document approve it. Original signatures of all nonregistered persons must be obtained before filing the document. The document must indicate the identity of each nonregistered signatory. The subscriber must retain the original document for one year after the date that the judgment has become final or the expiration of the time for seeking review. The subscriber must make the document available for inspection by the Commission upon request.

e) Documents filed electronically by a Commissioner or an Arbitrator under his or her identifier shall be deemed entered by that Commissioner or Arbitrator.

Section 9015.50 Service and Proof of Service

a) Electronic service is not capable of conferring jurisdiction. Documents requiring personal service to confer jurisdiction may not be served electronically.

b) All other documents may be served upon the other party or the party's representative electronically. The subscriber shall be responsible for completing electronic service of the documents. By registering in the electronic filing system, the subscribers consent to receipt of all other documents e-filed and e-served upon them.

c) Subscribers consent to receive all communication from the Commission, including but not limited to notice of hearing, orders, decisions, or any general correspondence via electronic filing. The Commission may also issue any Commission document via e-mail.

d) E-service shall be deemed complete as of the filed date and time listed by the e-file system. For the purpose of computing time for any party to respond, any document served is deemed to be served the next business day following the date of transmission.

e) The e-filing vendor is required to maintain an e-service list for each e-filed case.

Section 9015.60 Document Privacy and Errors in Electronic Filings

a) It is the responsibility of the filing party to insure that the documents filed electronically do not disclose private or confidential information.

b) The Commission shall not be liable for malfunction or errors occurring in electronic transmission or receipt of electronically filed or served documents.

c) If the electronic filing is not filed with the Commission for any of the causes listed in this subsection (c), the Commission may, upon satisfactory proof, enter an order permitting the document to be subsequently filed effective the date the filing was first attempted. The causes the Commission may consider in making this decision are:

1) an error in the transmission of the document to the vendor that was unknown to the sending party;

2) a failure to process the electronic filing when received by the vendor;

3) a rejection by the Commission;

4) other technical problems experienced by the filer;

5) the party was erroneously excluded from the service list.

d) In case of a filing error, absent extraordinary circumstances, anyone prejudiced by the Commission's order to accept a subsequent filing effective as of the date filing was first attempted shall be entitled to an order extending:

1) the date for any response; or

2) the period within which any right, duty or other act must be performed.

TITLE 50: INSURANCE
CHAPTER VI: WORKERS' COMPENSATION COMMISSION

PART 9020
PRE-ARBITRATION

Section

AUTHORITY: Implementing and authorized by Sections 16 and 19 of the Workers' Compensation Act [820 ILCS 305/16 and 19].

SOURCE: Filed and effective March 1, 1977; amended at 2 Ill. Reg. 49, p. 244, effective December 7, 1978; amended at 3 Ill. Reg. 4, p. 13, effective January 21, 1979; amended at 4 Ill. Reg. 26, p. 59, effective July 1, 1980; emergency amendment at 4 Ill. Reg. 41, p. 171, effective September 25, 1980, for a maximum of 150 days; amended at 5 Ill. Reg. 5530, effective May 12, 1981; emergency amendment at 6 Ill. Reg. 5820, effective May 1, 1982, for a maximum of 150 days; amended at 6 Ill. Reg. 8040, effective July 1, 1982; amended at 6 Ill. Reg. 11909, effective September 20, 1982; codified at 7 Ill. Reg. 2345; emergency amendment 8 Ill. Reg. 5986, effective August 16, 1984, for a maximum of 150 days; amended at 9 Ill. Reg. 16238, effective October 15, 1985; emergency amendment at 9 Ill. Reg. 19129, effective November 20, 1985, for a maximum of 150 days; amended at 10 Ill. Reg. 8096, effective May 5, 1986; amended at 15 Ill. Reg. 8221, effective May 17, 1991; amended at 17 Ill. Reg. 2206, effective February 16, 1993; amended at 20 Ill. Reg. 3842, effective February 15, 1996; recodified from 50 Ill. Adm. Code 7020 to 50 Ill. Adm. Code 9020 at 39 Ill. Reg. 9603; amended at 40 Ill. Reg. _____, effective _____.

Section 9020.10 Docketing and Numbering of Cases

a) All cases brought before the Illinois Workers' Compensation Commission (Commission) shall be docketed, time-stamped and given a letter, a number and the year of filing. All subsequent pleadings or correspondence should refer to this letter and number.

b) All documents filed with the Commission, including, but not limited to, Applications for Adjustment of Claim, Attorneys' Appearances, Motions and Petitions for Review, shall be served on all parties and shall have a certificate of service setting forth the time and manner of that service. A copy of all written communication addressed to the Commission with respect to a pending matter shall be sent to all parties at the time it is sent to the Commission; all such correspondence shall list the parties to whom copies have been sent. Any documents or written communication not submitted in compliance with this subsection constitutes an ex parte communication and therefore will be disregarded.

c) Upon presentation of paper documents at the Commission Office, the Commission will file and time stamp all documents presented for filing Monday through Friday, 8:30 a.m. to 5:00 p.m., except legal holidays. Electronically filed documents shall be filed in accordance with 50 Ill. Adm. Code 9015.30.

(Source: Amended at 40 Ill. Reg. _____, effective _____)

Section 9020.20 Application for Adjustment of Claim

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

b) An Application must be limited to one accident or claim. After an Application has been filed with the Commission, any other Applications for Adjustment of Claim covering that accident, but naming a different employer, shall be assigned the same docket number as the original Application.

c) Applications shall be completed in full and must provide an accident or manifestation of injury date, a description of how the accident occurred, the part of the body injured, the geographical location of the accident for purposes of establishing venue, and a description of how notice of the accident was given or acquired by the employer.

d) Once an Application is filed, the Commission will send the information on the Application, on a Notice of Hearing, to the opposing party at the address supplied by the filing party. If the Notice is returned to the Commission because the filing party has supplied the wrong address for the opposing party, the Commission will so inform the filing party. The filing party has the obligation of providing the Commission with the proper address so Notice can be sent to the opposing party.

e) Applications may be amended prior to a hearing on the merits by filing an Amended Application for Adjustment of Claim under the letter and number given the original Application. The Amended Application must be clearly labeled "Amended" with all changes clearly marked on all copies and must have attached to it all prior versions of the Application for Adjustment of Claim. Also attached must be proof that the filing party has served a copy of the Amended Application on the opposing party in the manner set forth in Section 9020.70. It shall be within the discretion of the Commission whether to allow any amendments to the Application after the commencement of a hearing on the merits.

(Source: Amended at 40 Ill. Reg. _____, effective _____)

Section 9020.30 Memorandum of Names and Addresses for Service of Notice and Attorneys' Appearance

a) Each party, upon instituting or responding to any proceedings before the Commission, shall file and timely update with the Commission, his/her address or the names and addresses of any agent upon whom notices shall be served, either personally or by regular mail, addressed to the party or agent at the last address filed with the Commission.

b) An Appearance, on forms provided by the Commission, shall be filed by any attorney or law firm representing any party in any proceedings before the Commission. Appearances filed by the Petitioner's attorney shall be accompanied by an Attorney Representation Agreement, on a form prescribed by the Commission, completely filled out and signed by the Petitioner and the attorney. No attorney or law firm will be recognized in any case before the Commission unless the attorney or the attorney's firm has duly entered a written Appearance. A subsequent attorney wishing to appear on an existing claim may file a Motion for Substitution of Counsel or a Motion to Seek Leave to File an Appearance, supported by a properly executed Attorney Representation Agreement and with proper notice to all parties and attorneys of record. When an Appearance has been duly filed by a law firm, any attorney member of that firm may appear and be recognized by the Commission. No party or insurance carrier may file an Appearance on behalf of an attorney or law firm.

c) Once an Appearance has been filed, Leave to Withdraw can only be had upon written order of the Commission or a duly designated Arbitrator of the Commission following appropriate notice to the client and the opposing side. Substitution of Counsel may be had by filing with the Commission and serving on the opposing party a notification of the substitution, signed by the attorney of record, the substituted attorney and the client.

(Source: Amended at 40 Ill. Reg. _____, effective _____)

Section 9020.40 Who May Appear-Unauthorized Practice

a) Only attorneys licensed to practice in the State of Illinois may appear on behalf of parties to litigation before the Commission. This specifically includes presentation of Settlement Contracts and Lump Sum Petitions. Attorneys licensed to practice in states other than Illinois may appear with leave of the Commission.

b) For routine matters, such as agreed continuances or other agreed ministerial acts, persons other than licensed attorneys shall be permitted to appear on behalf of a party at the status call.

c) Violations of this Section may be referred to the Attorney Registration & Disciplinary Commission in accordance with the Supreme Court rules.

(Source: Amended at 40 Ill. Reg. _____, effective _____)

Section 9020.50 Hearing: Place; Change of Venue

a) Except to the extent modified by Section 9020.80 in reference to proceedings under Section 19(b-1) of the Workers' Compensation Act [820 ILCS 305/19(b-1)] (Act), the provisions of subsection (b) apply:

b) Upon receipt of an Application for Adjustment of Claim, the Commission will fix a date and place for initial status before an Arbitrator of the Commission in accordance with the applicable Act. The place designated shall be a hearing site located in or nearest geographically to the vicinity in which the alleged accident or exposure occurred. However, the Commission may assign a different Arbitrator to balance Arbitrator caseloads at each hearing site. When the accident occurs outside the State of Illinois and the applicant resides in Illinois, the case shall be set at the hearing site geographically nearest to where the applicant resides. When the accident occurred outside of Illinois and the applicant resides outside of Illinois, the case shall be set at a hearing site most convenient to the parties.

c) Designation of a hearing site other than as provided in this subsection may be had upon showing to the Commission of extreme hardship worked upon a party or parties by the designated site, or by agreement of the parties. Absent agreement, any party seeking a change of venue may present a Motion for Change of Venue, setting forth the basis for the change.

(Source: Amended at 40 Ill. Reg. _____, effective _____)

Section 9020.60 Continuances on Arbitration, Notices, Monthly Status Calls, Voluntary Dismissal

a) Continuances on Arbitration; Notices
Written notices will be sent to the parties for the initial status call setting on Arbitration only. Thereafter, cases will be continued for 3 month intervals, or at other intervals upon notice by the Commission, until the case has been on file at the Commission for 3 years, has been set for trial pursuant to 50 Ill. Adm. Code 9030.20, or otherwise disposed of. The parties must obtain any continued status call dates from Commission records.

b) Monthly Status Calls

1) Each Arbitrator, subject to his or her availability, shall hold a monthly status call of cases that appear on the Arbitrator's docket that month.

A) In Cook County, each Arbitrator's monthly status call shall be held at 2:00 p.m. or at a time, date and place designated by the Chairman.

B) In areas outside of Cook County, each Arbitrator's monthly status call shall be held at 9:00 a.m. or at a time, date and place designated by the Chairman.

2) The monthly status call shall be conducted by an Arbitrator as follows:

A) Cases shall be called in the order that they appear on the monthly status call.

B) Cases will be continued in accordance with subsection (a) unless a request for a trial date is made in accordance with 50 Ill. Adm. Code 9030.20. A request for a trial date may be made in a case that does not appear on the monthly status call if:

i) a Petition under Section 19(b) of the Act has been filed in accordance with Section 9020.80(a);

ii) death benefits under Section 7 of the Act or permanent total disability benefits under Section 8 of the Act are claimed; or

iii) special circumstances exist that, in the opinion of the

Arbitrator, would warrant advancing the case for trial. The moving party must set forth in his or her motion the basis of the claimed special circumstance.

C) Motions for trial dates under subsection (b)(2)(B) shall be presented at the conclusion of the status call.

D) Cases on File 3 or More Years

i) In all cases that have been on file at the Commission for 3 years or more, the parties or their attorneys must be present at each status call at which the case appears. The case will be set for trial or dismissed unless a written request has been made to continue the case for good cause. The request shall be made part of the case file. The written request must be received by the Arbitrator at least 15 days in advance of the status call date and contain proof of service showing that the request for a continuance was served on all other parties to the case and/or their attorneys. Any objection to a continuance in the case must be received by the Arbitrator at least 7 days prior to the status call date and contain a similar proof of service. The Arbitrator shall rule on the requests for continuances or objections to the requests at the status call.

ii) Failure of the Petitioner or the Petitioner's attorney to request or answer a request for a continuance in accordance with subsection (b)(2)(D)(i) and to appear at the monthly status call at which the case appears shall result in the case being dismissed for want of prosecution.

iii) When the Arbitrator has set the matter for trial, the case shall proceed on the date set by the Arbitrator.

E) Section 19(b-1) Pretrials, Motions, Pro Se Settlement Contracts

i) In Cook County, each Arbitrator will hear motions and conduct pre-trial hearings on Petitions filed under Section 19(b-1) of the Act beginning at 8:45 a.m. on the monthly status call date. The Arbitrator shall hear other motions at the conclusion of the monthly status call. Pro se settlements may be presented on the morning of any monthly status call or on days designated by the Arbitrator.

ii) In all areas outside of Cook County, the Arbitrator will hear motions and conduct pre-trial hearings on Petitions filed under Section 19(b-1) of the Act, and hear other motions, at the conclusion of the monthly status call. Pro se settlement contracts may be presented at the conclusion of any monthly status call or on days designated by the Arbitrator.

c) Voluntary Dismissals

1) Any party may voluntarily dismiss his or her claim or any Petition or motion filed on his or her behalf upon motion signed by the party, if unrepresented, or his or her attorney of record.

2) A party may file a motion to dismiss his or her claim or any Petition or motion filed on his or her behalf without the signature of his or her attorney of record. The moving party must serve themotion on his or her attorney and the opposing party, in the manner set forth in Section 9020.20(a), and set the motion for hearing as set forth in Section 9020.70. In these cases, there shall be no disposition of the claim on its merits prior to the disposition of the motion.

(Source: Amended at 40 Ill. Reg. _____, effective _____)

Section 9020.70 Motion Practice, General

a) Form of Motions
All motions, except motions made during an Arbitration or Review hearing, motions for a continuance of cases in the regular review call, and petitions filed under Section 19(h) and/or Section 8(a) of the Act must be accompanied by a Commission form entitled Notice of Motion and Order and must be served on the Arbitrator or Commissioner and all other parties in accordance with subsection (b). All such motions must set forth the date on which the moving party will appear before the Arbitrator or Commissioner to present the motion and must include the type of motion and nature of the relief sought. A Notice of Motion and Order not accompanied by the motion may be stricken.

1) Motions on Arbitration

A) Motions requesting a trial date will be heard during the status call in accordance with Section 9020.60(b)(2).

B) All other motions will be heard in accordance with Section 9020.60(b)(2)(E). Each arbitrator will hear all motions, other than motions requesting a date certain for trial, on any case assigned to the Arbitrator, even if it does not appear on the status call.

2) Commissioners' Review Calls
Each Commissioner will hear motions at the hearing location on the days designated by the Commission.

b) Notice; Service of Papers; Proof of Service; and Waiver of Notice.

1) Notice and Service of Papers

A) For all motions except Petitions for Immediate Hearing and motions requesting a date for trial, notices of motion shall be in writing and shall be served upon the Arbitrator or Commissioner and the attorney of record of all other parties or, when any other party is not represented by counsel, upon the party himself, by personal or office delivery or by mailing of a copy of the notice with copies of the supporting papers. The service, if by personal or office delivery, shall be effected 5 days preceding the day of the status call set forth in the notice, exclusive of any intervening Saturday, Sunday or legal holiday. If service is had by mail, then the envelope enclosing a copy of the notice and supporting papers

shall be deposited in the post office or post office box at least 10 days before the motion is to be heard, exclusive of any intervening Saturday, Sunday or legal holiday.

B) Motions for an immediate hearing under Section 19(b) of the Act and motions requesting a date for trial shall be served on the Arbitrator and on all other parties 15 days preceding the status call date set forth in the notice.

C) Proof of service of notices or other papers shall be affixed:

i) in any case, by written acceptance of service;

ii) in case of service by delivery, by affidavit of the person delivering or leaving the papers; and

iii) in case of service by mail, by affidavit of the person depositing the papers in the mail. The affidavit shall state the time and place of mailing, the complete address that appeared on the envelope, and the fact that proper postage was prepaid.

D) When the opposite party has not appeared within the time fixed by rule, or has appeared but failed to designate a place for service, service may be directed to that party's last known business or residence address.

2) Waiver
Parties may waive the requirements of notice, service and proof of service.

c) Who Shall Hear Motions

1) When a cause is pending on the Arbitration call, all motions and settlement contracts, except when expressly otherwise provided in the Rules of the Commission (50 Ill. Adm. Code Ch. VI), shall be heard by the Arbitrator to whom the case has been assigned. If that Arbitrator is unavailable, the Commission may assign the motion or settlement contract to another Arbitrator for disposition.

2) When a cause is pending on Review, but not yet assigned to a specific Commissioner, all motions shall be assigned to a sitting Commissioner. Once the cause has been assigned to a particular Commissioner for hearing, that Commissioner shall hear all motions relative to the case.

(Source: Amended at 40 Ill. Reg. _____, effective _____)

Section 9020.80 Petitions for Immediate Hearing

a) Petition for Immediate Hearing Under Section 19(b)

1) In a Petition alleging that the Petitioner is not receiving benefits under Section 8(a) and/or 8(b) of the Act to which he or she is entitled, the Petitioner may file a Petition for Immediate Hearing, as provided for in Section 19(b) of the Act, on an appropriate form provided by the Commission. The Petition shall set forth:

A) a description of the attempts by parties or counsel to resolve the dispute requiring an immediate hearing, including the name of the representative of the opposing party with whom the Petitioner or his or her attorney has conferred, the date of the conference, and the result of the conference;

B) a statement that a signed physician's report of recent date relating to the employee's current inability to work, or a description of such other evidence of temporary total disability as is appropriate under the circumstances, has been delivered to the Respondent.

2) A response to the Petition shall be filed on an appropriate form provided by the Commission within 15 days after service of a Petition for Immediate Hearing. Failure to respond timely or in good faith may result in the assessment of the attorneys' fees under Section 16 of the Act. The Petition for Immediate Hearing shall be filed and heard in accordance with Section 9020.70.

3) The Arbitrator to whom the case is assigned shall attempt to resolve the matter informally. If the matter cannot be resolved at that time, and the Arbitrator determines the Petitioner is not receiving benefits as provided in subsection (a)(1), the Arbitrator shall order the case to formal hearing.

b) Petition for Immediate Hearing under Section 19(b-1).

1) Filing Petition for Emergency Hearing under Section 19(b-1)
An employee alleging that he or she is unable to work because of disability compensable under the Act or the Workers' Occupational Diseases Act [820 ILCS 310], and not receiving temporary total disability and/or medical, surgical or hospital benefits to which he or she is entitled under Section 8(a) or 8(b) of the Act, may file a Petition for Immediate Hearing before an Arbitrator as provided for in Section 19(b-1) of the Act.

The Petition shall be filed on an appropriate form provided by the Commission and must comply with all requirements of the Act.

2) Section 19(b-1) Proceedings before Arbitrators: Pre-trial Conferences

A) The Arbitrator will hold a pre-trial conference within 20 days after the Petition for Emergency Hearing is filed. If the venue is outside of Cook County, the pre-trial conference will be held at either the regularly scheduled hearing site or at another hearing site for the same Arbitrator available within that time period and located as close as practical to the original hearing site. Notice of pre-trial conference will be sent by the Commission to all parties of record.

B) Any challenges to the sufficiency of the Section 19(b-1) Petition will be heard at the pre-trial conference.

C) If the Section 19(b-1) Petition is found by the Arbitrator to be insufficient, the Arbitrator will allow the Petitioner 5 business days to cure all insufficiencies, and all time limits under the statute are tolled until the Arbitrator has determined that the amended Petition is sufficient. During this time period, the amended Section 19(b-1) Petition, with proof of service to opposing party, shall be filed with the Commission. If the insufficiencies are not cured within the time limit, the Section 19(b-1) Petition will be dismissed without prejudice by the Arbitrator and notices of the dismissal will be sent by the Commission to all parties of record.

D) If, within the time period provided in subsection (b)(2)(C), the insufficiencies are cured and the parties have not received from the Commission notices of dismissal of the Section 19(b-1) Petition, the Respondent shall have 15 days from receipt of the amended Section 19(b-1) Petition to respond.

3) Section 19(b-1) Hearing, Decisions, and Transcripts

A) Hearings

i) If, at the pre-trial conference, the Arbitrator finds the Section 19(b-1) Petition to be sufficient, he or she will set the case to be tried within 15 days at either the regularly scheduled hearing site or at another hearing site for the same Arbitrator available within that time period and located as closely as practical to original hearing site.

ii) If the Section 19(b-1) Petition is insufficient, the Arbitrator will set the case to be tried within 35 days after the pre-trial conference at either the regularly scheduled hearing site for the same Arbitrator or at another hearing site for the same Arbitrator available within the time period and located as closely as practical to the original hearing site. If, within the time period provided in subsection (b)(2), the insufficiencies are cured and the parties have not received from the Commission notices of dismissal of the Section 19(b-1) Petition, the trial will be held as scheduled.

iii) Proofs are to be closed within 45 days after a Section 19(b-1) Petition, or an amended Petition curing any insufficiencies as provided in subsection (b)(3)(A)(ii) is filed, unless for good cause the Arbitrator extends the time for closing proofs for an additional period or periods not to exceed a total extension period of 30 days. Good cause is defined as, but not limited to, additional medical records needed and taking of depositional evidence.

B) Arbitrator Decision

The Arbitrator's decision is to be filed with the Commission within 25 days after proofs are closed. The Arbitrator's decision shall contain the final cost of the arbitration transcript, or the estimated cost of the transcript if the final cost is not available at the time the Arbitrator's decision is issued.

C) Transcripts

i) At the beginning of each hearing at which a record is made, the Arbitrator shall state the following for the record:

Upon the closing of proofs, at the request of any party, the Arbitrator shall order the Court Reporter to prepare an original transcript of this hearing, to be authenticated by the Arbitrator for use by the Commission in the event it is required for further proceedings, including any proceedings for a review of the Arbitrator's decision. The parties may order copies of the transcript of today's hearing at the close of the hearing, to be charged at the rate provided in Section 16 of the Workers' Compensation Act for copies of transcript. Each party shall pay the cost of its copy. If a

Petition for Review is filed, the appealing party shall pay the cost of the original transcript. If no Petition for Review is filed, the parties shall pay the cost of the original transcript, to be divided equally among the parties. At the close of each day's hearing on Arbitration, the Court Reporter shall provide an estimate of the cost of preparing the transcript. The estimated cost of the transcript may not be the final cost of the transcript for which a party is liable. If the party orders the transcript at a later time, it is unlikely it will be received in sufficient time for use in preparation of the party's Statement of Exceptions and Supporting Brief, or a response to that statement, in the event either party files a Petition for Review of the Arbitrator's decision. If the original is not on file, in the event a transcript is ordered, it will be prepared as an original and the party will be charged at a rate provided for in Section 16 of the Workers' Compensation Act. The Commission will not consider the unavailability of the transcript good cause for the failure to file a timely Statement of Exceptions and Supporting Brief, or a response to that statement.

ii) When the transcript of proceedings has been ordered pursuant to subsection (b)(3)(C)(i), the transcript shall be authenticated by the Arbitrator and a copy of the statement of the final cost of the preparation of the transcript shall be filed by the Court Reporter at the Commission within 25 days after proofs are closed. When the transcript of the proceedings is ordered at the time a Petition for Review is filed and the transcript has been received, the transcript shall be authenticated and filed pursuant to subsection (b)(4)(A)(iii).

4) Section 19(b-1) Proceedings before the Commission

A) Perfecting a Review
A Petition for Review must be filed in duplicate at the Commission within the time provided by Section 19 of the Workers' Compensation Act. The Petition must contain or be accompanied by the following:

i) A Certificate of Service on the opposing party by personal service or certified mail;

ii) A certification that payment for the transcript in the amount set forth in the Arbitrator's Decision has been made to the Court Reporter. The Petition shall be accompanied by a copy of the check or money order sent to the Court Reporter. When the amount paid is an estimate, the balance of the cost, if any, shall be paid upon receipt of the statement from the Court Reporter setting forth the final cost of the transcript. An order entered pursuant to Section 20 of the Workers' Compensation Act may be submitted for payment of the transcript;

iii) An order for the transcript of proceedings at Arbitration, when the transcript was not ordered at Arbitration. The transcript of proceedings authenticated by the Arbitrator shall be filed by the Court Reporter at the Commission within 25 days after the filing of the Petition for Review.

iv) A statement of Appellant's specific exceptions to the Arbitrator's Decision; attachment of the Statement of Exceptions and Supporting Brief required by subsection (b)(4)(B) will satisfy this requirement.

B) Statement of Exceptions and Supporting Brief

i) Any party filing a Petition for Review with the Commission shall file a Statement of Exceptions and Supporting Brief with attached proof of service within 15 days after the filing of the Petition for Review. If the Appellee elects to file a response to the Petition, the response must be filed and served on the opposing party within 15 days after the last day allowed for the filing of the Appellant's Statement of Exceptions and Supporting Brief. Each party filing a Statement of Exceptions and Supporting Brief, or a response, shall file 3 copies. The Statement of Exceptions and Supporting Brief, or response, shall be written or printed on one side of no more than 20 8½ x 11" sheets of paper or contain no more than 5,200 words, whichever is greater, and shall follow the format set forth in 50 Ill. Adm. Code 9040.70(a). Failure of any appellant or petitioning party to file timely a Statement of Exception(s) and Supporting Brief may result in denial of oral argument.

ii) Timely filing shall be shown by: the date file stamped on the document at the time of receipt by the Commission at its office in Chicago, Illinois; a legible postmark date at least 2 calendar days prior to and exclusive of the date on which the document was due to be filed in accordance with this Section, applied by the U.S. Postal Service, and not by a party, to the envelope in which the document is received by the Commission at its office in Chicago, Illinois, or the date applied by the U.S. Postal Service to a certified or registered mail receipt bearing the same certification or registry number as the envelope in which the document was received by the Commission at its offices in Chicago, Illinois, showing a date of mailing that is not less than 2 calendar days prior to and exclusive of the date on which document was due to be filed. If the date required for filing or mailing falls on a Saturday, Sunday, or holiday, the time for filing or mailing shall be the next date that is not a Saturday, Sunday or holiday. Electronically filed documents shall be filed in accordance with 50 Ill. Adm. Code 9015.30.

C) Hearing on Review and Oral Arguments
No Hearing on Review will be held by the Commission. Immediately after the Petition for Review has been filed, it will be assigned to a Commissioner who will promptly schedule the case for oral argument before a panel of 3 Commissioners, as provided in Section 19(e) of the Act.

D) The Commission shall file its decision no more than 90 days after the filing of the Petition for Review, and not later than 180 days after the filing of the Petition under Section 19(b-1) of the Act, whichever is sooner.

5) Service in Section 19(b-1) Proceedings
All service required pursuant to this Section must be by personal service or certified mail with return receipt. After initial service to the employer, service shall be made on the employer's attorney or designated representative.

(Source: Amended at 40 Ill. Reg. _____, effective _____)

Section 9020.90 Petitions to Reinstate

a) When a cause has been dismissed from the Arbitration call for want of prosecution, the parties shall have 60 days from receipt of the dismissal order to file a Petition to Reinstate the cause onto the Arbitration call. Notices of dismissal shall be sent to the parties.

b) Petitions to Reinstate must be in writing. The Petition shall set forth the reason the cause was dismissed and the grounds relied upon for reinstatement. The Petition must also set forth the date on which the Petitioner will appear before the Arbitrator to present the Petition. A copy of the Petition must be served on the other side at the time of filing with the Commission in accordance with the requirements of Section 9020.70. The Respondent may file a response to the Petition.

c) Petitions to Reinstate shall be docketed and heard by the same Arbitrator to whom the case is assigned. Both parties must appear at the time and place set for hearing. Parties will be permitted to present evidence in support of, or in opposition to, the Petition. The Arbitrator shall apply standards of fairness and equity in ruling on the Petition to Reinstate and shall consider the grounds relied on by the Petitioner, the objections of the Respondent, and the precedents set forth in Commission decisions. A record shall be made of a hearing on any contested Petition.

d) A cause shall be reinstated upon stipulation of the parties filed with the Commission, which will docket the stipulation.

e) Nothing in this Section abridges the rights found in the applicable Statute of Limitations of the Illinois Workers' Compensation Act (Section 6(d) of the Act) or Section 6(c) of the Illinois Occupational Diseases Act.

(Source: Amended at 40 Ill. Reg. _____, effective _____)

Section 9020.100 Medical Examinations

a) Notice of Medical Examination
The petitioner need not present himself for any examination requested by the respondent unless the name and address of the examining physician and surgeon is furnished the petitioner in writing at the time the request for such examination is made.

b) Cost to Petitioner
The costs and expenses incurred by the petitioner as a result of submitting to an examination requested by the respondent shall be reimbursed him in the manner and amount provided in Section 12 of the applicable act.

c) Impartial Medical Examination

1) The Commission may order an impartial medical examination pursuant to Section 19(c) of the Act. The Secretary of the Commission shall notify the Illinois State Medical Society in writing that an impartial medical examination has been ordered by the Commission and shall state the name and address of the person to be examined, the nature of the disputed condition and the type of medical specialist required. The Illinois State Medical Society shall select an impartial physician and arrange the time and place of the examination and shall notify the secretary of the Commission. The Secretary shall notify the parties and the impartial examining physician of time and place of the examination.

2) The impartial examining physician shall examine the Petitioner named in the order and shall transmit his signed report to the Secretary and the attorneys for the parties within 20 days of the examination. At the same time the physician shall return to the Secretary all the records and the data listed in the order and a statement for fees.

3) Either party may request the testimony of the impartial examining doctor. The doctor shall be subject to cross-examination by each party. If the testimony of the physician is requested, the impartial medical physician shall not be subpoenaed. The parties shall notify the Secretary of the request for testimony and the Secretary shall notify the physician and all parties of when and where the physician is to testify. The Commission may order the testimony of the physician by deposition only.

4) Attorneys are to avoid direct contact with the impartial examining physician.

(Source: Rule 2(10) (now Section 9020.100) renumbered from rule 2(9) at 6 Ill. Reg. 11909, effective September 20, 1982)

TITLE 50: INSURANCE
CHAPTER VI: WORKERS' COMPENSATION COMMISSION

PART 9030
ARBITRATION

Section

AUTHORITY: Implementing and authorized by the Workers' Compensation Act [820 ILCS 305] and the Workers' Occupational Diseases Act [820 ILCS 310].

SOURCE: Filed and effective March 1, 1977; amended at 4 Ill. Reg. 26, p. 159, effective July 1, 1980; emergency amendment at 5 Ill. Reg. 8547, effective August 3, 1981, for a maximum of 150 days; amended at 6 Ill. Reg. 3570, effective March 22, 1982; emergency amendment at 6 Ill. Reg. 5820, effective May 1, 1982, for a maximum of 150 days; amended at 6 Ill. Reg. 8040, effective July 7, 1982; amended at 6 Ill. Reg. 11909, effective September 20, 1982; codified at 7 Ill. Reg. 2514; amended at 9 Ill. Reg. 19722, effective December 6, 1985; emergency amendment at 14 Ill. Reg. 4913, effective March 9, 1990, for a maximum of 150 days; emergency expired August 6, 1990; amended at 14 Ill. Reg. 13141, effective August 1, 1990; amended at 15 Ill. Reg. 8214, effective May 17, 1991; amended at 20 Ill. Reg. 4053, effective February 15, 1996; amended at 36 Ill. Reg. 17913, effective December 4, 2012; recodified from 50 Ill. Adm. Code 7030 to 50 Ill. Adm. Code 9030 at 39 Ill. Reg. 9605; amended at 40 Ill. Reg. 15732, effective November 9, 2016.

Section 9030.10 Arbitration Assignments

a) In cases arising in Cook County, cases shall be assigned at the time of the First Notice of Hearing to Arbitrators on a random basis.

b) In cases arising outside Cook County, cases shall be assigned to an Arbitrator, on a random basis, at the time of the First Notice of Hearing, depending on the place of the accident. Each Arbitrator outside Cook County shall be given a zone.

c) All assignments on Arbitration are final, except as otherwise provided in Section 14 of the Workers' Compensation Act [820 ILCS 305] (Act), Section 9030.30 of this Part, and 50 Ill. Adm. Code 9070.40, or when consolidation with a previously filed case is required.

d) In the event a Petitioner has an Application for Adjustment of Claim pending and files one or more Applications for Adjustment of Claim against the same Respondent, or against different Respondents alleging accidental injuries to the same part of the body, subsequent cases shall, on motion of any party, be assigned to the Arbitrator of the case filed first. However, the Commission may make an exception based on a showing of good cause by the objecting party.

e) When more than one Petitioner files a claim against the same Respondent relating to the same accident, the cases may be consolidated, upon the motion of any party. The Arbitrator assigned to the case filed first shall determine whether consolidation would promote consistency and efficiency of administration. Motions to consolidate must be heard by the Arbitrator that is assigned to the earliest filed claim.

f) If a case is dismissed or otherwise closed and the Petitioner files an Application for Adjustment of Claim relating to the same accident, the case will be assigned to the Arbitrator assigned to the first case filed involving that accident.

(Source: Amended at 40 Ill. Reg. 15732, effective November 9, 2016)

Section 9030.20 Setting a Case for Trial

a) A written request for a date certain for trial may be made by any party at the monthly status call on which the case appears. A request for a trial date in a case that does not appear on the monthly status call may only be made in accordance with 50 Ill. Adm. Code 9020.60(b)(2)(B).

b) If the parties, by agreement, request a trial date, the Arbitrator shall assign a specific date and time for trial. A pre-trial conference may be held by the Arbitrator. Either party may request a pre-trial conference prior to the start of trial.

c) The motions for trial dates shall be filed and heard pursuant to 50 Ill. Adm. Code 9020.70 and 9020.60.

1) The Arbitrator shall set the matter for trial on a date certain if:

A) the Arbitrator determines that proper and timely 15 days notice was given of the motion for trial date to the opposing party;

B) the opposing party was provided with a completed Request for Hearing;

C) the case appears on the monthly status call on the date the motion is heard, or if the case is not on the status call, the Arbitrator has determined that the case falls within the exceptions in 50 Ill. Adm. Code 9020.60(b)(2)(B); and

D) the Arbitrator determines that the matter should proceed to trial.

2) If any party fails, without good cause, to appear, the Arbitrator will hear the motion for trial date ex parte and, if the Arbitrator determines the matter is ready for trial, will set a trial date convenient to the Arbitrator and the party that appeared. The party that appeared shall notify the opposing party of the trial date.

d) On each trial day, each party or, if represented, the party's attorney of record must appear before the Arbitrator between 8:45 a.m. and 9:30 a.m. During this time period, the Arbitrator may establish the order in which cases shall proceed that day. The Arbitrator may give priority to cases in which a Petition under Section 19(b) or 19(b-1) of the Act has been filed, death benefits under Section 7 of the Act or permanent total disability benefits under Section 8 of the Act are claimed,

or other cases in which special circumstances exist that, in the opinion of the Arbitrator, warrant granting priority to the case in the trial order. Request for Hearing forms must be completed, signed and submitted to the Arbitrator prior to the beginning of the hearing in the case.

e) Failure of the Petitioner to appear before 9:30 a.m. may bar the case from being heard that day or may result in dismissal of the claim. Failure of the Respondent to appear may result in an ex parte hearing on the merits of the claim.

f) On each trial day, the Arbitrator shall begin hearing cases at 9:30 a.m., after establishing the order in which cases will proceed. Any party who requests a date certain for trial must be prepared, absent good cause shown, to proceed to trial. On the trial day, parties may report the case settled or request a continuance . If the moving party does not respond when the case is called for trial by the Arbitrator, the case may be placed at the end of the trial order.

g) Bifurcated hearings will be allowed only for good cause. Examples of good cause include, but are not limited to, situations in which the number or location of witnesses makes it impossible to conclude the hearing in one day or the testimony of a witness must be taken prior to a deposition. All cases, except those heard under Section 19(b-1) of the Act, should be concluded within 3 months after the first hearing date or the Arbitrator will close proofs, absent good cause shown, and render a decision.

(Source: Amended at 40 Ill. Reg. 15732, effective November 9, 2016)

Section 9030.40 Request for Hearing

Before a case proceeds to trial on Arbitration, the parties (or their counsel) shall complete and sign a form provided by the Workers' Compensation Commission called Request for Hearing. However, in the event a party (or counsel) fails or refuses to complete and sign the document, the Arbitrator, in his or her discretion, may allow the case to be heard and may impose upon that party whatever sanctions permitted by law the circumstances may warrant. The completed Request for Hearing form, signed by the parties (or counsel), shall be filed with the Arbitrator as the stipulation of the parties and a settlement of the questions in dispute in the case.

(Source: Amended at 40 Ill. Reg. 15732, effective November 9, 2016)

Section 9030.50 Subpoena Practice

a) Issuance
A blank form of subpoena for the attendance of witnesses or the production of documents will be furnished by the Secretary of the Commission upon request of the parties or their attorneys.

b) Use
Unless otherwise agreed by the parties, witnesses or documents may only be subpoenaed to appear or be produced at the time and place set for hearing of the cause.

c) Service
Service of the subpoena is required and payment of the statutory fee and travel expense (see Sections 16 and 20 of the Act and 705 ILCS 35/4.3) must accompany the service.

d) Failure to Honor Subpoena

1) Upon failure of any person, firm or organization to obey a subpoena of the Commission, a party seeking enforcement of the subpoena (or counsel) shall prepare an Application to the Circuit Court of the county in which the hearing or claim is pending requesting enforcement of the subpoena pursuant to Section 16 of the Act. The party seeking enforcement shall present, file and serve on the opposing party the Application, together with the original subpoena and proof of service to the Arbitrator or Commissioner designated to hear the claim. If no Arbitrator or Commissioner has been designated, the Application shall be presented to the Chairman of the Commission.

2) A hearing under 50 Ill. Adm. Code 9020.70 shall be held at which the Commissioner or Arbitrator to whom the Application is presented shall determine if the subpoena requested relevant information and was properly issued and served, and if the Application is proper in form. If the Commissioner or Arbitrator so finds, he or she shall sign the Application. The party seeking enforcement of the subpoena (or counsel) may then file and prosecute the Application in the Circuit Court.

(Source: Amended at 40 Ill. Reg. 15732, effective November 9, 2016)

Section 9030.60 Depositions

a) Evidence depositions of any witness may be taken before a hearing, by stipulation of the parties. If there is no agreement as to the deposition, the Arbitrator or Commissioner shall hold a hearing and may issue an order, called a dedimus potestatem, pursuant to Section 16 of the Act. In ruling on an Application for Dedimus Potestatem, the Arbitrator or Commissioner shall give consideration to the judgment of the applicant. Evidence depositions of any witness may be taken after the hearing begins only by stipulation of the parties or upon Order of the Arbitrator or Commissioner, for good cause shown. Except as provided in subsection (f), an Application for Dedimus Potestatem shall be in writing and shall contain the following:

1) The reasons for the issuance of the dedimus potestatem, clearly and concisely stated.

2) The date upon which the dedimus should be issued and the name and address of the party to whom the dedimus is to be directed.

3) The names and addresses of the witnesses whose depositions are sought to be taken.

4) A statement as to whether the depositions are to be taken by oral or written interrogatories. The written application shall be made either upon a printed form prescribed and furnished by the Commission or in a similar document prepared by the party applying for the dedimus.

b) The time for taking depositions pursuant to the issuance of the dedimus potestatem shall be on a date set not less than 10 days after the issuance of the dedimus potestatem.

c) Notice and Objection

1) Except as provided in subsection (f), no dedimus potestatem shall be issued unless a copy of the Application, together with all documents required by this Section to be attached to the Application, has been served on the opposing party and proof of service of the copy has been made as provided in 50 Ill. Adm. Code 9020.70.

2) The opposing party may, within 5 days after the receipt of the copy of the Application, file written objections to the issuance of the dedimus potestatem. The Arbitrator or Commissioner shall rule on the objections

before the issuance of the dedimus potestatem.

d) Except as provided in subsection (f), notice of the issuance of the dedimus potestatem shall be given in sufficient time so that the receipt of the copy of the dedimus potestatem shall not be less than 10 days before the date set for the taking of the deposition. If the deposition is to be taken by written interrogatories, those interrogatories shall be filed in triplicate with the Application for Dedimus Potestatem and a copy of the interrogatories shall be attached to the copy of the dedimus potestatem mailed to each party. If cross-interrogatories are desired, they shall be filed with the Commission not more than 5 days after the receipt of the written interrogatories, and the party filing them shall mail a copy, within the same period of time, to the applicant for dedimus potestatem.

e) No dedimus potestatem shall be issued to take the depositions of any medical witnesses:

1) when the party applying for the dedimus potestatem has refused or failed to comply with the provisions of Section 12 of the Act; and

2) unless the applying party served the other side with a signed report of the medical witness (other than a treating physician) giving his or her findings and conclusions.

f) Exceptions

1) However, when it is shown that, by complying with the time requirements prescribed in this Section, the party seeking the dedimus may be deprived of the evidence sought to be obtained by the deposition, the Arbitrator or Commissioner to whom a case has been assigned for hearing may, in his or her discretion:

A) on notice and hearing before trial, waive or reduce the requirements; or

B) permit a party to present an oral Application for a dedimus potestatem immediately before or during trial and, after due consideration of the Application and any objections to the Application that may be orally raised by the opposite party, rule upon the Application.

2) When a dedimus potestatem is issued upon oral application, the hearing officer shall allow the parties reasonable time to complete the deposition and submit the transcript of the deposition before closing proofs in the

case.

g) When any party takes an evidence deposition, that deposition shall be filed and become part of the record as an exhibit of the party who applied for the dedimus to take the deposition, unless the parties agree otherwise.

h) All objections to questions propounded or answers adduced in the evidence deposition shall be fully explained on the record of the deposition. It shall be the duty of the hearing officer to note his or her ruling on each objection in the margin of the transcript of the deposition or at a hearing on the record.

(Source: Amended at 40 Ill. Reg. 15732, effective November 9, 2016)

Section 9030.70 Rules of Evidence

a) The Illinois Rules of Evidence shall apply in all proceedings before the Commission, either upon Arbitration or Review, except to the extent they conflict with the Act, the Workers' Occupational Diseases Act [820 ILCS 310], or the Rules Governing Practice Before the Workers' Compensation Commission (50 Ill. Adm. Code Chapter VI).

b) Exhibits offered in evidence, whether admitted or rejected, shall be retained by the assigned Arbitrator or Commissioner until a decision is issued in the matter. Exhibits may not be removed by the parties. Once a final decision is rendered, exhibits shall be retained by the Commission pursuant to the requirements of Section 17 of the Act.

(Source: Amended at 40 Ill. Reg. 15732, effective November 9, 2016)

Section 9030.80 Briefs, Arbitrators' Decisions

a) At the close of proofs, the Arbitrator may require that each party tender a proposed decision or a brief within 14 days. The proposed decision or brief must set forth all issues in dispute and the party's position on each issue. The proposed decision or brief must be served on the Arbitrator and all other parties and shall contain proof of service. The proposed decision shall be written in the same manner and form as that which is required under subsection (b). The proposed decision shall not be considered an admission of a party and shall not be made part of the record.

b) After the closing of proofs, the Arbitrator shall issue a written decision that shall include:

1) the Commission number of the case, the names of the parties, and the name of the county in which the case was heard;

2) the issues agreed to and in dispute;

3) the Arbitrator's findings of fact and conclusions of law, separately stated, upon each contested issue, if requested by either party;

4) applicable orders resulting from the findings of fact and conclusions of law;

5) a statement of the requirements for perfecting a review pursuant to 50 Ill. Adm. Code 9040.10;

6) when applicable, a statement of the rate of interest due under Section 19(n) of the Act.

(Source: Amended at 40 Ill. Reg. 15732, effective November 9, 2016)

Section 9030.100 Voluntary Arbitration under Section 19(p) of the Workers' Compensation Act and Section 19(m) of the Workers' Occupational Diseases Act

a) Selection of Arbitrators to Hear Cases under Voluntary Arbitration

1) The Workers' Compensation Advisory Board shall compile a list of not fewer than 7 certified Arbitrators, each of whom shall be approved by at least 7 of the 9 members of the Advisory Board, to conduct hearings. The Advisory Board shall submit the list to the Chairman of the Commission (the Chairman).

2) Within 30 days after submission of the list by the Advisory Board, the Chairman shall select 5 Arbitrators from the list to conduct hearings. The Chairman shall publish the selections within 15 days.

3) If a vacancy occurs among the Arbitrators selected by the Chairman to conduct hearings, the Chairman shall select an Arbitrator from the list chosen by the Advisory Board to fill that vacancy. At any time the list contains fewer than 7 names of currently certified Arbitrators, the Chairman shall request that the Advisory Board provide a list of additional certified Arbitrators from which to make selections.

b) Request for Voluntary Arbitration

1) After filing an Application for Adjustment of Claim but prior to the hearing on Arbitration, the parties may voluntarily agree to submit the application for decision by an Arbitrator from a list of 5 Arbitrators selected by the Chairman to hear cases under this Section. If the parties cannot agree on an Arbitrator from the list of 5 Arbitrators, they may, by agreement, select an Arbitrator from the American Arbitration Association.

2) Only Applications for Adjustment of Claim that involve a dispute over temporary total disability, permanent partial disability or medical expenses may be submitted for decision by an Arbitrator under this Section.

3) The agreement of the parties to submit the case to voluntary Arbitration shall be in writing and shall be filed with the Commission. The written agreement shall be on a form provided by the Commission. The form shall contain the following:

A) a statement indicating the voluntary nature of the proceedings, the

waiver of certain rights by the parties, and the statement in subsection (c)(2) to be read by the Arbitrator at the beginning of the hearing.

B) a certification by the Arbitrator and any party not represented by an attorney that the statement in subsection (c)(2) was made on the record by the Arbitrator at the beginning of the hearing and the party elected to proceed without counsel.

4) When an agreement to submit a case for decision by an Arbitrator under this Section has been filed with the Commission, the application shall be assigned to the call of the Arbitrator chosen by the parties to conduct the hearing. In cases in which the parties agree to select an Arbitrator of the American Arbitration Association, the Commission shall notify the parties of the time and place of the hearing.

c) Conduct of Hearings

1) The Arbitrator conducting the hearing shall advise the parties on the record at the beginning of the hearing of their rights under Section 19(p) of the Act or 19(m) of the Workers' Occupational Diseases Act and of the voluntary nature of the proceedings.

2) In all cases in which any party is not represented by an attorney, the following statement shall be made on the record by the Arbitrator at the beginning of the hearing:

Voluntary Arbitration under Section 19(p) or 19(m) requires an understanding of the Workers' Compensation Act or Workers' Occupational Diseases Act as well as the laws of evidence and trial procedure. You are entitled to be represented by an attorney if you so desire. The Arbitrator's decision under this procedure is conclusive on all findings of fact and your rights of appeal to the Courts are strictly limited to questions of law.

3) The Rules Governing Practice Before the Workers' Compensation Commission (50 Ill. Adm. Code: Chapter VI) shall apply to hearings in cases submitted for decision by an Arbitrator under Section 19(p) of the Act or 19(m) of the Workers' Occupational Diseases Act, except when inconsistent with this Section or Section 19(p) of the Act or Section 19(m) of the Workers' Occupational Diseases Act.

d) The Commission shall pay reasonable costs for services of an Arbitrator of the

American Arbitration Association.

(Source: Amended at 40 Ill. Reg. 15732, effective November 9, 2016)

TITLE 50: INSURANCE
CHAPTER VI: WORKERS' COMPENSATION COMMISSION

PART 9040
REVIEW

Section

AUTHORITY: Implementing Section 19 and authorized by Section 16 of the Workers' Compensation Act [820 ILCS 305/19 and 16].

SOURCE: Filed and effective March 1, 1977; amended at 2 Ill. Reg. 22, p. 90, effective May 25, 1978; amended at 6 Ill. Reg. 8040, effective July 1, 1982; emergency amendment at 6 Ill. Reg. 15307, effective December 7, 1982, for a maximum of 150 days; codified at 7 Ill. Reg. 2345; amended at 8 Ill. Reg. 4499, effective March 28, 1984; amended at 9 Ill. Reg. 13744, effective August 21, 1985; amended at 9 Ill. Reg. 16249, effective October 15, 1985; emergency amendment at 9 Ill. Reg. 19133, effective November 20, 1985, for a maximum of 150 days; amended at 10 Ill. Reg. 8100, effective May 5, 1986; emergency amendment at 14 Ill. Reg. 4940, effective March 9, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 13173, effective August 1, 1990; recodified from 50 Ill. Adm. Code 7040 to 50 Ill. Adm. Code 9040 at 39 Ill. Reg. 9607; amended at 40 Ill. Reg. 15748, effective November 9, 2016.

Section 9040.10 Perfecting a Review

a) Time for Filing

1) Petitions for Review of Decision of the Arbitrator shall be filed in duplicate with the Illinois Workers' Compensation Commission (Commission), unless filed electronically, within the time provided by statute.

2) The Petition for Review shall contain a statement of the reviewing party's specific exceptions to the Decision of the Arbitrator.

b) Order of Arbitration Transcript

1) Transcripts of arbitration proceedings before the Commission shall be furnished to the parties only upon written request filed with the Commission.

2) For purposes of perfecting a review, an arbitration transcript must be ordered within the time fixed by statute. The estimated cost of the transcript of proceedings may be obtained from the Commission, and the party requesting the transcript shall deposit a sum of money covering the estimated cost before the reporter is required to complete the transcript. An order entered pursuant to Section 20 of the Workers' Compensation Act (the Act) [820 ILCS 305/20] may be submitted for the monetary deposits.

3) In cases in which Section 19(b-1) Petitions have been filed, transcripts shall be ordered in accordance with 50 Ill. Adm. Code 9020.80(b)(3)(C).

c) Authentication of Transcript

1) For purposes of perfecting a review, the transcript of arbitration proceedings shall be authenticated in the manner provided by Section 19(b) of the Workers' Compensation Act and Section 19(b) of the Workers' Occupational Diseases Act [820 ILCS 310/19(b)], and filed with the Commission on or prior to the designated time and place set by the Commission as the Return Date on Review.

2) The Return Date on Review shall be limited to the filing of the authenticated transcript.

A) The Commission shall notify the parties at least 30 days prior to the date and time set for the Return Date on Review.

B) The reviewing party shall file the authenticated transcript in person, by mail, or in any manner provided by the Commission in its notice of the Return Date of Review.

C) Unless electronically filed, the authenticated transcript shall be accompanied by 2 completed copies of the Commission's Transcript Receipt Form and, if filed by mail, a self-addressed stamped envelope.

D) Timely filing by mail may be shown by:

i) a legible postmark date applied by the U.S. Postal Service, and not by a party, to the envelope in which the document is received by the Commission at least 2 calendar days prior to the Return Date on Review; or

ii) the date applied by the U.S. Postal Service to a certified or registered mail receipt bearing the same certification or registry number as the envelope in which the document was received by the Commission, showing a date of mailing that is not less than 2 calendar days prior to the Return Date on Review.

3) In cases in which Section 19(b-1) Petitions have been filed, the transcript shall be authenticated and presented in accordance with 50 Ill. Adm. Code 9020.80.

(Source: Amended at 40 Ill. Reg. 15748, effective November 9, 2016)

Section 9040.20 Assignment of Reviews

a) At the conclusion of every work week, the transcript clerk shall deliver to the review clerk a list of the arbitration transcripts completed during that week. The transcript list shall be in numerical order according to the Commission docket number of each case. No information other than the transcript name and number shall appear on the list.

b) Upon receipt of the list of completed arbitration transcripts, the review clerk will cause those cases to be randomly assigned to a Commissioner by a computer program.

c) Petitions filed post-arbitration under Section 7(a), 8(a) and 19(h) of the Act shall be assigned to the original hearing Commissioner or the Commissioner assigned to the particular territory where the original hearing was held.

d) Assignments shall be final except upon disqualification of a Commissioner as provided in 50 Ill. Adm. Code 9030.30 or upon motion by any party for good cause shown.

(Source: Amended at 40 Ill. Reg. 15748, effective November 9, 2016)

Section 9040.30 Review Hearing: Date and Place

The Commission will give notice to the parties of the date, place and time set for a Review hearing.The notice will be given at least 10 days prior to the hearing.

(Source: Amended at 40 Ill. Reg. 15748, effective November 9, 2016)

Section 9040.40 Conduct of Review Hearings

a) In all cases on Review, no additional evidence shall be introduced by the parties before the Commission unless relating to procedural issues relevant to the Review process.

b) Special Findings on Review

1) Either party may request in writing that the Commission make up to 5 special findings upon any questions of law or fact submitted to it concerning issues raised by the Review.

2) The interrogatories shall be filed at the time of filing the parties' Statement of Exceptions.

3) A copy of the interrogatories must be served on all parties with appropriate proof of service.

(Source: Amended at 40 Ill. Reg. 15748, effective November 9, 2016)

Section 9040.50 Remanding Orders (Repealed)

(Source: Repealed at 40 Ill. Reg. _____, effective _____)

Section 9040.60 Continuances for Oral Arguments and Extensions of Time for Filing Statements of Exceptions and Supporting Briefs and Abstracts

Parties shall present their oral arguments at the time and date set by the Commission. Continuance of an oral argument or extension of time for filing Statements of Exception(s) and Supporting Briefs and Abstracts shall be granted by Order of the Commission only for good cause shown.

(Source: Amended at 40 Ill. Reg. 15748, effective November 9, 2016)

Section 9040.70 Statements of Exceptionsand Supporting Briefs and Abstracts

a) In the event that more than one party files for Review, without regard to who filed first, each party may file its own Statement of Exception(s), as well as a Response.

b) Except in cases in which Section 19(b-1) Petitions have been filed, each party filing a Petition for Review of an Arbitrator's decision, or other proceedings in which the right to oral arguments has been granted, or in which written statements of the parties have been ordered by the Commission, shall file its Statement of Exceptions and Supporting Brief setting forth:

1) the identity of the party filing;

2) the names of the parties and the Commission number assigned to the case or cases;

3) the name of the Commissioner to whom the case has been assigned on Review;

4) the date, if any, scheduled for oral argument;

5) the name of the Arbitrator who rendered the decision or entered the order most recently prior to the filing of the party's petition;

6) the Arbitrator's findings, to include, whenever applicable:

A) date of accident and/or (last) exposure found or alleged;

B) the number of weeks of temporary total disability compensation awarded and the amount of compensation paid;

C) the dollar amount of medical expenses awarded;

D) the nature of the disability and/or disfigurement and the number of weeks, for disfigurement, or the percentage of loss, for permanent partial disability or specific loss, if any, awarded, or that an award of benefits by reason of death or permanent total disability was granted;

E) the dollar amount of any awards, or other findings, under Sections 4(i), 8(f), 16, 19(k) and 19(l), of the Act, if any;

7) appellant's Statement of Exceptions to the Arbitrator's decision to include:

A) separate headings identifying each issue asserted as an exception or addition;

B) statements of particular evidence in the record pertaining to each issue, together with citation of any legal authorities, including Commission decisions, that support the position of the issue.

c) Three (3) copies of the appellant's Statement of Exceptions and the Supporting Brief shall be filed with the Commission and served on all parties not later than 30 days from the Return Date on Review. The appellee may submit a response, filing 3 copies of the response with the Commission, and shall serve copies of the response on all parties within 15 days from the last day allowed for the filing of appellant's Statements of Exceptions and Supporting Brief. A Statement of Exceptions and Supporting Brief,
and any response to those documents:

1) shall be written or printed on one side of no more than 20 8½ x 11" sheets of paper or shall contain no more than 5,200 words, whichever is greater; and

2) shall include a certificate of the date and manner of service of copies on all other parties.

d) All documents filed under this Section shall bear the caption of the case, including the Commission case number, and shall include, directly under the case number in the caption, the name of the Commissioner to whom the case has been assigned for the Review proceedings, together with the date set for oral argument, when applicable. Documents filed pursuant to this Section will not be considered to have met the requirements for filing if they do not comply with the requirements of subsection (e). Oral arguments will be limited to the issues raised in both the Review proceedings stipulation form or its equivalent for proceedings such as those under Section 19(h) and (f) of the Act and in the party's Statement of Exceptions and Supporting Brief, and to those in any complying response to those documents. Failure of any party to timely file any Statement of Exceptions and Supporting Brief or Response Brief required by this Section, including an abstract when required under subsection (f), shall constitute a forfeiture of the right to oral argument by that party. When a party has timely filed, that party may petition the Commission to present oral arguments in support of its Statement of Exceptions and Supporting Brief and/or Response Brief. Within 15 days after the date the last filing was due, a party that has timely filed may petition the Commission for

oral argument. The assigned Commissioner may order oral argument at his or her discretion, not withstanding anything to the contrary in this Part.

e) Timely filing shall be shown by:

1) the date file stamped on the document at the time of receipt by the Commission;

2) a legible postmark date applied by the U.S. Postal Service, and not by a party, to the envelope in which the document is received by the Commission at least 2 calendar days prior to the date on which the document was due to be filed in accordance with this subsection (e). If the date required for filing or mailing falls on a Saturday, Sunday or holiday, the time for filing or mailing shall be the next date that is not a Saturday, Sunday or holiday;

3) an Order entered at the discretion of the assigned Commissioner upon written Motion.

f) Abstracts on Review

1) Any reviewing Commissioner may, by notice to the parties, order the party first filing for Review to file an Abstract of the Record and serve a copy of that abstract upon all other parties within 30 days after the notice. Any other party may file a supplemental Abstract within 15 days after receipt of the original Abstract.

2) Upon Motion, any party may request leave to file an Abstract of the Record, which may be allowed at the discretion of the reviewing Commissioner, as provided in subsection (f)(1).

(Source: Amended at 40 Ill. Reg. 15748, effective November 9, 2016)

Section 9040.80 Commission Decision on Review

In all cases in which, at or before the closing of proofs on Review, a party has filed a written request for a full written decision pursuant to Section 19(e) of the Act, the Commission will issue a decision, which shall include:

a) the Commission's number assigned to the case, the names of the parties, and the name of the county in which the case was heard on Arbitration;

b) the Arbitrator's findings as relevant to the issues on Review, including, if relevant:

1) the date or dates of the accident, exposure or last exposure;

2) the number of weeks for which temporary total disability compensation was awarded, if any;

3) the dollar amount of medical expenses awarded, if any;

4) the nature and number of weeks, in case of disfigurement, or percentages, in case of partial losses of use, awarded with respect to disfigurement and permanent partial disability; the nature and the number of weeks awarded with respect to any specific losses under Section 8(e) of the Act, if any; or the fact that benefits were awarded on account of death or permanent total disability;

5) findings under Section 4(i), 8(j), 16, 19(k) or 19(1) of the Act, if applicable;

c) the identities of the parties who have filed a Petition for Review, or other proceedings as under Section 19(h), 8(a) or 8(f) of the Act, and a statement of the issue to be decided on Review;

d) the Commission's findings of fact and conclusions of law upon each claim of exceptions to the Arbitrators decision, including a statement of the particular evidence in the record upon which the findings and conclusions are based;

e) applicable Orders resulting from the findings of fact and conclusions of law;

f) a statement of the conditions, if any, for a judicial review of the Commission's decision in accordance with the requirements of 50 Ill. Adm. Code 9060.

(Source: Amended at 40 Ill. Reg. 15748, effective November 9, 2016)

TITLE 50: INSURANCE
CHAPTER VI: WORKERS' COMPENSATION COMMISSION

PART 9050
ORAL ARGUMENTS

Section

AUTHORITY: Implementing Section 19 and authorized by Section 16 of the Workers' Compensation Act [820 ILCS 305/19 and 16].

SOURCE: Filed and effective March 1, 1977; amended at 3 Ill. Reg. 4, p. 13, effective January 21, 1979; amended at 6 Ill. Reg. 8040, effective July 1, 1982; codified at 7 Ill. Reg. 2348; recodified from 50 Ill. Adm. Code 7050 to 50 Ill. Adm. Code 9050 at 39 Ill. Reg. 9609; amended at 40 Ill. Reg. 15764, effective November 9, 2016.

Section 9050.10 Right to Oral Argument

Upon the request of any party that complies with 50 Ill. Adm. Code 9040.70, and no later than the conclusion of the review hearing, or upon order of the assigned Commissioner, a cause shall be set down for Oral Argument before not less than a majority of the members of the assigned Commission panel.

(Source: Amended at 40 Ill. Reg. 15764, effective November 9, 2016)

Section 9050.20 Time Allotted

a) Oral Argument on all cases in which nature and extent of injury is the sole issue shall be limited to 5 minutes for each side.

b) Oral Argument shall be limited to 10 minutes for each side, inclusive of rebuttal time, on:

1) all other cases; and

2) those cases in which a total permanent disability or death award has been entered, regardless of the number of issues involved.

(Source: Amended at 40 Ill. Reg. 15764, effective November 9, 2016)

Section 9050.30 Section 19(h) Petitions

Oral Argument may be had on hearings under Section 19(h) of the Workers' Compensation Act in the same manner as provided in Section 9050.20.

(Source: Amended at 40 Ill. Reg. 15764, effective November 9, 2016)

Section 9050.40 Petitioner's Presence at Oral Argument

a) The Petitioner has a right to be present at any Oral Argument.

b) The Petitioner shall be present for examination at the time set for Oral Argument if:

1) the Petitioner desires to be present and requests examination by a Commissioner; or

2) a Commissioner of the assigned panel requests the Petitioner to be present.

c) In the event that the Petitioner does not choose to be present and no Commissioner requests the presence of the Petitioner, the Respondent may request the Petitioner's presence, subject to the discretion of a Commissioner of the assigned panel. If that presence is ordered, the Respondent shall pay the Petitioner directly, or his or her attorney, if represented, in advance of the time fixed for Oral Argument:

1) sufficient monies to defray the necessary expense of travel by the most convenient means to and from the place of examination; and

2) reimbursement for any loss of wages caused because of loss of working time.

(Source: Amended at 40 Ill. Reg. 15764, effective November 9, 2016)

TITLE 50: INSURANCE
CHAPTER VI: WORKERS' COMPENSATION COMMISSION

PART 9060
JUDICIAL REVIEW

Section

AUTHORITY: Implementing Section 19 and authorized by Section 16 of the Workers' Compensation Act [820 ILCS 305/19 and 16].

SOURCE: Filed and effective March 1, 1977; amended at 6 Ill. Reg. 8040, effective July 1, 1982; codified at 7 Ill. Reg. 1242; amended at 9 Ill. Reg. 2496, effective February 11, 1985; expedited correction at 19 Ill. Reg. 292, effective February 11, 1985; recodified from 50 Ill. Adm. Code 7060 to 50 Ill. Adm. Code 9060 at 39 Ill. Reg. 9610; amended at 40 Ill. Reg. 15770, effective November 9, 2016.

Section 9060.10 Certification of Record: Conditions

a) Receipt of Notice of Intent to File for Review in the Circuit Court
Judicial review of Commission decisions is had by summons as provided in the Workers' Compensation Act [820 ILCS 305/19]. No request for a summons may be filed and no summons shall issue unless the party seeking to review the decision of the Commission exhibits to the clerk of the Circuit Court proof of filing with the Commission of the notice of the intent to file for review in the Circuit Court or an affidavit of the attorney setting forth that notice of intent to file for review in the Circuit Court has been given in writing to the Secretary or Assistant Secretary of the Commission.

b) Amount of Bond
In its decision on review, pursuant to Section 19(f)(2) of the Act, the Commission, or any member thereof, shall fix the amount of bond, if any, required to be filed by the appealing party as a return to the summons. Bond shall be set at an amount equal to $100 over the total unpaid amount of the award rendered by the Commission on review subject to a maximum of $75,000.

(Source: Amended at 40 Ill. Reg. 15770, effective November 9, 2016)

Section 9060.20 Orders on Judicial Review

a) Upon receipt of a final Order from the reviewing court or an Order from the reviewing court that remands the matter back to the Commission, the moving party shall file a copy of the Order with the Commission within 30 days after receipt, with notice of filing to all parties.

b) Upon receipt of an Order from a reviewing court, the Commission shall docket the Order and set the matter for hearing in the same manner as Petitions for Review, except that, when practical, the cause shall be returned to the original Commissioner.

(Source: Added at 40 Ill. Reg. 15770, effective November 9, 2016)

TITLE 50: INSURANCE
CHAPTER VI: WORKERS' COMPENSATION COMMISSION

PART 9070
SETTLEMENT CONTRACTS AND LUMP SUM PETITIONS

Section

AUTHORITY: Implementing Section 19 and authorized by Section 16 of the Workers' Compensation Act [820 ILCS 305/19 and 16].

SOURCE: Filed and effective March 1, 1977; amended at 2 Ill. Reg. 49, p. 244, effective December 7, 1978; amended at 3 Ill. Reg. 4, p. 13, effective January 21, 1979; amended at 4 Ill. Reg. 26, p. 159, effective July 1, 1980; emergency rule at 4 Ill. Reg. 41, p. 171, effective September 25, 1980 for a maximum of 150 days; amended at 5 Ill. Reg. 4580, effective April 13, 1981; emergency rule at 5 Ill. Reg. 8547, effective August 12, 1981 for a maximum of 150 days; amended at 6 Ill. Reg. 3570, effective March 22, 1982; amended at 6 Ill. Reg. 8040, effective July 1, 1982; codified at 7 Ill. Reg. 2349; recodified from 50 Ill. Adm. Code 7070 to 50 Ill. Adm. Code 9070 at 39 Ill. Reg. 9611; amended at 40 Ill. Reg. 15775, effective November 9, 2016.

Section 9070.10 Settlement Contracts

a) Filing Requirements

1) Settlement Contracts shall be filed in quadruplicate on a form provided by the Commission and docketed. One copy shall be provided for each additional case number listed on the contract. When an application is pending, the contracts must bear the docket number of the application. When no application has been filed, the contracts shall be given an original number and letter in the same manner as an application. In cases involving payment into the Second Injury Fund, one additional copy shall be filed for record purposes. In addition, a stamped envelope must be submitted, addressed to each person who is to receive copies of the approved contract by mail.

2) Settlement Contracts shall be accompanied by an "Attorney Representation Agreement" if not previously filed.

b) Contents
Settlement Contract forms shall be completed in full and accompanied by an appropriate signed physician's report concerning the nature and extent and probable duration of the disability resulting from the alleged accident. Settlement Contract forms are available at http://www.iwcc.il.gov/forms.htm.

1) In cases involving claim for death benefits, the report shall refer to the medical cause of death. In addition, in death cases, copies of the death certificate and, when applicable, marriage certificate of the decedent and birth certificates of any minor children of the decedent shall accompany the Settlement Contracts.

2) The Petitioner shall, upon request, provide any other information relevant to determining the appropriateness of the settlement.

c) Assignment

1) Settlement Contracts on cases originating in Cook County that have not previously been assigned to an Arbitrator or Commissioner may be assigned randomly to an Arbitrator in the appropriate venue by a computer program.

2) If a Petitioner is not represented by an attorney, a different assignment procedure may be established from time to time by directive of the

Chairman for the benefit of those Petitioners. An attorney may make a motion requesting an immediate hearing on a settlement for good cause. If the motion is granted, the settlement may be assigned in the same manner as settlements of non-represented Petitioners.

3) When the venue is outside Cook County, the parties may present Settlement Contracts by appearing personally before an Arbitrator assigned to that venue and requesting approval of the contracts.

d) Appearance of Petitioner Discretionary
If both parties are represented by an attorney, the Arbitrator or Commissioner to whom the Settlement Contract has been assigned may approve or reject the Settlement Contract solely on the basis of information in the settlement and the medical and other reports required to be submitted pursuant to subsection (b). Prior to rejection of a Settlement Contract, the Arbitrator or Commissioner shall give the parties an opportunity to be heard.

(Source: Amended at 40 Ill. Reg. 15775, effective November 9, 2016)

Section 9070.20 Agreed Petitions for Lump Sum Settlement

a) All of the requirements set forth in Section 9070.10 shall have equal applicability to agreed Petitions for Lump Sum Settlement.

b) In all cases, but particularly those involving either minor Petitioners or minor beneficiaries, the Commission reserves the right to elicit evidence concerning the use to which the proceeds of the settlement are to be put pursuant to Section 9 of the Act.

c) When commutation is requested, the Commission reserves the sole right to compute the allowable commutation and enter the net amount ordered paid by the Respondent.

(Source: Amended at 40 Ill. Reg. 15775, effective November 9, 2016)

Section 9070.30 Contested Petitions for Lump Sum Settlement

Contested Lump Sum Settlement Petitions shall be docketed and set for hearing pursuant to 50 Ill. Adm. Code 9040.20(c).

(Source: Amended at 40 Ill. Reg. 15775, effective November 9, 2016)

Section 9070.40 Action by Commission

a) Upon presentation of Settlement Contracts or Petitions for Lump Sum Settlement, the Commission shall, after hearing or otherwise, either "approve" or "reject" the Contract or Petition for Lump Sum Settlement. If rejected, the Settlement Contract or the Petition for Lump Sum Settlement shall remain in the Commission file to accompany the application filed, or any to be filed, for the accidental injuries alleged in the Contract or Petition, until the case is assigned to an Arbitrator for hearing. At that time, the Rejected Settlement Contract shall be removed from the file and kept in a separate file until a final award has been entered by the Commission. In no event shall that case be assigned to any Arbitrator who has previously rejected a Settlement Contract presented in that case.

b) When a Settlement Contract has been rejected by an Arbitrator and the venue of the case lies outside Cook County, it shall be the duty of the Arbitrator to return the file to the Commission, which will transfer the case to a new Arbitrator in the nearest contiguous geographical territory. The Commission shall notify all parties of the time, place and date of further action.

c) When a Settlement Contract has been rejected by an Arbitrator and the venue of the case lies in Cook County, it shall be the duty of the Arbitrator to notify the Commission, which will transfer the case to a new Arbitrator chosen randomly from all Arbitrators located in Cook County.

d) When a Settlement Contract has been rejected by a Commissioner and reassigned to an Arbitrator for hearing, no Settlement Contract may be approved by any Arbitrator. Any additional Settlement Contract must be presented to the Commissioner who rejected the prior Settlement Contract for consideration and possible approval.

e) Parties may reserve the right to amend an approved Settlement Contract by stipulation and Order of a Commissioner to conform with regulatory requirements including, but not limited to, those of Social Security and Medicare. In no event may those amendments abridge the substantive rights of the parties as listed in the previously approved Settlement Contract.

(Source: Amended at 40 Ill. Reg. 15775, effective November 9, 2016)

TITLE 50: INSURANCE
CHAPTER VI: WORKERS' COMPENSATION COMMISSION

PART 9080
ATTORNEY'S FEES

Section

AUTHORITY: Implementing Section 19 and authorized by Section 16 of the Workers' Compensation Act [820 ILCS 305/19 and 16].

SOURCE: Filed and effective March 1, 1977; amended at 6 Ill. Reg. 8040, effective July 1, 1982; codified at 7 Ill. Reg. 2350; recodified from 50 Ill. Adm. Code 7080 to 50 Ill. Adm. Code 9080 at 39 Ill. Reg. 9612.

Section 9080.10 Petition For Fees

a)

1) Whether a dispute has arisen between a Petitioner and his attorney or former attorney concerning the amount of payment of fees for services rendered or reimbursement of costs incurred in the prosecution of a claim, or a claim is made for fees in excess of the fees provided in Section 16(a) of the Workers' Compensation Act for extraordinary services, either the Petitioner or his attorney or former attorney may file with the Commission a Petition to Fix Fees which shall set forth the facts surrounding the dispute and the relief requested.

2) On receipt of said Petition, the Commission shall set the matter down for hearing after giving at least ten (10) days notice to parties and all the attorneys for Petitioner. After hearing, the Commission may enter an order dismissing the Petition or an award granting relief.

b) The Commission may also enter an award setting partial attorney's fees for an attorney who has withdrawn based on the reasonable value of services rendered and the actual time expended. This award shall be taken into consideration in fixing the final attorney's fees in the matter so that in no event shall the total of all attorney's fees awarded to all attorneys exceed that allowable under Section 16(a) of the Workers' Compensation Act.

(Source: Amended at 6 Ill. Reg. 8040, effective July 1, 1982)

Section 9080.20 Payment of Proceeds of Litigation

Unless otherwise directed by the petitioner or the Commission, the respondent, its agent or insurance carrier, shall deliver the first payment of accrued compensation following an award or settlement to the offices of the attorney of record for the petitioner. Unless otherwise directed by the petitioner or the Commission, all subsequent payments of an award shall be delivered to the petitioner.

TITLE 50: INSURANCE
CHAPTER VI: WORKERS' COMPENSATION COMMISSION

PART 9090
DISCIPLINE OF ATTORNEYS; AGENTS

Section

AUTHORITY: Implementing Section 19 of, and authorized by Section 16 of, the Workers' Compensation Act [820 ILCS 305/16 and 19].

SOURCE: Filed and effective March 1, 1977; codified at 7 Ill. Reg. 1243; recodified from 50 Ill. Adm. Code 7090 to 50 Ill. Adm. Code 9090 at 39 Ill. Reg. 9613; amended at 40 Ill. Reg. 15783, effective November 9, 2016.

Section 9090.10 Disciplining of Attorneys: Procedure

When a verified, written allegation of improper, unethical or contemptuous conduct is made against an attorney, relating to practice before the Commission, by a party to pending litigation or any officer of the Commission, the Commission may refer that matter to the Attorney Registration and Disciplinary Commission.

(Source: Amended at 40 Ill. Reg. 15783, effective November 9, 2016)

Section 9090.20 Disciplining of Agents: Procedure

a) Whenever the Commission finds that an insurer, self-insurer, claims service or other association, or an agent of one of these entities, is practicing a policy of unfairness toward the claimant in the handling and processing of claims under the Workers' Compensation or Occupational Diseases Act, the Commission may issue a Rule to Show Cause why the carrier or agent should not be suspended from writing insurance or processing workers' compensation claims within the State.

b) The recipient of the Rule to Show Cause shall be entitled to be informed of the charges against it and to have an evidentiary hearing on the merits of the charges. The recipient shall have the right to be present, to call witnesses, and to provide other pertinent evidence.

c) After a full hearing, the Commission may invoke appropriate sanctions against the recipient as authorized by statute, specifically including citation (i.e., submission) to the Attorney General for action on any violation of the law or certification to the Director of Insurance for discipline of license.

(Source: Amended at 40 Ill. Reg. 15783, effective November 9, 2016)

TITLE 50: INSURANCE
CHAPTER VI: WORKERS' COMPENSATION COMMISSION

PART 9100
INSURANCE REGULATIONS

Section

AUTHORITY: Implementing Section 4 of the Workers' Compensation Act [820 ILCS 305] and Section 4 of the Workers' Occupational Diseases Act [820 ILCS 310], and authorized by Section 16 of the Workers' Compensation Act and Section 16 of the Workers' Occupational Diseases Act.

SOURCE: Filed and effective March 1, 1977; amended at 5 Ill. Reg. 8910, effective August 24, 1981; codified at 7 Ill. Reg. 2345; emergency amendment at 8 Ill. Reg. 15976, effective August 16, 1984, for a maximum of 150 days; amended at 9 Ill. Reg. 3705, effective March 12, 1985; emergency amendment at 10 Ill. Reg. 6003, effective April 18, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 15615, effective September 10, 1986; emergency amendment at 14 Ill. Reg. 4920, effective March 9, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 13149, effective August 1, 1990; amended at 15 Ill. Reg. 16969, effective November 12, 1991; amended at 20 Ill. Reg. 3826, effective February 15, 1996; recodified from 50 Ill. Adm. Code 7100 to 50 Ill. Adm. Code 9100 at 39 Ill. Reg. 9614; amended at 40 Ill. Reg. 15788, effective November 9, 2016.

Section 9100.20 Policy Information Page

a) Every insurer, upon issuance of an insurance policy, must, within 10 days, file a policy information page with the National Council on Compensation Insurance showing the locations and character of the business operations, the date effective, and the policy number. The policy information page must be countersigned by a duly authorized agent of the insurance company.

b) A policy information page shall be required when a previous policy information page has been filed and the coverage has been extended, renewed or otherwise continued by the same insurance carrier.

(Source: Amended at 10 Ill. Reg. 15615, effective September 10, 1986)

Section 9100.40 Requirements for Approval as a Self-Insurer

a) Application

1) Initial Application

A) Any private employer under the Workers' Compensation Act [820 ILCS 305] (the Act) and/or the Workers' Occupational Diseases Act [820 ILCS 310] (WODA) who desires to be approved as a self-insurer shall file with the Commission an Application for Approval on a form prescribed by the Commission and the most current 3 years' audited financial statements. *A private employer does not include group self-insured employers under Section 4(a) of* the Act *or Section 4(a) of WODA or the State of Illinois, any political subdivision of the State, unit of local government or school district, or any other public authorities or quasi-governmental bodies, including any subunits of the foregoing entities.* (Section 4a-2(c) of the Act) Any reference in this Part to workers' compensation insurance coverage shall encompass coverage under both the Act and WODA.

B) *The application and current financial statements shall be signed and sworn to by the president or vice-president and secretary or assistant secretary of the employer, if it is a corporation, or by all of the partners, if it is a copartnership, or by the owner if it is neither a copartnership nor a corporation.* (Section 4(a)(1) of the Act)

C) In the event the employer does not have audited financial statements, the employer must submit financial statements that have been prepared by an outside accounting firm.

D) Each controlled employer or subsidiary requesting approval as a self-insurer shall provide the current financial statements of the parent corporations or each of its controlling persons designated by the Commission.

i) A subsidiary means any entity in which another company, directly or indirectly, owns, controls or holds, with the power to vote a majority (more than 50 percent) of the outstanding voting securities of the company.

ii) Controlled employer means a not-for-profit corporation with respect to which an individual or another entity has the right either to elect or appoint, directly or indirectly, a majority of the directors, trustees or other governing body of a not-for-profit corporation, or has the right to approve or disapprove, directly or indirectly, the persons appointed as a majority of the directors, trustees or other governing body of a not-for-profit corporation.

iii) Controlling person means an individual or entity that has the right to elect or appoint, directly or indirectly, a majority of the directors, trustees or other governing body of a not-for-profit corporation, or has the right to approve or disapprove, directly or indirectly, the persons appointed as a majority of the directors, trustees or other governing body of a not-for-profit corporation.

E) *All initial applications and financial statements shall be submitted at least 60 days prior to the requested effective date of self-insurance.* (Section 4(a)(1) of the Act)

F) All initial applications must include evidence of current workers' compensation insurance coverage that shall be maintained until final approval as a self-insurer is granted.

G) Each private employer applying for self-insurance shall indicate how it will service its self-insurance program. The employer shall provide adequate facilities for the investigation, administration and payment of claims or shall contract with a service company possessing the personnel and facilities to provide those services. In determining whether facilities are adequate for the investigation, administration and payment of claims, the following shall be considered:

i) whether there is personnel experienced in the adjudication of workers' compensation claims;

ii) whether there is a reporting system for workers' compensation claims;

iii) whether the reporting system is automated and the frequency of reports generated by the system;

iv) the response system to claims filing; and

v) whether a current estimate of the expected total cost for each claim is established based on facts of each claim, medical information, and provisions of the Act. This estimation is not trended, based on discounted present value, or actuarially developed.

H) If the employer has contracted with a service company for the administration of claims, a copy of the contract shall be submitted with the initial application.

2) Renewal Application

A) Each private self-insurer shall, upon notice from the Commission, file annually an application to continue the self-insurance privilege. The renewal application shall be on a form prescribed by the Commission and shall be accompanied by thefinancial statements described in subsection (a)(1)(A). The renewal application and financial statements shall be signed and sworn to in accordance with subsection (a)(1)(B). Each subsidiary or controlled employer requesting approval as a self-insurer shall provide the current financial statement of its parent corporations or controlling persons designated by the Commission.

B) The self-insurer shall indicate any change in how it will service its self-insurance program. If the employer has contracted with a service company for the administration of claims, a copy of the current contract shall be submitted with the renewal application.

b) Application Fee

1) *Each private employer applying for self-insurance and each private self-insurer applying for renewal* (continuation) *of the self-insurance privilege shall pay a nonrefundable application fee of $500 that shall be deposited upon receipt by the Commission into the Self-Insurers Administration Fund.* (Section 4a-4(a) of the Act)

2) If the applicant is a corporation, *an application fee shall be required of each corporation and each and every corporate subsidiary.* (Section 4a-4(a) of the Act) If the applicant is a not-for-profit corporation employer, an application fee shall be required for each and every controlling person and each and every employer applying for the self-insurance privilege or

the renewal of the self-insurance privilege.

3) The application fee shall be paid by check or money order, payable to the Self-Insurers Administration Fund.

c) Review of Application

1) *Within 45 days after receipt of an initial application or an application to renew the self-insurance privilege, the Self-Insurer's Advisory Board* (the Board) *shall review* or see to the review of the application *and submit its recommendations for disposition to the chairman of the Commission* (the Chairman). (Section 4(j) of the Act)

2) The review of the application shall include, but not be limited to, consideration of the earned points on the financial ratios set forth in this subsection (c)(2):

A) Earned Points on Financial Ratios

i) Current Assets to Current Liabilities

2	:	1	=	6 points
1.75	:	1	=	5 points
1.6	:	1	=	4 points
1.4	:	1	=	3 points
1.25	:	1	=	2 points
1.1	:	1	=	1 points
1	:	1	=	0 points

(A negative ratio, one in which current assets are less than current liabilities, may be considered a reason to reject a new application.)

ii) Capital & Retained Earnings (Net of Treasury Stock) to Sales (Less Discounts)

20%	=	6 points
17.5%	=	5 points
13.5%	=	4 points
10%	=	3 points
8.5%	=	2 points
7%	=	1 points
5%	=	0 points

iii) Capital & Retained Earnings to Long Term Debt

2	:	1	=	6 points
1.75	:	1	=	5 points
1.6	:	1	=	4 points
1.4	:	1	=	3 points
1.25	:	1	=	2 points
1.1	:	1	=	1 points
1	:	1	=	0 points

B) An employer who earns a total of 18 points in the 3 financial ratios in subsection (c)(2)(A) in each year of the most current 3 years' audited financial statements and has been self-insured for a minimum of 3 consecutive years may be deemed to have satisfied the Commission of its financial strength to meet its workers' compensation obligations without the necessity of furnishing security, indemnity or bond or making some other provision satisfactory to the Commission for securing its workers' compensation obligations pursuant to subsection (c)(3).

C) A total of 9 to 18 points earned in the 3 financial ratios in subsection (c)(2)(A) shall create a rebuttable presumption that the employer's application should be approved conditional upon the furnishing of appropriate security or other means satisfactory to the Commission for securing its workers' compensation obligations pursuant to subsection (c)(3).

D) The Board may recommend for approval applicants who earn less than 9 points in the financial ratios of subsection (c)(2)(A) if the employer's application and financial statement, together with appropriate security or other means satisfactory to the Commission for securing its workers' compensation obligations pursuant to subsection (c)(3), demonstrate the ability of the employer to meet its obligations under the Act/WODA.

3) Security

When an applicant is required to furnish security or provide some other means satisfactory to the Commission to guarantee payment of its workers' compensation obligation, the furnishing of that security or other provision shall be a condition precedent to the approval of the initial or renewal application for self-insurance. The Chairman shall also require that the applicant further secure payment of liabilities under the

Act/WODA by obtaining a policy of excess workers' compensation insurance on such form as may be required by the Commission.

A) Security Determination

i) The amount of the security shall be based upon, but not be limited to, such criteria as the employer's financial strength, industry, the amount of excess insurance, and demonstrated loss experience.

ii) An employer's financial strength shall be determined by applying the financial ratio summarization in this subsection (c)(3)(A). The financial ratio summarization is based upon the total number of earned points as calculated by applying the financial ratios in subsection (c)(2)(A). A financial factor (percentage) is assigned to the financial ratio summarization. The applicable financial factor is applied in determining the amount of security in subsections (c)(3)(B) and (C).

Financial Ratio Summarization

Financial Factor		Earned Points
16 - 18 points	=	35%
14 - 15 points	=	40%
12 - 13 points	=	60%
9 - 11 points	=	70%

B) Security/Loss Fund Determination

i) When the employer submits audited financial statements containing an unqualified opinion, the security requirement shall be determined by using the highest amount of security obtained after applying the following formulas:

Minimum security to be not less than $200,000.

RESERVE FORMULA

Total outstanding loss reserves are multiplied by the applicable trending factor. In the event that an employer's losses are affected by growth or size of the entity, the reserves may be equalized. The following formula is then

applied:

total outstanding loss reserves (loss fund) x applicable trending factor x applicable financial factor = security.

PAID LOSS FORMULA

Paid losses for up to each of the last 5 years are multiplied by the applicable trending factors. The total of paid losses is divided by the number of years used to obtain the average yearly paid loss. However, in the event that an employer's losses are affected by growth or size of the entity, the paid losses may be equalized. The following formula is then applied:

average yearly paid loss (loss fund) x applicable trending factor x applicable financial factor = security.

ii) If the employer submits financial statements that do not contain an unqualified opinion or are not audited, the security requirements shall be determined by using the highest amount of security obtained after applying the following formulas:

Minimum security to be not less than $200,000.

RESERVE FORMULA

total outstanding loss reserves (loss fund) x applicable trending factor x 125% = security.

PAID LOSS FORMULA

Paid losses for up to each of the last 5 years are multiplied by the applicable trending factors. The total of paid losses is divided by the number of years used to obtain the average yearly paid loss. The following formula is then applied:

average yearly paid loss (loss fund) x applicable trending factor x 125% = security

iii) If the employer self-administers its workers' compensation claims program, or if the claims administration contract with an outside administrator does not include service on a life of claim basis, a factor of 120% is applied to the formulas used in subsection (c)(3)(B)(i) and (ii) to cover the contingent claims cost in the event of insolvency.

iv) All trending factors used in this subsection (b)(3)(C) are adopted by resolution of the Board and are available from the Board or the Commission upon request. Trending factors are determined by reviewing the rates of inflation for self-insurance, including claim payments, both medical and indemnity, and costs of claim administration. The trending factor shall be determined after consultation with a Fellow of the Casualty Actuarial Society.

C) The security requirement for self-insurers who, upon initial or renewal application, earn less than 9 points after applying the financial ratios in subsection (c)(2)(A), shall be determined as a percentage of the loss fund size as follows:

Points Scored	Loss Fund Size	Percentage of Loss Fund
6 - 8.9	0 - 250,000	130
	250,001-500,000	120
	500,001-1,0000,000	110
	1,000,001 +	100
3 - 5.9	0 - 250,000	150
	250,001-500,000	130
	500,001-1,000,000	120
	1,000,001 +	110
0 - 2.9	0 - 250,000	200
	250,001-500,000	175
	500,001-1,000,000	150
	1,000,001 +	130

If the percentage of loss fund referred to in this subsection (b)(3)(C) is less than 125% and the employer has submitted financial statements that do not contain an unqualified opinion or

are not audited, the percentage of loss fund used will be 125%. In addition, if the employer self-administers its workers' compensation claims program or if the claims administration contract with an outside administrator does not include service on a life of claim basis, a factor of 120% is applied to cover the contingent claims cost in the event of insolvency.

D) Acceptable Security Instruments

i) Surety Bond: Must be on a form prescribed by the Commission. No surety bond may be terminated unless the Chairman has received written notice of the prospective termination at least 60 days prior to the termination date.

ii) Escrow Agreement: *Deposits under escrow agreements shall be cash, negotiable United States government bonds or negotiable general obligation bonds of the State of Illinois. The cash or bonds shall be deposited in escrow with any State or national bank or trust company having trust authority in the State of Illinois.* (Section 4(b) of the Act) All escrow agreements shall be on a form provided by the Commission. Securities used to fund an escrow account shall have at all times a market value at least equal to the security requirement determined by the Chairman. (See subsection (c)(3)(A).)

iii) Letter of Credit: Must be issued by a financial institution acceptable to the Commission and be written in conformity with prescribed format. All letters of credit must be accompanied by a Self-Insurer's Agreement to Post on a form prescribed by the Commission.

4) Guarantee Agreement

A subsidiary or a controlled employer shall obtain a guarantee agreement executed by the parent company or controlling persons designated by the Commission. Pursuant to the agreement, the parent company or the controlling persons shall guarantee that the obligations of the subsidiary or the controlled employer under the Act/WODA shall be paid. The guarantee agreement shall be submitted on a form prescribed by the Commission. Whenever a guarantor under such an agreement ceases to be a parent company or controlling persons with respect to the subsidiary or controlled employer whose obligations it has guaranteed, the former parent company and subsidiary or controlling persons and controlled

employer shall notify the Commission immediately. Notwithstanding any other provisions of this Part, if the Board determines that a controlled person or subsidiary is controlled by an alien controlling person or parent company, is a utility, or is unable or unwilling to provide a guarantee agreement, the Chairman may, in his or her discretion, waive the requirement that the controlled employer or subsidiary provide a guarantee agreement; if the controlled employer or subsidiary or utility furnishes to the Commission security in an amount to be determined by the same methods used when an unaudited financial statement has been provided in accordance with subsection (c)(3)(B)(ii). "Alien controlling person" or "parent company" means a controlling person or parent company created or organized under the laws of a jurisdiction other than the United States of America or any political subdivision thereof.

d) Decision

Within 45 days after receipt of an initial application or application to renew (continue) *the self-insurance privilege, the Board shall advise the Chairman of its recommendations regarding the disposition of that initial or renewal application. If the Chairman disagrees with any of the Board's recommendations, the Chairman shall, within 30 days after receipt of the Board's recommendations, notify the Board of the reasons in support of the decision. The Chairman shall also promptly notify the employer of the decision within 15 days after receipt of the recommendation of the Board.* (Section 4(j) of the Act)

1) Approval

A) The Chairman shall notify the applicant in writing that it has been approved as a self-insurer. Approval may be conditioned upon the furnishing of appropriate and adequate security. The notice shall set forth the requirements to be met, including, but not limited to, the furnishing of security and the basis for the security, obtaining appropriate excess workers' compensation insurance, submission of an appropriate claims administration and loss control program, and payment of assessments prescribed by the Commission (see Section 4a-7 of the Act).

B) Within 60 days after receipt of the notice described in subsection (d)(1)(A), the conditionally approved employer shall comply with all of the requirements of conditional approval stated in the notice. The Chairman shall then issue a certificate of approval as a self-insurer. The effective date of self-insurance shall be set forth in the certificate of approval.

C) Failure of the conditionally approved employer to comply with all requirements of conditional approval within 60 days after receipt of the notice or to file a request for reconsideration pursuant to subsection (f) shall cause the Chairman to issue an Order denying the request for approval as a self-insurer. The Order shall be subject to review under subsection (h). Nothing in this subsection (d)(1) shall bar the employer from reapplying for approval as a self-insurer.

2) Denial

A) The Chairman shall notify the employer in writing that the employer's initial or renewal application and financial statement do not warrant approval of the self-insurance privilege. The notice shall set forth the reasons why the employer's application for approval as a self-insurer should be denied.

B) Failure of the employer to file a request for reconsideration pursuant to subsection (f) shall cause the Chairman to issue an Order denying the request for approval as a self-insurer. The Order shall be subject to review under subsection (h).

C) When the Chairman denies an application for renewal of the self-insurance privilege, nothing in this subsection (d)(2) shall bar an employer from reapplying for approval as a self-insurer. A reapplication shall be considered an initial application and must qualify under subsection (c)(2).

e) Additional Information

1) The Chairman may at any time, on his or her own initiative or at the request of the Board, require a self-insurer to file additional information related to the self insurer's ability to adequately secure payment of its financial obligations under the Act/WODA. That information shall include, but not be limited to, information related to:

A) the employer's financial condition;

B) the employer's ability to provide an adequate claims administration program;

C) the employer's loss control or safety program; and

D) the employer's ability to provide adequate excess insurance coverage.

2) Upon review of the additional information, if the Chairman finds, after consultation with the Board, that the security furnished by the self-insurer should be adjusted or that the self-insurance privilege should be terminated, the Chairman shall notify the employer of any change in the security requirement or of his or her intent to terminate the self-insurance privilege and the reasons for termination. The notice shall set forth a time and place of hearing on the matter, which shall be within 30 days after the date of the notice. The Chairman shall notify the employer of the decision in writing after the hearing date. These decisions shall be subject to review under subsection (h).

3) Failure of a self-insurer to comply with a request for additional information, without good cause, may cause the Chairman to initiate proceedings to terminate the self-insurance privilege.

f) Petition for Reconsideration

1) Within 21 days after receipt of a notice of conditional approval or a notice that the employer's initial or renewal application does not warrant approval of the self-insurance privilege, the employer may file a petition for reconsideration of the Chairman's determination.

2) The petition for reconsideration shall be made in writing and must state the reasons why the Chairman should reconsider the decision.

3) The petition shall be accompanied by any documents that support the employer's position and, if applicable, any information not previously considered. The information may include, but is not limited to, evidence of an improving financial condition that was not available to the Board when the application was reviewed.

4) Request for Hearing

A) The employer may request a hearing on the petition for reconsideration. The request for hearing must be filed with the request for reconsideration.

B) Upon the filing of a timely petition for reconsideration and request for hearing, the Chairman shall issue a notice that sets forth a place and time of hearing, which shall be within 30 days after the date of

the notice.

C) Hearings on the petition for reconsideration shall be conducted in accordance with subsection (g).

D) In the absence of a request for hearing, the Chairman may consider all matters at issue from the petition for reconsideration and accompanying documentation.

5) The Chairman shall issue an order notifying the employer of his or her final decision and the reasons for that decision. The Order shall be subject to review under subsection (h).

g) Conduct of Hearings

1) All hearings under this Section shall be conducted by the Chairman or a Commissioner designated by the Chairman.

2) All hearings shall be conducted in accordance with the requirements of Article 10 of the Illinois Administrative Procedure Act [5 ILCS 100/Art. 10].

3) At the hearing, the employer shall have the right to respond and to call witnesses, cross-examine witnesses and present evidence.

4) *The Commission, or any member of the Commission, shall have the power to administer oaths, to subpoena and examine witnesses, and issue subpoena duces tecum requiring the production of such books, papers, records or documents as may be evidence to determine the issues of* denial or termination of the self-insurance privilege or adjustment of the security. (Section 16 of the Act)

5) The Illinois Rules of Evidence and Article VIII of the Code of Civil Procedure [35 ILCS 5/Art. VIII] shall apply at the hearing.

h) Appeal
All Orders made by the Chairman under Section 4(j) of the Act *shall be subject to review in the same manner and within the same time as provided by Section 19(f) of the Act for review of awards and decisions of the Commission.* (Section 4(j) of the Act)

i) Requirements Following Termination of the Self-Insurance Privilege

1) Termination of the employer's self-insurance privilege does not terminate its obligation to provide the Commission with security. The Chairman shall approve release of the security when the Chairman determines, in his or her discretion, that the employer, as a private self-insurer, has no outstanding liability under the Act/WODA.

2) *Former self-insurers shall be liable for any and all assessments until they have discharged all obligations to pay compensation that arose during the self-insurance period.* (Section 4a-7(b) of the Act)

(Source: Amended at 10 Ill. Reg. 15615, effective September 10, 1986)

Section 9100.60 Administration of Claims Against Securities, Indemnity or Bonds of Self-Insurers

a) Determination of Self-Insurer's Insolvent Condition
This Section applies whenever:

1) Any self-insured employer who is unable to pay compensation under Sections 7(f), 8(a), 8(b), 8(c), 8(d)(1), 8(d)(2), 8(e), 8(f), 19(a) and 19(g) of the Act and Section 7(7) of WODA has filed a written notice of that inability to pay with the Commission; or

2) Any person who has filed an Application for Adjustment of Claim against a self-insured employer gives written notice to the Commission that the Commission determines has raised a question with respect to that employer's ability to pay compensation under the Act/WODA; or

3) It is established that a court of competent jurisdiction has determined or is conducting proceedings to determine that a self-insured employer is unable to pay compensation under the Act/WODA; or

4) Any self-insurer has filed for, or is the subject of, any proceeding under the federal Bankruptcy Reform Act of 1978 (11 USC 101 et seq.) or is a party, whether plaintiff or defendant, in any proceeding in which a receiver, liquidator, custodian, rehabilitator, sequestrator or trustee, or similar officer for the self-insurer or its property, has been appointed;

b) The Commission, on its own motion or on the motion of any other party, shall hold a hearing to determine the ability of the self-insurer to pay compensation under the Act and to determine the existence and status of any action described in subsection (a). *The Commission or any member of the Commission shall have the power to administer oaths, to subpoena and examine witnesses, and to issue subpoena duces tecum requiring the production of such books, papers, records or documents as may be evidence to determine such issues.* [820 ILCS 305/16]

c) Duty to Notify
A self-insured employer that is claiming it is unable to pay compensation under the Act/WODA and that is a party to a bankruptcy proceeding described in subsection (a)(4), or that is the subject of an order set forth in subsection (a)(3) or (4), shall file written notice of that fact with the Commission within 10 days after the occurrence of the event.

d) Stay

Upon notification of any of the actions described in subsection (a), the Commission shall, on its own motion, stay all proceedings before the Commission involving that self-insured employer for at least 60 days.

e) Transfer of Securities, Indemnity or Bonds to the Commission

1) The Commission will issue notification, within 20 days after a hearing, of its determination that the self-insured employer is unable to pay compensation due under the Act/WODA, has filed for, or is the subject of, any bankruptcy proceeding (seesubsection (a)(4)), or is the subject of an order under subsection (a)(3) or (4). Any holder of any securities, indemnity or bonds furnished by that employer guaranteeing the payment of compensation under the Act/WODA shall notify the Commission in writing whether it is willing and able to administer those funds. Unless the holder has provided written notification to the Commission within the 20 day period that it is able and willing to administer the funds, the holder shall immediately deliver all such securities, indemnity or bonds to the Commission; otherwise, the Commission shall order the delivery or refer the matter to the Attorney General's Office for litigation to collect or recover all such securities, indemnity or bonds.

2) Upon receipt of the securities, indemnity or bonds, the Commission shall deposit the proceeds of those securities, indemnity or bonds with any state or national bank or trust company having trust authority in the State of Illinois that has been ranked in the upper 10% in the Annual Report submitted by the State of Illinois Director of the Division of Banking of the Department of Financial and Professional Regulation and that has the lowest fees for administration of escrow funds. Deposits in the bank or trust company shall be in the form of negotiable United States government bonds or negotiable general obligation bonds of the State of Illinois. The bank or trust company shall administer the funds and, upon the order of the Commission, shall distribute the funds. The administration fees for the bank or trust company shall be payable only from the interest accrued on the proceeds from time of deposit.

f) Filing Periods for Claims Against Securities, Indemnity or Bonds

1) If the bankruptcy proceedings described in subsection (a)(4) have been commenced or the Order affecting an entity under subsection (a)(3) or (4) was entered prior to September 17, 1984, any claim against the securities, indemnity or bonds with respect to a case for which an Application for Adjustment of Claim has not already been filed pursuant to 50 Ill. Adm. Code 9020.20 must have been filed on or before September 17, 1984.

2) If the bankruptcy proceedings described in subsection (a)(4) have been commenced or the Order affecting an entity under subsection (a)(3) or (4) was entered on or after September 17, 1984, any claim with respect to a case for which an Application for Adjustment of Claim has not already been filed pursuant to 50 Ill. Adm. Code 9020.20 must be filed on or before 12 months after the date of the commencement of those proceedings or the entry of the Order.

g) Distribution of Securities, Indemnity or Bonds

1) Upon determination by the Commission of the extent of the Self-Insured's liability under the Act in all cases for which Applications for Adjustment of Claims or Settlement Contract Petitions have been filed or for which claims are pending against the securities, indemnity or bonds, the Commission shall hold a hearing to determine the proceeds of the securities, indemnity or bonds. Notice of this hearing will be by mail at least 15 business days prior to the hearing and shall be given to all parties, including the holders of the securities, indemnity or bonds.

2) If, after a hearing pursuant to subsection (g)(1), the Commission has determined that the proceeds of the securities, indemnity or bonds are sufficient to pay all claims against the assets in full, it shall order the holder or the depository bank or trust company to make payment to the parties entitled to the assets who have perfected claims against those assets, in accordance with the terms of awards or settlements the Commission has entered or approved.

3) If the Commission determines that the proceeds of securities, indemnity or bonds are not sufficient to pay all claims in full, those claims that are for compensation for death and for temporary and total permanent disability and claims for medical expenses shall, as a class, be payable prior to payment of any other claims. If the proceeds are not sufficient to pay all claims within this class in full, payment of those claims will be prorated on the basis of the amount of each claim in proportion to the amount of the securities, indemnity and bonds available for distribution.

4) After all claims within the class have been paid in full, if any amount from the proceeds of securities, indemnity or bonds remains for distribution, payments of all other claims will be prorated on the basis of the amount of each identified claim in proportion to the amount of the remainder of the securities, indemnity or bonds.

5) If, after all identified claims are paid in full, any surplus securities, indemnity or bond amounts remain, the Commission shall order those amounts returned to the employer, bond company, or other party with legal right to those monies.

(Source: Amended at 10 Ill. Reg. 15615, effective September 10, 1986)

Section 9100.85 Administration of Claims Against the Injured Workers' Benefit Fund

a) Reimbursement

1) *The Commission shall have the right to obtain reimbursement for any compensation obligations paid by the Injured Workers' Benefit Fund (IWBF) from* any individual employer/owner, corporate officer, director of a corporate employer, partner of an employer partnership, or member of an employer limited liability company. (Section 4(d) of the Act)

2) *If an injured employee or his or her personal representative receives payment from the IWBF, the State of Illinois has the same rights under Section 5(b) of the Act/WODA that the employer who failed to pay the benefits due to the injured employee would have had if the employer had paid those benefits. Any moneys recovered by the State as a result of the State's exercise of its rights under those statutes shall be deposited into the IWBF for the payment of claims.* (Section 4(d) of the Act)

b) Administration for IWBF Payout
To qualify for payment from the IWBF, a claimant must have filed an Application for Adjustment of Claim against the employer (see 50 Ill. Adm. Code 9020.20) and must have named the State Treasurer as ex-officio custodian of the IWBF as a party respondent, or must have amended the Application of Adjustment of Claim to do so.

(Source: Added at 9 Ill. Reg. 3705, effective March 12, 1985)

Section 9100.90 Insurance Coverage: Compliance

a) Employers to Insure Payment of Compensation
Any employer subject to Section 3 of the Act or any employer who elects to provide and pay the compensation provided for in the Act/WODA shall insure payment of that compensation as required by Section 4(a) of the Act/WODA by obtaining approval from the Commission to operate as a self-insurer or by insuring its entire liability to pay the compensation in some insurance carrier authorized, licensed or permitted to do such insurance business in Illinois.

b) Failure to Insure Payment of Compensation Liability; Penalty
Penalties may be assessed by the Commission after reasonable notice and hearing in accordance with Section 4 of the Act and Section 4 of WODA.

c) Notice of Non-Compliance

1) The Commission shall give Notice of Non-Compliance to the employer at the employer's last known address or to the employer's representative. The notice shall be accompanied by a certificate of service by the Commission on the employer, setting forth the time and manner of service.

2) The Notice of Non-Compliance shall be a written statement setting forth, but not limited to, the following information:

A) the name and address of the employer;

B) a statement of the Section of the statute alleged to be violated, the periods of non-compliance and the penalty that may be imposed;

C) a statement that the employer must submit evidence of compliance or otherwise respond within 30 days after the date of receipt of the notice. Examples of evidence of compliance are:

i) a copy of the policy information page required to be filed under Section 9100.20 that indicates coverage for the periods of alleged non-compliance;

ii) a self-insurance certificate of approval covering the periods of alleged non-compliance;

iii) a copy of a pooling agreement showing membership in a

licensed group workers' compensation pool authorized by the Illinois Department of Insurance during the alleged periods of non-compliance;

D) a statement that failure to respond to the Notice of Non-Compliance within the prescribed time period shall cause the Commission to set this matter for hearing in accordance with subsection (d).

3) Informal Conference

A) When a Notice of Non-Compliance has been sent, the Commission shall, at the request of the employer or its attorney, or may on its own initiative, schedule the matter for an informal conference at which a designated representative of the Commission shall meet with the employer in an attempt to resolve the matter.

B) A request by the employer or its attorney for an informal conference must be received by the Commission within 15 days after the receipt of the Notice of Non-Compliance.

C) The Commission shall send written notice to the employer or its attorney at least 7 days prior to the scheduled conference.

D) The conference shall be held at a site designated by the Commission.

E) If the matter cannot be resolved at the conference, the Commission shall set the matter for hearing in accordance with subsection (d).

d) Hearings

1) Notice of Hearing; Locations

A) A matter under this Section is commenced by the Commission by service of a Notice of Hearing upon the employer at least 30 days prior to the time fixed for hearing. If service cannot be made by personal service, service of the Notice shall be by United States registered or certified mail addressed to the employer at the last known address or to the employer's representative.

B) The Notice of Hearing shall be a written statement setting forth, but not limited to, the following information:

i) the name and address of the employer;

ii) the time, date and place of hearing;

iii) the name of the Commissioner;

iv) a statement of the Section of the statute alleged to be violated, periods of non-compliance and the penalty that may be imposed; and

v) a statement that failure to appear at the hearing, if no continuance has been obtained prior to the hearing, shall constitute a default and shall result in a finding that there has been a knowing and willful failure of the employer to insure his or her liability to pay compensation in accordance with Section 4(a) of the Act or to comply with an Order of the Commission under Section 4(c) and an assessment of penalties under Section 4(d).

C) The hearing shall be set at a site designated by the assigned Commissioner.

2) Assignment

A) In all cases in which the employer is principally located in Cook County, a matter to be scheduled for hearing under this Section shall be randomly assigned to a Commissioner.

B) In all other cases, a matter to be scheduled for hearing under this Section shall be assigned to the Commissioner who serves that territory within which the employer is principally located.

3) Conduct of Hearings

A) At the hearing, a representative of the Commission shall have the opportunity to introduce evidence, to call and examine witnesses, and to cross-examine witnesses. The employer or its attorney shall be given the opportunity to show that there has been compliance with Section 4(a) of the Act or an Order of the Commission under Section 4(c) or show cause why compliance has not been accomplished. The employer or its attorney shall have the opportunity to introduce evidence, to call and examine witnesses,

and to cross-examine witnesses. The representative of the Commission shall have the right of rebuttal.

B) *The Commission or any member of the Commission shall have the power to administer oaths, to subpoena and examine witnesses, and to issue subpoenas duces tecum requiring the production of such books, papers, records or documents as may be evidence to determine the issue* of non-compliance. (Section 16 of the Act)

C) The Illinois Rules of Evidence and Article VIII of the Code of Civil Procedure [735 ILCS 5/Art. VIII] shall apply except to the extent they conflict with the Workers' Compensation Act, the Workers' Occupational Diseases Act, or the Rules Governing Practice Before the Workers' Compensation Commission (50 Ill. Adm. Code: Chapter VI).

D) A certification from an employee of the National Council on Compensation Insurance stating that no policy information page has been filed in accordance with Section 9100.20 shall be deemed prima facie evidence of that fact.

E) A certification from an employee of the Commission stating that an employer has not been approved as a self-insurer shall be deemed prima facie evidence of that fact.

e) Decision
The Commission, after the hearing is concluded, shall issue a Decision that includes:

1) the findings of the Commission;

2) when applicable, the dates of failure to insure and the amount of penalty assessed for each day;

3) the payment procedures provided in subsection (f); and

4) a statement of the conditions for a judicial review of the Commission's Decision in accordance with the requirements of 50 Ill. Adm. Code 9060.

f) Payment Procedures
When the Commission assesses a penalty against an employer in accordance with Section 4(d) of the Act/WODA, payment shall be made according to the following procedure:

1) payment of the penalty shall be made by certified check or money order made payable to the Illinois Workers' Compensation Commission;

2) payment shall be mailed or presented within 30 days after the final Order of the Commission or the order of the court on review after final adjudication to:

Workers' Compensation Commission
Insurance Compliance Division
100 West Randolph Street
Suite 8-328
Chicago, Illinois 60601

3) or as otherwise directed by www.iwcc.il.gov.

g) Work-Stop Order

1) Failure to Insure Payment of Compensation Liability; Work-Stop Order When the panel has issued a decision under subsection (g)(5), the Commission may issue a Work-Stop Order on an employer requiring the cessation of all business operations at the employer's places of employment or job sites.

2) Hearings, Notice, Locations

A) A matter under this Section is commenced by the Commission's Insurance Compliance Division by service of a Notice of Work-Stop Hearing upon an employer at least 5 days prior to the time fixed for hearing.

B) If service cannot be made by personal service, by United States registered or certified mail addressed to the employer at the last known address or to the employer's representative, service may be effectuated by posting a copy of the Notice of Work-Stop Hearing at the entrance of the employer's places of employment or in a prominent place at the job sites.

C) The Notice of Work-Stop Hearing shall set forth the following information:

i) The name and address of the employer;

ii) The time, date and place of hearing;

iii) A statement of the Section of the statute alleged to be violated, periods of non-compliance, and that a Work-Stop Order may be issued;

iv) A statement that failure to appear at the hearing shall constitute a default and shall result in a finding that:

- there has been a knowing failure of the employer to provide coverage required by Section 4(a) of the Act;
- the failure to insure is deemed an immediate serious danger to public health, safety and welfare; and
- a Work-Stop Order shall be issued by the Commission hearing panel at the close of evidence.

3) Assignments

A) A matter to be scheduled for a Work-Stop Order hearing in Chicago shall be randomly assigned to any available Commissioner.

B) A matter to be heard in Springfield shall be scheduled to a Commissioner at his or her next available review date.

C) The hearing shall be held within 7 days after the date of the Notice of Work-Stop Hearing.

4) Hearings under this subsection (g) shall be conducted in accordance with subsection (d)(3).

5) Decision

A) A panel of 3 Commissioners (one member representing the employing class, one member representing the employee class, and one member representing neither the employing or employee class) shall issue a decision at the close of the hearing that shall include:

i) The findings of the Commission;

ii) The dates of failure to insure;

iii) A statement of the conditions for a judicial review of the Commission's decision in accordance with the requirements of 50 Ill. Adm. Code 9060.

B) If the panel's decision finds that the *employer has knowingly failed to provide the* WC *coverage required by Section (4)(a) of the Act, that failure is* statutorily *deemed an immediate serious danger to public health, safety and welfare justifying service by the Commission of a Work-Stop Order* under subsection (g)(1). (Section 4(d) of the Act)

6) Issuance and Posting of Work-Stop Order

A) A Work-Stop Order shall take effect immediately upon issuance by the Commission.

B) Posting of Work-Stop Order

i) Upon taking effect, the Commission shall cause a Notice of Work-Stop Order to be posted at the employer's places of employment or job sites reflecting the decision of the Commission.

ii) The Notice of Work-Stop Order shall be in the form of a sign of sufficient size and visibility to serve as notice to the public or persons at or entering the employer's places of employment or job sites that a Work-Stop Order is in effect. The notice shall be affixed to the employer's places of employment or job sites in any manner possible, including, but not limited to, windows, doors and fencing.

iii) Upon request by the Commission, any law enforcement agency in the State shall render assistance to the Commission to carry out the provision of Section 4(d) of the Act, including, but not limited to, preventing any employee from remaining at the employer's place of employment after a Work-Stop Order has taken effect.

7) Release of Work-Stop Order

A) A Work-Stop Order shall remain in effect until the Commission

issues a Release of the Work-Stop Order upon a finding that the employer is in compliance with the workers' compensation insurance coverage requirements of Section 4(a) of the Act. An employer may request a Release of the Work-Stop Order by demonstrating compliance by submitting a copy of the policy information page issued by an insurance carrier (see Section 9100.20) and proof of payment of premium for at least 90 days. The documentation provided must be to the Commission's satisfaction.

B) Release of a Work-Stop Order does not relieve the employer and/or officers of any fines, penalties or decision that may be assessed for prior noncompliance periods.

(Source: Amended at 10 Ill. Reg. 15615, effective September 10, 1986)

TITLE 50: INSURANCE
CHAPTER VI: WORKERS' COMPENSATION COMMISSION

PART 9110
MISCELLANEOUS

Section

AUTHORITY: Implementing and authorized by the Workers' Compensation Act [820 ILCS 305].

SOURCE: Filed and effective March 1, 1977; amended at 5 Ill. Reg. 5533, effective May 12, 1981; amended at 6 Ill. Reg. 8040, effective July 1, 1982; codified at 7 Ill. Reg. 2352; emergency amendment at 14 Ill. Reg. 4929, effective March 9, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 13161, effective August 1, 1990; emergency amendment at 30 Ill. Reg. 1912, effective February 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 11743, effective June 22, 2006; amended at 33 Ill. Reg. 2850, effective February 1, 2009; emergency amendment at 34 Ill. Reg. 10222, effective July 6, 2010, for a maximum of 150 days; emergency rule repealed by emergency amendment at 34 Ill. Reg. 17471, effective October 28, 2010, for the remainder of the 150 days; amended at 36 Ill. Reg. 16349, effective November 5, 2012; amended at 36 Ill. Reg. 17108, effective November 20, 2012; recodified from 50 Ill. Adm. Code 7110 to 50 Ill. Adm. Code 9110 at 39 Ill. Reg. 9616; amended at 40 Ill. Reg. 15823, effective November 9, 2016.

Section 9110.5 Definitions

"Act" means the Illinois Workers' Compensation Act [820 ILCS 305].

"Arbitrator" is an employee appointed pursuant to Section 14 of the Act.

"Commission" means the Illinois Workers' Compensation Commission.

"Commissioner" means one of the 10 persons appointed by the Governor pursuant to Section 13 of the Act.

"Handbook" means the handbook describing the rights and obligations of employers and employees under the Act that is published by the Commission pursuant to Section 15a of the Act.

(Source: Added at 30 Ill. Reg. 11743, effective November 5, 2012)

Section 9110.10 Vocational Rehabilitation

a) An employer's vocational rehabilitation counselor, in consultation with the injured employee and, if represented, with his or her representative, shall prepare a written assessment of the course of medical care and, if appropriate, vocational rehabilitation required to return the injured worker to employment. The vocational rehabilitation assessment is required when it can be reasonably determined that the injured worker will, as a result of the injury, be unable to resume the regular duties in which he or she was engaged at the time of injury. When the period of total incapacity for work exceeds 365 days, the written assessment required by this subsection shall likewise be prepared.

b) The assessment shall address the necessity for a plan or program that may include medical and vocational evaluation, modified or limited duty, and/or retraining, as necessary.

c) At least every 4 months thereafter, or until the matter is terminated by Order or Award of the Commission or by written agreement of the parties approved by the Commission, the employer, or his or her representative, in consultation with the employee and, if represented, with his or her representative, shall:

1) if the most recent previous assessment concluded that no plan or program was then necessary, prepare a written review of the continued appropriateness of that conclusion; or

2) if a plan or program had been developed, prepare a written review of the continued appropriateness of that plan or program, and make in writing any necessary modifications.

d) A copy of each written assessment, plan or program, review and modification shall be provided to the employee and/or his or her representative at the time of preparation, and an additional copy shall be retained in the file of the employer and, if insured, in the file of the insurance carrier. Copies shall be made available for review by the Commission, on its request, until the matter is terminated by Order or Award of the Commission or by written agreement of the parties approved by the Commission.

e) The rehabilitation plan may be prepared on a form furnished by the Commission.

f) Nothing in this Section abridges the rights of the parties.

(Source: Amended at 40 Ill. Reg. 15823, effective November 9, 2016)

Section 9110.20 Petitions under Sections 19(h), 8(a), and 7(a) of the Act (Repealed)

(Source: Repealed at 40 Ill. Reg. 15823, effective November 9, 2016)

Section 9110.30 Commission Meetings: Minutes

The Commission shall keep a record of the minutes of all its duly convened meetings, exclusive of deliberations on cases pending before the Commission. The minutes shall be open to the public for inspection.

(Source: Amended at 30 Ill. Reg. 11743, effective June 22, 2006)

Section 9110.40 Petition to Suspend Compensation for Failure to Submit to Proper Medical Treatment

Petitions to suspend compensation, as provided in Section 19(d) of the Act, shall be docketed and set for hearing in the same manner as Petitions filed pursuant to Section 19(b), as set forth in 50 Ill. Adm. Code 9020.80. All Petitions shall give the nature of the injury and the treatment required. Reasonable notice of the time and place of hearing shall be served upon the injured party, if unrepresented, either personally or by registered mail.

(Source: Amended at 40 Ill. Reg. 15823, effective November 9, 2016)

Section 9110.50 Petitions under Section 19(o) of the Act

a) A petition filed under Section 19(o) of the Act alleging that the insurer made payments in a case that was not compensable shall provide the following information:

1) name and address of the employer;

2) name and address of the employee;

3) name and address of the insurance carrier;

4) date of the alleged accident giving rise to the petition;

5) benefits paid by the insurance carrier and the dates of the payment;

6) whether Application for Adjustment of Claim was filed with the Commission and the Commission number assigned to the application;

7) a brief statement of the basis for the insured's claim that the case was not compensable.

b) Consideration of a Section 19(o) Petition

1) The Commission, on receipt of the 19-o petition, shall docket the petition and forward a copy of the petition to the insurance carrier and the attorney of record, together with notice of a hearing date not less than 30 days nor more than 60 days from the date the petition is filed.

2) The insurance carrier may answer the 19-o petition by filing with the Commission and serving the employer with a copy of its answer within 30 days after receipt of the petition. The answer shall bear the same heading as the 19-o petition and shall respond to the allegations on a paragraph-by-paragraph basis.

3) The 19-o matter shall, on the hearing date, be assigned to an Arbitrator in the same manner as an arbitrated case. The Arbitrator shall then hold an informal hearing with the employer and the insurance company in an attempt to resolve the dispute or narrow the issues. If the dispute cannot be resolved at the informal hearing, the Arbitrator shall file a written statement of the issues to be resolved by a Commissioner and the positions of each party. If possible, the statement should be agreed to by each party.

The matter will then be assigned for hearing before a Commissioner in the same manner as reviews are assigned.

(Source: Amended at 30 Ill. Reg. 11743, effective June 22, 2006)

Section 9110.60 Commission Handbook

The Commission Handbook will be maintained on the Commission website pursuant to Section 15a of the Act.

(Source: Amended at 40 Ill. Reg. 15823, effective November 9, 2016)

Section 9110.70 Explanation of Basis of Non-Payment, Termination or Suspension of Temporary Total Compensation or Denial of Liability or Further Responsibility for Medical Care

a) When an employee becomes unable to work due to an accidental or occupational disease arising out of or in the course of his or her employment, or alleges that he or she is unable to work, the employer, individually or by his or her agent, service company or insurance carrier, shall, within 14 calendar days after notification or knowledge of such inability or alleged inability to work:

1) begin payment of temporary total compensation, if any is then due; or

2) if the employer denies liability for payment of temporary total compensation for whatever reason, provide the employee with a written explanation of the basis for the denial; or

3) if the employer has insufficient information to determine its liability for payment of temporary total compensation, advise the employee in writing of the information needed to make that determination and provide in a written explanation why the requested information is necessary.

b) When an employer begins payment of temporary total compensation and later terminates or suspends further payment before an employee in fact has returned to work, the employer shall provide the employee with a written explanation of the basis for the termination or suspension of further payment no later than the date of the last payment of temporary total compensation.

c) When an employer takes the position that it has insufficient medical information to determine its liability for the initial payment of temporary total compensation, or the continuation of such payment, the employer shall have the initial responsibility to promptly seek the desired information from those providers of medical, hospital and surgical services of which the employer has knowledge. The employee shall have the responsibility to provide or execute authorizations for release of medical information as the employer may reasonably request from time to time, and the employer shall promptly provide the employee or his or her representative, upon request, with copies of the complete medical records and reports it obtains with the authorizations.

d) When an employer denies liability for payment of the cost of all or a part of an employee's medical care, or initially accepts liability but subsequently declines further responsibility for providing or paying for all or a part of such care (for any reason including but not limited to the necessity or propriety of the care, or

continuing care, or the unreasonableness of the cost of care), the employer shall promptly notify the employee with a written explanation of the basis for the denial of liability or further responsibility.

e) Failure by either party to comply with the provisions of subsection (a), (b), (c) or (d) of this Section, without good and just cause, shall be considered by the Commission or an Arbitrator when adjudicating a petition for additional compensation pursuant to Section 19(l) of the Act, or a petition for assessment of attorneys' fees and costs pursuant to Section 16 of the Act.

(Source: Amended at 30 Ill. Reg. 11743, effective June 22, 2006)

Section 9110.80 Rate Adjustment Fund and Second Injury Fund Contributions: Compliance

a) Employers Required to Make Payments to Rate Adjustment Fund and Second Injury Fund
Any employer who shall come within the provisions of Section 3 of the Act or any employer who shall elect to provide and pay the compensation provided for in the Act and the Workers' Occupational Diseases Act [820 ILCS 310] shall pay into the Rate Adjustment Fund and the Second Injury Fund in accordance with the provisions of Section 7(f) of the Act.

b) Penalties

1) *If the Commission finds, after reasonable notice and hearing* in accordance with subsection (e), *that an employer or insurance carrier on behalf of the employer has wilfully and knowingly failed to pay any obligations accruing after December 18, 1989 into the Rate Adjustment Fund or the Second Injury Fund as required by Section 7(f) of the Act or if such payments are not made within the time periods prescribed by Section 7(f) of the Act, the employer shall, in addition to such payments, pay a penalty of 20% of the amount required to be paid or $2,500, whichever is greater, for each year or part thereof of such failure to pay.* (Section 7(f) of the Act)

2) Obligations accruing prior to December 18, 1989:

A) *Any obligations of an employer or insurance carrier to the Rate Adjustment Fund or the Second Injury Fund accruing prior to December 18, 1989 shall be paid in full by such employer within 5 years of December 18, 1989, with at least one-fifth of such obligation to be paid during each year following December 18, 1989.* (Section 7(f) of the Act)

i) Such obligations shall be paid pursuant to an agreement signed by the employer or by the insurance carrier on behalf of the insured employer.

ii) The agreement shall include the amount of the obligation and the date each payment is due.

B) *If the Commission finds, after reasonable notice and hearing* in accordance with subsection (e), *that an employer or insurance carrier has failed to make timely payments of any obligation*

accruing in subsection (b)(2)(A), *the employer shall, in addition to all other payments required, be liable for a penalty equal to 20% of the overdue obligation or $2,500, whichever is greater, for each year or part thereof, that the obligation is overdue.* (Section 7(f) of the Act)

3) *The Commission may for good cause shown waive all or part of any penalty assessed.* The decisions of the Commission under Section 7(f) of the Act shall serve as precedents in determining good cause.

c) Verification of amounts paid by employers into the Rate Adjustment Fund and Second Injury Fund.

1) *The Chairman shall* by May 1 of each year *furnish to the Director of the Illinois Department of Insurance a list of the amounts paid into the Second Injury Fund and the Rate Adjustment Fund by each insurance company on behalf of their insured employers. The Director shall verify to the Chairman*on or before September 1 of each year *that the amounts paid by each insurance company are accurate as best the Director can determine from the records available to the Director.*

2) *The Chairman shall verify that the amounts paid by each self-insurer are accurate as best as the Chairman can determine from records available to the Chairman.* (Section 7(f) of the Act) The Chairman may, upon written notice, require that each self-insurer provide the following:

A) *Information* on forms provided by the Commission *concerning the total compensation payments made upon which contributions to the Rate Adjustment Fund and Second Injury Fund are predicated, and*

B) *Any additional information establishing that payments have been made into the Rate Adjustment Fund and the Second Injury Fund.*(Section 7(f) of the Act) Such additional information shall include, but not be limited to, cancelled checks or other proof of payment.

3) Any information requested under subsection (c)(2) shall be provided to the Commission by the self-insurer within 30 days after the date of the notice.

d) Notice of Deficiency – Informal Conference

1) Notice of Deficiency

A) When the records of the Commission or the Department of Insurance show that a deficiency exists regarding payment into the Rate Adjustment Fund or the Second Injury Fund, the Commission shall give notice of the deficiency to the insurance carrier or the self-insured employer. Service of the Notice of Deficiency shall be by United States registered or certified mail, addressed to the insurance company or the self-insured employer at the last known address, or to a representative thereof, and to the State Treasurer as ex-officio Custodian of the Rate Adjustment Fund and the Second Injury Fund.

B) The Notice of Deficiency shall be a written statement setting forth, but not limited to, the following information:

i) the name and address of the insurance carrier, or the self-insured employer or representative;

ii) a statement of the statute alleged to be violated, the dates of non-payment or underpayment, the amount of deficiency and the penalty that may be imposed;

iii) a statement that the self-insured employer or insurance carrier must cure the deficiency or otherwise respond in writing within 30 days after the receipt of the Notice;

iv) a statement that the failure to respond to a Notice of Deficiency within the prescribed time period shall cause the Commission to set the matter for hearing in accordance with subsection (e).

2) Informal Conference

A) When a Notice of Deficiency has been sent, the Commission may, at the request of the self-insured employer or insurance carrier, or on its own initiative, schedule the matter for an informal conference at which a designated representative of the Commission shall meet with the self-insured employer or the insurance carrier in an attempt to resolve the matter. An informal conference will not be scheduled when the self-insured employer or the insurance carrier cures the deficiency within 30 days after receipt of the Notice of Deficiency.

B) A request by the self-insured employer or the insurance carrier for an informal conference shall be included in the response to the Notice of Deficiency.

C) The Commission shall send written notice of the time and place of the conference to the self-insured employer or the insurance carrier and State Treasurer as ex-officio Custodian of the Rate Adjustment Fund and the Second Injury Fund at least 15 days prior to the scheduled conference.

D) The conference shall be held at a site designated by the Commission.

E) If the matter cannot be resolved at the conference, the Commission shall set the matter for hearing in accordance with subsection (e).

e) Hearings

1) Notice of Hearing; Locations

A) Any matter under this Section is commenced by the Commission by service of a Notice of Hearing upon the insurance carrier or self-insured employer, and the State Treasurer as ex-officio Custodian of the Rate Adjustment Fund and the Second Injury Fund. Notice of Hearing shall be given at least 30 days prior to the time fixed for hearing. Service of the Notice of Hearing shall be by United States registered or certified mail, addressed to the insurance carrier or the self-insured employer at the last known address, or to a representative thereof, and to the State Treasurer as ex-officio Custodian of the Rate Adjustment Fund and the Second Injury Fund.

B) The Notice of Hearing shall be a written statement setting forth, but not limited to, the following information:

i) the name and address of the insurance carrier or self-insured employer;

ii) the time, date and place of hearing;

iii) the name of the hearing Commissioner;

iv) a statement of the statute alleged to be violated and the penalty that may be imposed;

v) a statement of the amount of the deficiency and the dates of non-payment or underpayment;

vi) a statement that failure to appear at the hearing, where no continuance has been obtained from the Commissioner prior to the hearing, shall constitute a default and will result in a finding that there has been a wilful and knowing failure to comply with Section 7(f) of the Act, and an assessment of penalties.

C) The hearing shall be set at a site designated by the assigned Commissioner.

2) Assignment

A) In cases in which the employer is principally located in Cook County, a matter to be scheduled for hearing under this Section shall be randomly assigned to a Commissioner.

B) In all other cases, a matter to be scheduled for hearing under this Section shall be assigned to a Commissioner who serves the territory within which the employer is principally located.

3) Conduct of Hearings

A) A representative of the Commission shall have the opportunity to introduce evidence, to call and examine witnesses and to cross-examine witnesses. The records of the Commission and the Department of Insurance regarding deficiency in payment shall be considered prima facie evidence of failure to comply with Section 7(f) of the Act.

B) At the hearing, the insurance carrier or self-insured employer, or its attorney, shall be given the opportunity to rebut the evidence of deficiency.

C) Any party, including the State Treasurer as ex-officio Custodian of the Rate Adjustment Fund and the Second Injury Fund, shall have the right to introduce evidence, to call and examine witnesses and

to cross-examine witnesses. The representative of the Commission shall have the right of rebuttal.

D) *The Commission, or any member thereof, shall have the power to administer oaths, to subpoena and examine witnesses and to issue subpoena duces tecum requiring the production of such books, papers, records or documents as may be evidence to determine the issue* of non-compliance. (Section 16 of the Act)

E) The Illinois common law rules of evidence and Article VIII of the Code of Civil Procedure [735 ILCS 5/Art. VIII] shall apply at the hearing except to the extent they conflict with the Act, the Workers' Occupational Diseases Act and the Rules Governing Practice Before the Illinois Workers' Compensation Commission (50 Ill. Adm. Code Ch. II).

f) Decision

The Commission, after the hearing is concluded, shall issue a decision in accordance with Section 7(f) of the Act, which shall include:

1) the findings of the Commission;

2) where applicable, the amount of the penalty assessed and the basis for the amount;

3) the payment procedures as provided in subsection (g);

4) a statement of the conditions for a judicial review of the Commission decision in accordance with the requirement of 50 Ill. Adm. Code 7060.

g) Payment Procedure

When the Commission assesses a penalty against an employer in accordance with Section 7(f) of the Act, payment shall be made according to the following procedure:

1) payment of the penalty shall be made by certified check or money order made payable to the State of Illinois.

2) payment shall be mailed or presented within 30 days after the final order of the Commission or the order of the court on review after final adjudication to:

Illinois Workers' Compensation Commission

Fiscal Office
100 West Randolph Street
Suite 8-328
Chicago, Illinois 60601
1-312/814-6625

(Source: Amended at 30 Ill. Reg. 11743, effective June 22, 2006)

Section 9110.90 Illinois Workers' Compensation Commission Medical Fee Schedule

a) In accordance with Sections 8(a), 8.2 and 16 of the Workers' Compensation Act [820 ILCS 305/8(a), 8.2 and 16] (the Act), the Illinois Workers' Compensation Commission Medical Fee Schedule, including payment rates, instructions, guidelines, and payment guides and policies regarding application of the schedule, is adopted as a fee schedule to be used in setting the maximum allowable payment for procedures, treatment, products, services or supplies for hospital inpatient, hospital outpatient, emergency room, ambulatory surgical treatment centers, accredited ambulatory surgical treatment facilities, prescriptions filled and dispensed outside of a licensed pharmacy, dental services and professional services covered under the Act. The fee schedule is published on the Internet at no charge to the user via a link from the Commission's website at www.iwcc.il.gov. The fee schedule may be examined at any of the offices of the Illinois Workers' Compensation Commission.

b) The payment rates for procedures, services or treatments in the fee schedule were established in accordance with Section 8.2 of the Act by determining 90% of the 80th percentile of charges utilizing health care provider and hospital charges from August 1, 2002 through August 1, 2004. The charges were adjusted by the Consumer Price Index-U for the period August 1, 2004 through September 30, 2005. For procedures, treatments, services or supplies covered under the Act and rendered or to be rendered on or 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. The payment rates in the fee schedule are designated by geozip (geographic area in which all zip codes have the same first 3 digits). Starting January 1, 2012, the payment rates in the fee schedule shall be grouped into geographic regions pursuant to Section 8.2 of the Act.

c) The fee schedule applies to any medical procedure, treatment or service covered by the Act and rendered on or after February 1, 2006, regardless of the date of injury.

d) Under the fee schedule, the employer pays the lesser of the rate set forth in the schedule or the provider's actual charge. If an employer or insurance carrier contracts with a provider for the purpose of providing services under the Act, the rate negotiated in the contract shall prevail.

e) Reimbursement Not Covered by Fee Schedule

1) Prior to September 1, 2011, whenever the fee schedule does not set a specific fee for a procedure, treatment or service in the schedule, the amount of reimbursement shall be at 76% of actual charge, except where

this Section provides that revenue codes (codes that identify a specific accommodation or ancillary charge on a UB-04/CMS 1450 uniform billing form used by hospitals) are to be deducted from the charge and reimbursed at 65% of charge billed at the provider's normal rates under its standard chargemaster. A standard chargemaster is the provider's list of charges for procedures, services and supplies used to bill payers in a consistent manner. If the provider cannot use the chargemaster to demonstrate the charge is the provider's normal rate, the provider shall provide evidence that the charge is billed at the provider's normal rate.

2) On and after September 1, 2011, whenever the fee schedule does not set a specific fee for a procedure, treatment or service in the schedule, the amount of reimbursement shall be at 53.2% of actual charge, except where this Section provides that revenue codes (codes that identify a specific accommodation or ancillary charge on a UB-04/CMS 1450 uniform billing form used by hospitals) are to be deducted from the charge and reimbursed at 65% of charge billed at the provider's normal rates under its standard chargemaster. A standard chargemaster is the provider's list of charges for procedures, services and supplies used to bill payers in a consistent manner. If the provider cannot use the chargemaster to demonstrate the charge is the provider's normal rate, the provider shall provide evidence that the charge is billed at the provider's normal rate.

f) Reimbursement under the fee schedule for a procedure, treatment or service, as designated by the geozip or region where the treatment occurred, shall be based on the place of service.

g) Out-of-State Treatment

1) Procedure Codes

A) Prior to June 28, 2011, if the procedure, treatment or service is rendered outside the State of Illinois, the amount of reimbursement shall be the greater of 76% of actual charge or the amount set forth in a workers' compensation medical fee schedule adopted by the state in which the procedure, treatment or service is rendered, if such a schedule has been adopted. Charges for a procedure, treatment or service outside the State shall be subject to the instructions, guidelines, and payment guides and policies in this fee schedule.

B) On and after June 28, 2011, providers of out-of-state procedures, treatments, services, products, or supplies shall be reimbursed at

the lesser of that state's fee schedule amount or the fee schedule amount for the region in which the employee resides. If no fee schedule exists in that state, the provider shall be reimbursed at the lesser of the actual charge or the fee schedule amount for the region in which the employee resides. If the employee does not reside in this State, providers of out-of-state treatments, services, products or supplies shall be reimbursed at the lesser of the actual charge or the fee schedule amount for the location of the hearing site. "Hearing site" means the location established by the Commission for arbitration and Commission hearings.

2) Implants

A) Prior to September 1, 2011, when the charges are for facility fees (ambulatory surgical treatment center, hospital inpatient (standard and trauma), and hospital outpatient services), the following revenue codes are pass-through charges to be deducted from the charge and reimbursed at 65% of actual charge: 0274 (prosthetics/orthotics); 0275 (pacemaker); 0276 (lens implant); 0278 (implants); 0540 and 0545 (ambulance); 0624 (investigational devices); and 0636 (drugs requiring detailed coding). Charges billed under these revenue codes shall be billed at the provider's normal rates under its standard chargemaster. If the provider cannot use the chargemaster to demonstrate the charge is the provider's normal rate, the provider shall provide evidence that the charge is billed at the provider's normal rate.

B) On and after September 1, 2011, implants, which include revenue codes 0276 (lens implant) and 0278 (implants) or any other substantially similar updated code as determined by the Commission, shall be reimbursed at 25% above the net manufacturer's invoice price less rebates, plus actual reasonable and customary shipping charges whether or not the implant charge is submitted by a provider in conjunction with a bill for all other services associated with the implant, submitted by a provider on a separate claim form, submitted by a distributor, or submitted by the manufacturer of the implant. The following revenue codes shall be paid at 65% of actual charge, which is the provider's normal rates under its standard chargemaster: 0274 (prosthetics/orthotics); 0275 (pacemaker); 0540 and 0545 (ambulance); 0624 (investigational devices); and 0636 (drugs requiring detailed coding). A standard chargemaster is the provider's list of charges for procedures, treatments, products, supplies or services used to bill payers in a

consistent manner. If the provider cannot use the chargemaster to demonstrate the charge is the provider's normal rate, the provider shall provide evidence that the charge is billed at the provider's normal rate.

h) The fee schedule includes the following service categories:

1) Ambulatory Surgical Treatment Center (ASTC) and Accredited Ambulatory Surgical Treatment Facility (ASTF)

A) This schedule applies to licensed ambulatory surgical treatment centers as defined by the Illinois Department of Public Health (77 Ill. Adm. Code 205.110) and accredited ambulatory surgical treatment facilities accredited by one of the following organizations: American Association for the Accreditation of Ambulatory Surgical Facilities (AAAASF), The Joint Commission (formerly JCAHO), or Accreditation Association for Ambulatory Health Care (AAAHC).

B) The use of this schedule is in accordance with the Current Procedural Terminology, American Medical Association, 515 North State Street, Chicago, Illinois 60610 (2006), no later dates or editions.

C) This schedule provides the maximum fee schedule amount for surgical services administered in an ASTC or ASTF setting for codes 10021 through 69990. The schedule is a partial global reimbursement schedule in that all charges rendered during the operative session are subject to a single fee schedule amount, except as provided in subsections (h)(1)(D) and (h)(1)(F).

D) Implants

i) Prior to September 1, 2011, the following revenue codes are pass-through charges to be deducted from the charge and reimbursed at 65% of actual charge: 0274 (prosthetics/orthotics); 0275 (pacemaker); 0276 (lens implant); 0278 (implants); 0540 and 0545 (ambulance); 0624 (investigational devices); and 0636 (drugs requiring detailed coding). Charges billed under these revenue codes shall be billed at the provider's normal rates under its standard chargemaster. If the provider cannot use the chargemaster to demonstrate the charge is the provider's

normal rate, the provider shall provide evidence that the charge is billed at the provider's normal rate.

ii) On and after September 1, 2011, implants, which include revenue codes 0276 (lens implant) and 0278 (implants) or any other substantially similar updated code as determined by the Commission, shall be reimbursed at 25% above the net manufacturer's invoice price less rebates, plus actual reasonable and customary shipping charges whether or not the implant charge is submitted by a provider in conjunction with a bill for all other services associated with the implant, submitted by a provider on a separate claim form, submitted by a distributor, or submitted by the manufacturer of the implant. The following revenue codes shall be paid at 65% of actual charge, which is the provider's normal rates under its standard chargemaster: 0274 (prosthetics/orthotics); 0275 (pacemaker); 0540 and 0545 (ambulance); 0624 (investigational devices); and 0636 (drugs requiring detailed coding). A standard chargemaster is the provider's list of charges for procedures, treatments, products, supplies or services used to bill payers in a consistent manner. If the provider cannot use the chargemaster to demonstrate the charge is the provider's normal rate, the provider shall provide evidence that the charge is billed at the provider's normal rate.

E) All professional services performed in an ASTC or ASTF setting are subject to the HCPCS Level II schedule in subsection (h)(5) or the professional services schedule in subsection (h)(8).

F) This schedule does not apply to the professional or technical components of radiology and pathology and laboratory services performed in an ASTC or ASTF setting. Charges for these services must be submitted on a separate claim form and shall be subject to the professional services schedule in subsection (h)(8).

G) Surgery services under this schedule shall be reimbursed in accordance with the Multiple Procedure and Bilateral Surgery provisions of the Payment Guide in Section 8B of the instructions and guidelines in the fee schedule and the applicable modifiers in Section 8F of the instructions and guidelines in the fee schedule.

2) Anesthesia

A) The use of this schedule is in accordance with the Current Procedural Terminology, American Medical Association, 515 North State Street, Chicago, Illinois 60610 (2006), no later dates or editions, and the Relative Value Guide, American Society of Anesthesiologists, 520 North Northwest Highway, Park Ridge, Illinois 60068-2573 (2006), no later dates or editions.

B) This schedule was established utilizing health care provider charges from August 1, 2002 through August 1, 2004 from which a conversion factor was established. The maximum fee schedule reimbursement amount is determined by multiplying the conversion factor set forth in the schedule by the sum of all units according to guidelines set forth in the Relative Value Guide as follows:

i) Base Value + Time Units + Modifying Units = Total Units

Total Units x Conversion Factor = Total Fee

ii) Physical status modifying units may be added to the basic value and time units and, in addition, units may be added for qualifying circumstances (extraordinary circumstances) in accordance with the Relative Value Guide.

C) Special coding situations, such as those involving multiple procedures, additional procedures, unusual monitoring, prolonged physician services, postoperative pain management, monitored (stand-by) anesthesia, invasive anesthesia and chronic pain management services, require application of the fee schedule in a manner consistent with the Relative Value Guide.

D) Anesthesia time begins when an anesthesiologist or certified registered nurse anesthetist (CRNA) physically starts to prepare the patient for the induction of anesthesia in the operating room (or its equivalent) and ends when the anesthesiologist is no longer in constant attendance (when the patient is safely put under postoperative supervision).

3) Dental

Prior to September 1, 2011, all procedures, treatments and services are reimbursed at 76% of actual charge unless services are billed under the HCPCS Level II schedule in subsection (h)(5) or professional fee schedule

in subsection (h)(8). On and after September 1, 2011 and until the Commission posts a fee schedule for dental bills, all dental bills shall be paid at 53.2% of actual charge unless the services are billed under the HCPCS Level II schedule in subsection (h)(5) or professional fee schedule in subsection (h)(8).

4) Emergency Room

A) This schedule applies to any department or facility of a hospital licensed by the Illinois Department of Public Health pursuant to the Hospital Licensing Act [210 ILCS 85] that:

i) operates as an emergency room or emergency department, whether situated on or off the main hospital campus; and

ii) is held out to the public as providing care for emergency medical conditions without requiring an appointment, or has provided at least one-third of all its outpatient visits for the treatment of emergency medical conditions on an urgent basis during the previous calendar year.

B) All procedures, treatments and services subject to this schedule are reimbursed at 76% of actual charge. Procedures, treatments and services subject to this schedule rendered on or after September 1, 2011 are reimbursed at 53.2% of actual charge.

C) Radiology, pathology and laboratory and physical medicine and rehabilitation services performed in an emergency room shall be reimbursed in accordance with the radiology schedule in subsection (h)(7)(C), the pathology and laboratory schedule in subsection (h)(7)(D) and the physical medicine and rehabilitation schedule in subsection (h)(7)(E).

D) Emergency room facility charges, and professional services delivered in an emergency room facility billed by the facility using the facility's tax identification number, shall be subject to the emergency room facility schedule and are not subject to the HCPCS Level II schedule in subsection (h)(5) or the professional services schedule in subsection (h)(8). Health care professionals who perform services in an emergency room facility and bill for services using their own tax identification number on a separate claim form shall be subject to the HCPCS Level II schedule in subsection (h)(5) or the professional services schedule in

subsection (h)(8) and are not covered under the emergency room facility schedule.

5) HCPCS (Healthcare Common Procedure Coding System) Level II
The use of this schedule is in accordance with the HCPCS Level II, U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244 (2006), no later dates or editions. Level II of the HCPCS is a standardized coding system used to identify products and services not included in the Current Procedural Terminology codes.

6) Hospital Inpatient: Standard and Trauma

A) The use of these schedules is in accordance with the Diagnosis-Related Group (DRG) classification system established by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, 42 CFR 405 (2005), no later dates or editions. A DRG is a diagnosis-related group code that groups patients into homogeneous classifications that demonstrate similar length-of-stay patterns and use of hospital resources. The DRG determines the maximum fee schedule amount for an inpatient hospital stay, except as provided in subsections (h)(6)(F) and (h)(6)(G).

B) No later than June 30, 2009, the use of these schedules will be in accordance with the Medicare Severity Diagnosis Related Group (MS-DRG) classification system established by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, 42 CFR 411 (2007), no later dates or editions. An MS-DRG is a diagnosis related group code that groups patients based on the severity of a patient's condition and resource consumption. The MS-DRG determines the maximum fee schedule amount for an inpatient hospital stay, except as provided in subsections (h)(6)(F) and (h)(6)(G).

C) Inpatient care shall be defined as when a patient is admitted to a hospital where services include, but are not limited to, bed and board, nursing services, diagnostic or therapeutic services, and medical or surgical services.

D) Inpatient hospital bills are subject to the hospital inpatient standard schedule. Inpatient hospital bills from trauma centers designated as Level I and Level II trauma centers by the Illinois Department

of Public Health pursuant to 77 Ill. Adm. Code 515.2030 and 515.2040 and that contain an admission type of "5" on a UB-04/CMS 1450 FL 14 (uniform billing form used by hospitals; FL 14 is the form locator number that indicates where the codes are to be listed on the UB-04/CMS 1450 form) are subject to the hospital inpatient trauma schedule.

E) Hospital providers must identify the DRG code on each bill (UB-04/CMS 1450 claim form). The DRG assignment should be made in a manner consistent with the grouping practices used by the hospital when billing both government and private carriers.

F) Implants

i) Prior to September 1, 2011, the following revenue codes/pass-through charges are deducted from the DRG charge and reimbursed at 65% of actual charge: 0274 (prosthetics/orthotics); 0275 (pacemaker); 0276 (lens implant); 0278 (implants); 0540 and 0545 (ambulance); 0624 (investigational devices); and 0636 (drugs requiring detailed coding). If the maximum amount of payment for an inpatient hospital stay is 76% of actual charge or 53.2% of actual charge for services rendered on or after September 1, 2011, the DRG charge is determined after the pass-through charges are removed. Charges billed under these revenue codes shall be billed at the provider's normal rates under its standard chargemaster. If the provider cannot use the chargemaster to demonstrate the charge is the provider's normal rate, the provider shall provide evidence that the charge is billed at the provider's normal rate.

ii) On and after September 1, 2011, implants, which include revenue codes 0276 (lens implant) and 0278 (implants) or any other substantially similar updated code as determined by the Commission, shall be reimbursed at 25% above the net manufacturer's invoice price less rebates, plus actual reasonable and customary shipping charges whether or not the implant charge is submitted by a provider in conjunction with a bill for all other services associated with the implant, submitted by a provider on a separate claim form, submitted by a distributor, or submitted by the manufacturer of the implant. The following revenue codes shall be paid at 65% of actual charge, which is the

provider's normal rates under its standard chargemaster: 0274 (prosthetics/orthotics); 0275 (pacemaker); 0540 and 0545 (ambulance); 0624 (investigational devices); and 0636 (drugs requiring detailed coding). A standard chargemaster is the provider's list of charges for procedures, treatments, products, supplies or services used to bill payers in a consistent manner. If the provider cannot use the chargemaster to demonstrate the charge is the provider's normal rate, the provider shall provide evidence that the charge is billed at the provider's normal rate.

G) Cost Outliers

i) In the case of cost outliers (extraordinary treatment in which the bill for an inpatient stay is at least two times the fee schedule amount for the assigned DRG after pass-through revenue code charges referred to in subsection (h)(6)(F) have been deducted), the maximum reimbursement amount will be the assigned DRG fee schedule amount plus 76% of the charges that exceed that DRG amount. The pass-through revenue code charges are reimbursed at 65% of actual charge and shall be billed at the provider's normal rates under its standard chargemaster.

ii) On and after September 1, 2011, for cost outliers (extraordinary treatment in which the bill for an inpatient stay is at least 2.857 times the fee schedule amount for the assigned DRG after pass-through revenue code charges referred to in subsection (h)(6)(F) have been deducted), the maximum reimbursement amount will be the assigned DRG fee schedule amount plus 53.2% of the charges that exceed that DRG amount. The pass-through revenue code charges are reimbursed at 65% of actual charge and shall be billed at the provider's normal rates under its standard chargemaster. Implants shall be reimbursed at 25% above the net manufacturer's invoice price less rebates, plus actual reasonable and customary shipping charges.

H) Charges for professional services performed in conjunction with charges for other services associated with the hospitalization and billed by a hospital on a UB-04/CMS 1450 or a 1500 claim form (billing form established by Centers for Medicare and Medicaid Services for use by physicians) using the hospital's own tax

identification number shall be reimbursed at 76% of actual charge or 53.2% of actual charge for services rendered on or after September 1, 2011 in addition to the amount listed in this schedule for the assigned code. Health care professionals who perform services and bill for services using their own tax identification number on a separate claim form shall be subject to the HCPCS Level II schedule in subsection (h)(5) or the professional services schedule in subsection (h)(8).

7) Hospital Outpatient

A) The use of this schedule is in accordance with the Current Procedural Terminology, American Medical Association, 515 North State Street, Chicago, Illinois 60610 (2006), no later dates or editions.

B) This schedule includes radiology, pathology and laboratory, and physical medicine and rehabilitation as well as surgical services performed in a hospital outpatient setting that were not performed during an emergency room encounter or inpatient hospital admission. The radiology, pathology and laboratory, and physical medicine and rehabilitation schedules shall be applied to the number of units billed on the UB-04.

C) Radiology

i) This schedule provides the maximum fee schedule amount for radiology services performed in a hospital outpatient setting for codes 70010 through 79999. The schedule applies to the technical component of radiology services that are billed in conjunction with revenue codes 320 through 359, 400 through 409 and 610 through 619.

ii) This schedule does not apply when the bill type requires the application of the hospital inpatient schedule in subsection (h)(6) or the hospital outpatient surgical facility schedule in subsection (h)(7)(F).

iii) Professional radiology services billed by a hospital using the hospital's tax identification number are reimbursed at 76% of actual charge or 53.2% of actual charge for services rendered on or after September 1, 2011. Radiologists or radiology groups who perform services using their own tax

identification number shall be subject to the HCPCS Level II in subsection (h)(5) or the professional services schedule in subsection (h)(8) even though the technical component is performed in a hospital setting.

D) Pathology and Laboratory

i) This schedule provides the maximum fee schedule amount for pathology and laboratory services performed in a hospital outpatient setting for codes 80048 through 89356. This schedule applies to the technical component of pathology and laboratory services that are billed in conjunction with revenue codes 300 through 319.

ii) This schedule does not apply when the bill type requires the application of the hospital inpatient schedule in subsection (h)(6) or the hospital outpatient surgical facility schedule in subsection (h)(7)(F).

iii) Professional pathology and laboratory services billed by a hospital using the hospital's tax identification number are reimbursed at 76% of actual charge or 53.2% of actual charge for services rendered on or after September 1, 2011. Pathologists who perform services using their own tax identification number shall be subject to the HCPCS Level II in subsection (h)(5) or the professional services schedule in subsection (h)(8) even though the technical component is performed in a hospital setting.

E) Physical Medicine and Rehabilitation

i) This schedule provides the maximum fee schedule amount for physical therapy services performed in a hospital outpatient setting for codes 97001 through 97799. This schedule applies to all physical and occupational therapy services that are billed in conjunction with revenue codes 420 through 439.

ii) This schedule does not apply when the bill type requires the application of the hospital inpatient schedule in subsection (h)(6) or the hospital outpatient surgical facility schedule in subsection (h)(7)(F).

iii) All physical medicine and rehabilitation services provided in a hospital outpatient setting are subject to this schedule.

F) Hospital Outpatient Surgical Facility (HOSF)

i) This schedule provides a global maximum fee schedule amount for surgical services performed in a hospital outpatient setting for codes 10021 through 69990. All services performed in an operative session shall be reimbursed at a single fee schedule amount, except as provided in subsection (h)(7)(F)(ii). The single fee schedule amount shall represent the maximum amount payable for the total charges on a claim form that represents the total charges derived from all line items/revenue codes contained in the form. Except for the carve-out revenue codes listed in subsection (h)(7)(F)(ii), this fee schedule shall not be applied on a line item basis.

ii) Implants

- Prior to September 1, 2011, the following revenue codes are pass-through charges to be deducted from the charge and reimbursed at 65% of actual charge: 0274 (prosthetics/orthotics); 0275 (pacemaker); 0276 (lens implant); 0278 (implants); 0540 and 0545 (ambulance); 0624 (investigational devices); and 0636 (drugs requiring detailed coding). Charges billed under these revenue codes shall be billed at the provider's normal rates under its standard chargemaster. If the provider cannot use the chargemaster to demonstrate the charge is the provider's normal rate, the provider shall provide evidence that the charge is billed at the provider's normal rate.

- On and after September 1, 2011, implants, which include revenue codes 0276 (lens implant) and 0278 (implants) or any other substantially similar updated code as determined by the Commission, shall be reimbursed at 25% above the net manufacturer's invoice price less rebates, plus actual reasonable and customary shipping charges whether or not the implant charge is submitted by a provider in

conjunction with a bill for all other services associated with the implant, submitted by a provider on a separate claim form, submitted by a distributor, or submitted by the manufacturer of the implant. The following revenue codes shall be paid at 65% of actual charge, which is the provider's normal rates under its standard chargemaster: 0274 (prosthetics/orthotics); 0275 (pacemaker); 0540 and 0545 (ambulance); 0624 (investigational devices); and 0636 (drugs requiring detailed coding). A standard chargemaster is the provider's list of charges for procedures, treatments, products, supplies or services used to bill payers in a consistent manner. If the provider cannot use the chargemaster to demonstrate the charge is the provider's normal rate, the provider shall provide evidence that the charge is billed at the provider's normal rate.

iii) Surgery services under this schedule shall be reimbursed in accordance with the Multiple Procedure and Bilateral Surgery provisions of the Payment Guide in Section 8B of the instructions and guidelines in the fee schedule and the applicable modifiers in Section 8F of the instructions and guidelines in the fee schedule. The instructions and guidelines are available via a link from the Commission's website at www.iwcc.il.gov.

iv) Cost Outliers

- Prior to September 1, 2011, in the case of cost outliers (extraordinary treatment in which the bill for hospital outpatient facility surgical charges is at least two times the fee schedule amount for the assigned code after pass-through revenue code charges referred to in subsection (h)(7)(F)(ii) have been deducted) the maximum reimbursement amount will be the assigned code fee schedule amount plus 76% of the charges that exceed the code amount. The pass-through revenue charges are reimbursed at 65% of actual charge and shall be billed at the provider's normal rates under its standard chargemaster.

- On and after September 1, 2011, for cost outliers (extraordinary treatment in which the bill for hospital outpatient facility surgical charges is at least 2.857 times the fee schedule amount for the assigned DRG after pass-through revenue code charges referred to in subsection (h)(7)(F)(ii) have been deducted), the maximum reimbursement amount will be the assigned code fee schedule amount plus 53.2% of the charges that exceed that code amount. The pass-through revenue code charges are reimbursed at 65% of actual charge and shall be billed at the provider's normal rates under its standard chargemaster. Implants shall be reimbursed at 25% above the net manufacturer's invoice price less rebates, plus actual reasonable and customary shipping charges.

v) Surgical services performed in the emergency room (revenue codes 450 through 459) are not subject to this schedule and shall be subject to the emergency room facility schedule in subsection (h)(4).

vi) Charges for professional services performed in conjunction with charges for other services associated with the surgery and billed by a hospital on a UB-04/CMS 1450 or a 1500 claim form (billing form established by Centers for Medicare and Medicaid Services for use by physicians) using the hospital's own tax identification number shall be reimbursed at 76% of actual charge or 53.2% of actual charge for services rendered on or after September1, 2011 in addition to the amount listed in this schedule for the assigned surgical code. Health care professionals who perform services and bill for services using their own tax identification number on a separate claim form shall be subject to the HCPCS Level II schedule in subsection (h)(5) or the professional services schedule in subsection (h)(8).

8) Professional Services

A) The use of this schedule is in accordance with the Current Procedural Terminology, American Medical Association, 515

North State Street, Chicago, Illinois 60610 (2006), no later dates or editions.

B) Services in this schedule include evaluation and management, surgery, physician, medicine, radiology, pathology and laboratory, chiropractic, physical therapy, and any other services covered under the Current Procedural Terminology.

C) Reimbursement for services under this schedule shall be in accordance with the modifiers table in Section 8F of the instructions and guidelines in the fee schedule. The instructions and guidelines in the fee schedule are available via a link from the Commission's website at www.iwcc.il.gov.

D) Surgery services under this schedule shall be reimbursed in accordance with the Payment Guide to Global Days, Multiple Procedures, Bilateral Surgeries, Assistant Surgeons, Co-Surgeons, and Team Surgery in Section 8B of the instructions and guidelines in the fee schedule and the modifiers table in Section 8F of the instructions and guidelines in the fee schedule. The instructions and guidelines are available via a link from the Commission's website at www.iwcc.il.gov.

E) Medicine services under this schedule shall be reimbursed in accordance with the professional, technical and total component categories outlined in Section 8E of the instructions and guidelines in the fee schedule and the modifiers table in Section 8F of the instructions and guidelines in the fee schedule.

F) Pathology and laboratory services under this schedule shall be reimbursed in accordance with the professional, technical and total component categories outlined in Section 8D of the instructions and guidelines in the fee schedule and the modifiers table in Section 8F of the instructions and guidelines in the fee schedule.

G) Radiology services under this schedule shall be reimbursed in accordance with the professional, technical and total component categories outlined in Section 8C of the instructions and guidelines in the fee schedule and the modifiers table in Section 8F of the instructions and guidelines in the fee schedule.

9) Rehabilitation Hospitals

A) This schedule applies to inpatient rehabilitation hospitals that are freestanding.

B) This schedule reimburses a rehabilitation hospital one per diem rate per day, on the basis of the assigned primary diagnosis code. The single per diem rate shall reimburse the rehabilitation hospital for all services provided in the course of a day.

C) The use of this schedule is in accordance with The International Classification of Diseases, Ninth Revision, Clinical Modification, (ICD-9-CM), Volume 2, U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244 (2007), no later dates or editions.

10) Prescriptions

A) This schedule applies to prescriptions filled and dispensed outside of a licensed pharmacy.

B) *Prescriptions shall be billed at the Average Wholesale Price, plus a dispensing fee of $4.18.* [820 ILCS 305/8.2(a-3)]

C) *Average Wholesale Price or its equivalent as registered by the National Drug Code shall be set forth for that drug on that date as published in Medispan.* [820 ILCS 305/8.2(a-3)]

D) If a prescription has been repackaged, the Average Wholesale Price used to determine the maximum reimbursement shall be the Average Wholesale Price for the underlying drug product, as identified by its National Drug Code from the original labeler.

i) The fee schedule requires that services be reported with the HCPCS Level II or Current Procedural Terminology codes that most comprehensively describe the services performed. Proprietary bundling edits more restrictive than the National Correct Coding Policy Manual in Comprehensive Code Sequence for Part B Medicare Carriers, Version 12.0, U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244 (2006), no later dates or editions, are prohibited. Bundling edits is the process of reporting codes so that they most comprehensively describe the services performed.

j) An allied health care professional, such as a certified registered nurse anesthetist (CRNA), physician assistant (PA) or nurse practitioner (NP), is to be reimbursed at the same rate as other health care professionals when the allied health care professional is performing, coding and billing for the same services as other health care professionals.

k) Charges of an independently operated diagnostic testing facility shall be subject to the professional services and HCPCS Level II fee schedules where applicable. An independent diagnostic testing facility is an entity independent of a hospital or physician's office, whether a fixed location, a mobile entity, or an individual nonphysician practitioner, in which diagnostic tests are performed by licensed or certified nonphysician personnel under appropriate physician supervision.

l) No later than September 30, 2006 and each year thereafter, the Commission shall make an automatic adjustment to the maximum payment for a procedure, treatment or service in effect in January of that year. The Commission shall increase or decrease the maximum payment by the percentage change of increase or decrease in the Consumer Price Index-U for the 12-month period ending August 31 of that year. The change shall be effective January l of the following year. *The Consumer Price Index-U means the index published by the Bureau of Labor Statistics of the U.S. Department of Labor that measures the average change in prices of all goods and services purchased by all urban consumers, U.S. city average, all items, 1982-84=100*. (Section 8.2 of the Act)

(Source: Amended at 36 Ill. Reg. 17108, effective November 20, 2012)

TITLE 50: INSURANCE
CHAPTER VI: WORKERS' COMPENSATION COMMISSION

PART 9120
ANTI-CORRUPTION RULE

Section

AUTHORITY: Implementing and authorized by Section 16 of the Workers' Compensation Act [820 ILCS 305/16].

SOURCE: Filed and effective March 1, 1977; codified at 7 Ill. Reg. 2354; recodified from 50 Ill. Adm. Code 7120 to 50 Ill. Adm. Code 9120 at 39 Ill. Reg. 9618.

Section 9120.10 Prohibition of Payment or Thing of Value to Commission Personnel

It shall be a violation of the rules of the Workers' Compensation Commission for any party to a proceeding, a representative of any party to a proceeding, or any other person, firm or corporation having an interest in or connection with a pending proceeding or pay, lend or deliver or cause to be paid, lent or delivered to any member or employee of the Workers' Compensation Commission any money or other thing of value.

Section 9120.20 Prohibition of Request by Commission Personnel for Payment or Thing of Value

It shall be a violation of the rules of the Workers' Compensation Commission for any member or employee of the Commission to request, demand, receive, accept, or agree to receive or accept any payment, loan, or delivery of any money or any thing of value from any party to a proceeding, a representative of any party to a proceeding, or any other person, firm, or corporation having any interest in or connection with a pending proceeding.

Section 9120.30 Discipline for Violation

Any person, firm or corporation found to have violated the provisions of Section 9120.10 above shall be subject to suspension or revocation of their right to appear before the Workers' Compensation Commission or participate in any way in connection with any matters which may properly come before the Commission. Any employee of the Workers' Compensation Commission shall be subject to discipline, including discharge, for violations of Section 9120.20 above.

Section 9120.40 Statutory Fees Not Applicable

The provisions of this Part shall not be applicable in respect to any money payable to an employee of the Workers' Compensation Commission as a fee as prescribed by statute or by formal order of the Workers' Compensation Commission.

TITLE 50: INSURANCE
CHAPTER VI: WORKERS' COMPENSATION COMMISSION

PART 9130
HEARING LOSS GUIDELINES

Section

AUTHORITY: Implementing Section 8(e)(16) and authorized by Section 16 of the Workers' Compensation Act [820 ILCS 305/8(e)(16) and 16].

SOURCE: Filed and effective March 1, 1977; emergency rule at 4 Ill. Reg. 41, p. 171. effective September 25, 1980 for a maximum of 150 days; amended at 5 Ill. Reg. 4580, effective April 13, 1981; codified at 7 Ill. Reg. 2514; recodified from 50 Ill. Adm. Code 7130 to 50 Ill. Adm. Code 9130 at 39 Ill. Reg. 9620.

Section 9130.10 Causal Connection

a) The Workers' Compensation Commission shall use the following rebuttable presumptions to determine whether exposure between July 1, 1975 and September 15, 1980, to industrial noise caused a hearing loss:

1) Exposure to noise with the intensity of 90 decibels or more for 8 hours or its time weighted equivalent causes hearing loss, and

2) Exposure to noise with the intensity of less than 90 decibels or less for eight hours or its time weighted equivalent does not cause hearing loss.

b) Cases with a date of last exposure after September 15, 1981, shall be determined pursuant to Section 8(e)(16) of the Workers' Compensation Act [820 ILCS 305/8(e)(16)].

Section 9130.20 Nature and Extent of Disability

a) The Workers' Compensation Commission shall use the following rebuttable presumptions to determine percentage loss of hearing in cases where the hearing loss was caused by exposure between July 1, 1975, and September 15, 1980:

b) The percentage loss of hearing shall be calculated using the average, in decibels, of the thresholds of hearing for the frequencies of one thousand, two thousand and three thousand cycles per second. If such losses of hearing average thirty decibels American National Standards Institute (ANSI) or less in the three frequencies, such losses of hearing shall not constitute any hearing disability. If the losses of hearing average eighty-five decibels (ANSI) or more in the three frequencies, such losses of hearing shall constitute total loss of hearing. Every average decibel loss exceeding thirty decibels (ANSI) shall constitute 1.82 percent of loss of hearing.

c) Pure tone conduction audiometric instruments shall be used for measuring hearing loss pursuant to this guideline. Audiometric tests must not be conducted before a Petitioner has been separated from noise exposure for 16 hours or more.

Section 9130.30 Prior Hearing Loss

An employer shall be liable for the entire occupational deafness to which his employment contributed unless the employer can establish the extent of Petitioner's hearing loss prior to July 1, 1975. If the employer can establish prior hearing loss, the employer shall only be liable for the hearing loss caused by exposure to employer's noise after July 1, 1975.

TITLE 50: INSURANCE
CHAPTER VI: WORKERS' COMPENSATION COMMISSION

PART 9140
ALCOHOL AND DRUG SAMPLE COLLECTION AND TESTING

Section

AUTHORITY: Implementing and authorized by the Workers' Compensation Act [820 ILCS 305].

SOURCE: Adopted at 36 Ill. Reg. 16372, effective November 5, 2012.

Section 9140.5 Definitions

"Adulterated result" means a result that has been altered, as evidenced by test results showing either a substance that is not a normal constituent for that type of specimen or showing an abnormal concentration of an endogenous substance.

"Air Blank" means, in Evidential Breath Testing Devices using gas chromatography technology, a reading of the device's internal standard. In all other evidential breath testing devices, "air blank" means a reading of ambient air containing no alcohol.

"Alcohol" means the intoxicating agent in beverage alcohol, ethyl alcohol, or other low molecular weight alcohols, including methyl or isopropyl alcohol.

"Alcohol Concentration" means the alcohol in a volume of breath expressed in terms of grams of alcohol per 210 liters of breath as indicated by a breath test under this Part. Percentage by weight of alcohol in the blood is based on grams of alcohol per 100 milliliters of blood.

"Alcohol Confirmation Test" means a subsequent test using an Evidential Breath Test that provides quantitative data about alcohol concentration.

"Alcohol Screening Device" means a breath or saliva device, other than an Evidential Breath Testing Device, that is approved by the National Highway Traffic Safety Administration (NHTSA) and placed on a conforming products list for those devices.

"Alcohol Screening Test" means an analytic procedure to determine whether an employee may have a prohibited concentration of alcohol in a breath or saliva specimen.

"Alcohol Testing Site" means a place selected by the employer where employees present themselves for the purpose of providing breath or saliva for an alcohol test.

"Aliquot" means a fractional part of a specimen used for testing.

"Breath Alcohol Technician" means a person who instructs and assists employees in the alcohol testing process, operates an Evidential Breath Testing device, and meets the qualifications set forth in Section 9140.60.

"Certified Paramedic" means an individual licensed by the Illinois Department of Public Health as an Emergency Medical Technician (Intermediate) or Emergency Medical Technician (Paramedic) acting under the direction of a licensed physician as a phlebotomist.

"Chain of Custody Form" refers to the document set forth in Section 9140.10 that is used to ensure the integrity of urine and blood specimens and record testing results for the specimens.

"Collection Container" means a container into which the employee urinates to provide the urine specimen for testing.

"Collection Form" means the form required to document breath and saliva testing and includes the following information:

The employee's name, address and telephone number;

The Designated Employer Representative's name, address and telephone number;

The name, address and telephone number of the Breath Alcohol Technician;

The name, address and telephone number of the Screening Test Technician;

The name of the testing device, the serial number or lot number, and expiration of the testing device;

The activation time;

The reading time;

The result of the Alcohol Screening Test;

The result of the Alcohol Confirmation Test, if applicable; and

A space for remarks by the Screening Test Technician or the Breath Alcohol Technician.

"Collector" means a person who meets the qualifications set forth in Section 9140.30 and collects a urine specimen from an employer or person and who meets

the qualifications set forth in Section 9140.20 and collects a blood specimen from an employee.

"Designated Employer Representative" or "DER" means an employee authorized by the employer to make required decisions in the testing and evaluation processes. The DER also receives test results and other communications for the employer.

"Drugs" means cannabis as defined in the Cannabis Control Act [720 ILCS 550] or a controlled substance listed in the Illinois Controlled Substances Act [720 ILCS 570].

"Employee" means any person subject to testing for alcohol, drugs or other intoxicating compounds.

"Employer" means a person or entity employing the person subject to testing for alcohol, drugs or other intoxicating compounds.

"Evidential Breath Testing Device" means a device approved by NHTSA for the evidential testing of breath at .08 alcohol concentration, placed on NHTSA's Conforming Products List for Evidential Breath Measurement Devices and identified on the Conforming Products List as conforming with the model specifications available from NHTSA's Traffic Safety Program.

"HHS" means the federal Department of Health and Human Services.

"Intoxicating Compound" means an intoxicating compound listed in the Use of Intoxicating Compounds Act [720 ILCS 690].

"Invalid Result" means the result reported by a laboratory for a urine specimen that contains an unidentified adulterant, contains an unidentified interfering substance, has an abnormal physical characteristic, or has an endogenous substance at an abnormal concentration that prevents the laboratory from completing testing or obtaining a valid drug test result.

"Laboratory" means any U.S. laboratory certified by HHS under the National Laboratory Certification Program as meeting the minimum standards of Subpart C of the HHS Mandatory Guidelines for Federal Workplace Drug Testing Programs or a comparable accredited laboratory.

"Medical Review Officer" or "MRO" means a person who is responsible for performing the functions and the qualifications set forth in Section 9140.40.

"Negative Result" means the result reported by a laboratory to an MRO when a specimen contains no drugs, other intoxicating compounds, or less than .08 of alcohol concentration and the specimen is a valid specimen.

"Phlebotomist" means a person trained to collect blood from another individual through venipuncture.

"Positive Result" means the result reported by a laboratory when a specimen contains a drug or intoxicating compound or alcohol concentration of .08 or greater.

"Primary Specimen" means the blood or urine specimen that is tested by a first laboratory to determine whether the employee has alcohol, drugs or intoxicating compounds in his or her system.

"Reconfirmed" means the result reported for a split specimen when the second laboratory is able to corroborate the original result reported for the primary specimen.

"Screening Test Technician" means a person who instructs and assists employees in the alcohol testing process, operates an Alcohol Screening Device, and meets the qualifications set forth in Section 9140.60.

"Shipping Container" means the container that is used for transporting and protecting urine or blood specimen bottles and associated documents from the collection site to the laboratory.

"Specimen Bottle" means the bottle that, after being sealed and labeled according to the required procedures, is used to hold the urine specimen during transportation to the laboratory.

"Split Specimen" means a part of the urine or blood specimen that is sent to a first laboratory and retained unopened, and which is transported to a second laboratory if requested to be tested following a positive test of the primary specimen or an adulterated or substituted test result.

"Split Specimen Collection" means a collection in which, for a urine specimen, the urine collected is divided into two separate specimen bottles or containers, the primary specimen and the split specimen and, for a blood specimen, two separate samples are collected, the primary specimen and the split specimen.

"Substituted Result" means a urine specimen with creatinine and specific gravity values that are so diminished or so divergent that they are not consistent with normal human urine.

"Verified Test" means a test result from a laboratory that has undergone review and final determination by the MRO.

Section 9140.10 Chain of Custody Form

All blood and urine specimens collected for testing shall be accompanied by a Chain of Custody Form, to be completed by the collector of a blood or urine specimen, the laboratory testing the blood or urine specimen or split specimen, and the MRO when applicable. A Chain of Custody Form shall include all of the following information:

a) A section to be completed by the collector of the specimen, which includes all of the following information:

1) The collector's name, address and phone number;

2) The employee's name;

3) The name of the employer;

4) The name of the facility where the specimen was collected and its address and telephone number;

5) The date and time that the specimen was collected;

6) The date that the specimen was sent to a laboratory for testing;

7) The name and address of the laboratory where the specimen will be sent for testing;

8) For the collection of urine specimens, a section that indicates the temperature of urine specimens taken within 4 minutes after collection and any indication of the urine specimens unusual color, presence of foreign objects or material, or other signs of tampering;

9) A statement for the collector to sign incorporating the following language: I certify that the specimen identified on this form is the specimen presented to me or collected by me and that it has been collected, labeled and sealed; and

10) A place for remarks made by the collector of the specimen.

b) A section documenting the transfer of the specimen for the purpose of maintaining control and accountability for the specimen. At a minimum, this section shall indicate:

1) Dates the specimen has been transferred;

2) Signature and name of the person releasing the specimen; and

3) Signature and name of the person receiving the specimen.

c) A section to be completed by the laboratory that indicates the following:

1) An indication as to whether the specimen was received with intact specimen seals;

2) The test results;

3) A statement for the certifying scientist to sign incorporating the following language:

d) I certify that the specimen has been examined upon receipt, analyzed, and that the results set forth are for that specimen; and

1) A place for the certifying scientist to print his or her name, the signature of the certifying scientist, and the date.

e) A section to be completed by the MRO that includes the following:

1) The name, address and telephone number of the MRO;

2) The date the test results were received by the MRO;

3) A statement for the MRO to sign incorporating the following language:

f) I have reviewed and verified the laboratory tests for the specimen identified by this form;

1) The determination of the test results as verified by the MRO;

2) The time and date that the employee requested testing of a split specimen; and

3) A place for remarks made by the MRO.

g) The Chain of Custody Form shall be comprised of the following copies for distribution:

1) Original laboratory copy (Copy 1), which shall be routed to the laboratory

with the specimen.

2) Second original laboratory copy (Copy 2), which shall be routed to the laboratory with the specimen; as a means of reporting the test result, the laboratory will forward this copy to the MRO.

3) Split specimen copy (Copy 3), which must be prepared by the laboratory testing the primary specimen and accompany the split specimen to the second laboratory if split testing has been requested by the employee.

4) MRO copy (Copy 4), which shall be routed directly to the MRO by the collector.

5) Employee copy (Copy 5), which shall be given to the employee by the collector of the specimen.

6) Collector copy (Copy 6), which shall be retained by the collector.

7) DER copy (Copy 7), which shall be forwarded to the DER by the MRO.

h) Retention of Chain of Custody Forms. The collector, laboratory, laboratory testing the split specimen, MRO and DER shall retain their copies of the Chain of Custody Forms for a minimum of two years.

i) Transmission of Chain of Custody Forms. Chain of custody forms shall be transmitted in a secure manner, which may include fax, courier, mail or electronic transmission through which security and confidentiality are maintained.

Section 9140.20 Collection of Blood

The following procedures shall be used to obtain a blood sample from an employee to determine alcohol concentration and the presence of drugs or intoxicating compounds:

a) Collector of a Blood Specimen. All blood specimens shall be collected by a licensed physician, advanced practice nurse, registered nurse, licensed practical nurse, phlebotomist, or certified paramedic.

b) Collection Procedures. A blood specimen shall be collected using the following procedure:

1) The testing process shall start without undue delay. If the employee needs medical attention, this treatment shall not be delayed to collect a specimen.

2) The collector shall explain the basic collection procedure to the employee.

3) The blood specimen shall be collected using aseptic venipuncture technique.

4) The venipuncture site shall be cleansed with an antiseptic substance that does not contain ethanol prior to collection.

5) A sufficient amount of blood shall be collected to permit split testing.

6) Blood specimens shall be collected in a container or tube containing an anticoagulant and a preservative of sodium fluoride.

7) Immediately after collection, the collector shall rock the container or tube gently to mix the anticoagulant and preservative substance with the blood.

c) Collection Materials. A blood specimen shall be collected in tubes or containers with a visible tamper-evident system or seals that adequately protect again sample contamination.

d) Completion of Collection Process. To complete the collection process, the collector shall complete the following procedure:

1) The collector shall place the specimen in a shipping container designed to minimize the possibility of damage during shipment and seal the shipping container as appropriate.

2) The collector shall complete all applicable portions of the Chain of Custody Form as specified in Section 9140.10.

3) The collector shall ensure that each specimen collected is shipped to a laboratory as quickly as possible, but no later than 24 hours after collection or during the next business day after collection.

Section 9140.30 Collection of Urine

The following procedures shall be used to obtain a urine sample from a subject to determine alcohol concentration and the presence of drugs or intoxicating compounds:

a) Urine Collector

1) Urine specimens shall be collected by any of the following: a collector meeting the training requirements of 49 CFR 40.33 (2012), licensed physician, advanced practice nurse, registered nurse or licensed practical nurse.

2) The following persons shall not serve as a collector:

A) the immediate supervisor of the employee being tested, unless no other collector is available;

B) or a person employed by a laboratory who could link the employee with a urine specimen, testing result or laboratory report.

b) Collection Site. A collection site may be in a medical facility, a mobile facility, a dedicated collection facility, or any other location meeting the requirements of this Section. The collection site must have a source of water for washing hands that, if practicable, should be external to the closed room where urination occurs.

c) Prevention of Sample Adulteration. Collectors shall make all attempts to do the following before each collection to deter tampering with specimens:

1) Secure any water sources or otherwise make them unavailable to the employee providing the specimen;

2) Ensure that the water in the toilet is blue or secure any movable toilet tank top;

3) Ensure that no soap, disinfectants, cleaning agents or other possible adulterants are accessible to the employee at the collection site;

4) Inspect the collection site to ensure that no foreign or unauthorized substances are present;

5) Ensure that undetected access to the site is not possible; and

6) Secure areas and items that appear suitable for concealing contaminants.

d) Prevention of Sample Contamination. Collectors shall follow the following procedures to prevent contamination of the sample:

1) To avoid distraction that could compromise security, conduct only one collection for one employee at a time;

2) To the greatest extent possible, keep an employee's collection container within view of both the collector and the employee between the time the employee has urinated and the time the specimen is sealed;

3) Ensure that the collector is the only person in addition to the employee who handles the specimen before it is poured into the bottles and sealed with tamper-evident seals;

4) Maintain personal control over each specimen throughout the collection process; and

5) Minimize the number of persons handling the specimen.

e) Collection Materials

1) Urine shall be collected in containers that:

A) are a single-use container, made of plastic, large enough to easily catch and hold at least 55 mL of urine voided from the body;

B) have graduated volume markings clearly noting levels of 45 mL and above;

C) have a temperature strip providing graduated temperature readings 32-38 degrees Celsius or 90-100 degrees Fahrenheit, that is affixed or can be affixed at a proper level on the outside of the collection container. Other methodologies are acceptable, provided that the temperature measurement is accurate and that there is no potential for contamination of the specimen; and

D) are individually wrapped in a sealed plastic bag or shrink wrapping or must have a peelable, sealed lid or other easily visible tamper-evident system.

2) Urine shall be placed in specimen bottles that:

A) are large enough to hold at least 35 mL or, alternatively, they may be two distinct sizes of specimen bottles provided that the bottle designed to hold the primary specimen holds at least 35 mL of urine and the bottle designed to hold the split specimen holds at least 20 mL;

B) have screw-on or snap-on caps that prevent seepage of the urine from the bottles during shipment;

C) have markings clearly indicating the appropriate levels (30 mL for the primary specimen and 15 mL for the split specimen) of urine that must be poured into the bottles;

D) meet the following specifications:

i. are wrapped (with caps) together in a sealed plastic bag or shrink wrapping separate from the collection container; or

ii. are wrapped (with cap) individually in sealed plastic bags or shrink wrapping; or

iii. have peelable, sealed lid or other easily visible tamper-evident system; and

E) if made of plastic, are leach resistant.

3) Specimen bottles shall be placed in a plastic bag that:

A) has two sealable compartments or pouches that are leak-resistant or a single bag that is large enough to hold two specimen bottles;

B) demonstrates that any tampering or attempts to open either compartment have occurred; and

C) contain enough absorbent material to absorb the entire contents of both specimen bottles.

f) Collection Procedures. The collection of urine shall be performed in accordance with the following guidelines:

1) When the employee enters the collection site, the testing process shall start without undue delay. If the employee needs medical attention, this treatment shall not be delayed to collect a specimen.

2) The employee must provide identification to the collector before testing.

3) The collector shall explain the basic collection procedure to the employee.

4) If an employee normally voids through self-catheterization, the collector shall instruct the employee that he or she is required to provide a specimen in that manner.

5) The collector shall instruct the employee to wash and dry his or her hands at this time and instruct the employee not to wash his or her hands again until after delivering the specimen to the collector.

6) The employee may provide his or her urine specimen in a stall or otherwise partitioned enclosure that allows for individual privacy. The collector shall remain in the restroom or area, but outside the stall or partitioned enclosure.

7) The collector shall select, or allow the employee to select, an individually wrapped or sealed collection container from collection kit materials. Either the collector or the employee, with both the collector and the employee present, must unwrap or break the seal of the collection container. The collector shall not unwrap or break the seal on any specimen bottle at this time.

8) The employee shall only take the collection container into the room used for urination.

9) The collector shall collect a specimen of at least 45 mL.

g) Steps Following Collection of Urine Specimen. The collector shall perform the following after the collection of the urine specimen:

1) The collector shall check the temperature of the specimen no later than four minutes after the employee has given the specimen to the collector by reading the temperature strip attached to the collection container and report this information on the Chain of Custody Form.

2) The collector shall inspect the specimen for unusual color, presence of foreign objects or material, or other signs of tampering.

h) Direct Observation Collection Procedure. The collector shall initiate a direct observation collection procedure if: the temperature of the urine is outside of the temperature range of 32-38 degrees Celsius or 90-100 degrees Fahrenheit; the collector determines that material appears to be brought to the collection site with the intent to alter the specimen; or it is apparent from this inspection that the employee has tampered with the specimen. The direct observation collection procedure shall be performed in accordance with the following guidelines:

1) The collector shall explain to the employee the reason for a directly observed collection.

2) The observer shall be the same gender as the employee. The observer may be a different person from the collector and need not be a qualified collector.

3) The observer must request the employee to raise his or her shirt, blouse, dress or skirt, as appropriate, above the waist and lower clothing and underpants to show the collector, by turning around, that the employee does not have a prosthetic device. After the collector has determined that the employee does not have such a device, the employee may return his or her clothing to its proper position for observed urination.

4) The observer shall watch the employee urinate into the collection container.

5) The observer shall watch the specimen as the employee takes it to the collector. If the observer is not the collector, the observer shall not take the collection container from the employee.

6) If another person has acted as the observer, his or her name shall be recorded on the Chain of Custody Form.

i) Preparation of Urine Specimen. The collector shall take the follow steps after collection in the presence of the employee:

1) Pour at least 30 mL of urine from the collection container into one specimen bottle, to be used for the primary specimen.

2) Pour at least 15 mL of urine from the collection container into the second specimen bottle to be used for the split specimen.

3) Place and secure the lids or caps on the bottles.

4) Seal the bottles by placing the tamper-evident bottle seals over the bottle caps/lids and down the sides of the bottles.

5) Write the date on the tamper-evident bottle seals.

6) Discard any urine left over in the collection container after both specimen bottles have been appropriately filled and sealed.

7) Allow the employee to initial the tamper-evident bottle seals for the purpose of certifying that the bottles contain the specimens provided.

j) Completion of Collection Process. To complete the collection process, the collector shall follow the following procedure:

1) The collector shall secure the pouches of the plastic bag containing the specimens in the presence of the employee.

2) The collector shall place the sealed plastic bag in a shipping container designed to minimize the possibility of damage during shipment and seal the shipping container as appropriate.

3) The collector shall complete all applicable portions of the Chain of Custody Form as specified in Section 9140.10.

4) The collector shall ensure that each specimen collected is shipped to a laboratory as quickly as possible, but no later than 24 hours after collection or during the next business day after collection.

Section 9140.40 Review of Test Results of Blood and Urine Specimens

a) Verification of Test Results by the MRO. Prior to the transmission of test results to the DER, all results shall be reviewed and verified by an MRO.

b) Qualifications of the MRO. The MRO must meet the qualifications set forth in 49 CFR 40.121 (2012). The MRO shall not be employed by the laboratory performing testing pursuant to this Part. An employer or DER shall not serve as the MRO for his or her own employees.

c) Positive, Adulterated or Substituted Results

1) If an MRO receives a positive, adulterated or substituted result from a laboratory, the MRO shall contact the employee within 72 hours after receipt of the test result from the laboratory. The MRO shall allow the employee to provide any information the employee considers relevant to the positive, substituted or adulterated test result, including identification of currently or recently used prescription or nonprescription drugs and other relevant medical information. The MRO shall also inform the employee of his or her right to request testing of a split specimen pursuant to Section 9140.50.

2) If the MRO is unable to contact the employee with a positive, adulterated or substituted test result within 72 hours after receipt of the test results from the laboratory, the MRO shall contact the DER and request that the DER direct the employee to contact the MRO as soon as possible.

d) Verification of Positive, Substituted or Adulterated Results. To verify a positive, adulterated, or substituted test result, the MRO shall complete all of the following procedures:

1) Receive and review the test results from the laboratory;

2) Verify that the collector and the laboratory utilized proper collection techniques;

3) Ensure that the test result accurately identifies the employee;

4) Review any documentation provided by the employee regarding currently or recently used prescription or nonprescription drugs and other relevant medical information and whether this information could have produced a positive, substituted or adulterated result;

5) Review the results of the testing of a split specimen if that testing has been requested;

6) Notify the DER in writing of the verified positive, substituted or adulterated test result within seven days after receiving the test result from the laboratory;

7) Complete all applicable portions of the Chain of Custody Form and forward this form to the DER;

8) Within 24 hours after notification of the DER of a positive, adulterated or substituted test result, notify the laboratory that the positive, adulterated or substituted test result has been submitted to the DER.

e) Verification of Negative Results. To verify a negative test result, the MRO shall complete all of the following procedures:

1) Receive and review the test results from the laboratory;

2) Verify that the collector and the laboratory utilized proper collection techniques;

3) Ensure that the result accurately identifies the employee;

4) Notify the DER of the negative test result within 5 days after the receipt of the test result from the laboratory;

5) Complete all applicable portions of the Chain of Custody Form and forward this form to the DER;

6) Within 24 hours after notification of the DER of a negative test result, notify the laboratory that the negative test result has been submitted to the DER.

Section 9140.50 Split Testing of Urine and Blood Specimens

a) Request to Test a Split Specimen

1) When the MRO notifies the employee that the employee has a positive, substituted or adulterated result, the employee may request a test of the split specimen within 72 hours from the time of notification by the MRO. The request by the employee may be verbal or in writing.

2) If the employee has not requested a test of the split specimen within 72 hours, the employee may present to the MRO information documenting that serious injury, illness, lack of actual notice of the verified test result, inability to contact the MRO, or other circumstances unavoidably prevented the employee from making a timely request.

3) If the MRO concludes from the employee's information that there was a legitimate reason for the employee's failure to contact the MRO within 72 hours, the MRO must direct that the test of the split specimen take place.

4) When an MRO has been requested by the employee or directed by the MRO, the MRO shall immediately provide written notice to the laboratory that tested the primary specimen, directing the laboratory to forward the split specimen to a second laboratory. The laboratory shall forward a copy of the Chain of Custody Form to the second laboratory.

b) Cost of the Split Specimen Testing. The employer shall ensure that the split specimen testing is conducted as required by this Section. The employer may seek payment or reimbursement of all or part of the cost of the split specimen from the employee. An employer shall not condition compliance with this Section on the employee's payment of split testing.

c) Procedural Requirements for the Laboratory Testing the Primary Specimen

1) The first laboratory at which the primary and split specimen arrive must check to see whether the split specimen is available for testing. If the split specimen is unavailable or appears insufficient, the laboratory must do the following:

A) Continue the testing process for the primary specimen. The laboratory shall report the results for the primary specimen without providing the MRO information regarding the unavailable split specimen.

B) Upon receiving a letter from the MRO instructing the laboratory to forward the split specimen to another laboratory for testing, report to the MRO that the split specimen is unavailable for testing. The laboratory shall provide as much information as possible about the cause of the unavailability.

2) The laboratory testing the primary specimen is not authorized to open the split specimen under any circumstances.

3) When the laboratory that tested the primary specimen receives written notice from the MRO to send the split specimen to another laboratory, it must forward both the split specimen in its original specimen bottle, with the seal intact, and a copy of the MRO's written request to the second laboratory.

4) The laboratory that tested the primary specimen must not send to the second laboratory any information about the identity of the employee, excluding the initials of the employee on the specimen container or bottle.

d) Procedural Requirements for the Laboratory Testing the Split Specimen

1) Testing of a Split Specimen When it is Tested to Reconfirm the Presence of Alcohol, Drugs or Other Intoxicating Compounds

A) The laboratory testing the split specimen must test the split specimen for the alcohol, drugs or other intoxicating compounds detected in the primary specimen.

B) If the test fails to reconfirm the presence of the alcohol, drugs or other intoxicating compounds that were reported positive in the primary specimen, the laboratory must conduct validity tests in an attempt to determine the reason for being unable to reconfirm the presence of alcohol, drugs or other intoxicating compounds

C) In addition, if the test fails to reconfirm the presence of the alcohol, drugs or other intoxicating compounds reported in the primary specimen, at the employer's discretion the laboratory may send the specimen or an aliquot of it, if a sufficient amount is available, for testing at another laboratory that has the capability to conduct another reconfirmation test.

2) Testing of a Split Specimen When it is Tested to Reconfirm an Adulterated Test Result

A) The laboratory testing the split specimen must test the split specimen for the adulterant detected in the primary specimen, using the confirmatory test for the adulterant.

B) If the test fails to reconfirm the adulterant result reported in the primary specimen, the laboratory may send the specimen or an aliquot of it for testing at another laboratory that has the capability to conduct another reconfirmation test.

3) Testing of a split specimen when it is tested to reconfirm a substituted test result. The laboratory testing the split specimen must test the split specimen using the confirmatory tests for creatinine and specific gravity.

e) Reporting of Split Specimen Testing Results by Testing Laboratory. The laboratory responsible for testing the split specimen must report split specimen test results to the MRO immediately. The laboratory testing the split specimen shall not report results to or through the DER.

Section 9140.60 Collection and Testing of Breath and Saliva for Alcohol Testing

a) Collectors for Alcohol Testing. A Screening Test Technician shall conduct only alcohol screening tests. Breath Alcohol Technicians may conduct alcohol screening and confirmation tests. The immediate supervisor of an employee may not act as the Screening Test Technician or Breath Alcohol Technician (in this Section, "the Technician") when that employee is tested, unless no other Technician is available. A Technician must meet the training requirements set forth in 49 CFR 40.213 (2012).

b) Collection Site. The testing of breath and saliva may take place at a medical facility, a mobile facility, a dedicated collection facility, or any other location meeting the requirements of this Section. The collection site must provide visual and aural privacy to the employee being tested, sufficient to prevent unauthorized persons from seeing or hearing test results. The collection site must have all needed personnel, materials, equipment and facilities to provide for the collection and analysis of breath or saliva samples and a suitable clean surface for writing.

c) Collection by Law Enforcement Officers. Nothing in this Section shall preclude the collection and testing of breath or saliva by a law enforcement officer. Notwithstanding the procedures for the collection and testing of breath and saliva set forth in this Section, testing and collection performed by a law enforcement officer shall be considered acceptable procedure for the collection and testing of breath and alcohol. Any collection or testing of breath or saliva performed by a law enforcement officer shall be subject to any objection pursuant to the Illinois Rules of Evidence and statutory rules of evidence when applicable.

d) Collection Form. Alcohol testing shall be documented using a collection form as defined in Section 9140.5.

e) Devices for Alcohol Testing. All devices used for the testing of breath and saliva for alcohol shall meet the following requirements:

1) Alcohol Screening Test Devices. Evidential Breath Testing Devices and Alcohol Screening Devices on the NHTSA conforming products lists for evidential and non-evidential devices are the only devices allowed to be used to conduct alcohol screening tests. An Alcohol Screening Device shall be used only for screening tests for alcohol and not for alcohol confirmation tests.

2) Alcohol Confirmation Test Devices. An alcohol confirmation test shall be performed with an Evidential Breath Testing Device that:

A) is listed on the NHTSA Conforming Products Lists for Evidential Breath Testing Devices;

B) provides a printed triplicate result (or three consecutive identical copies of a result) of each breath test;

C) assigns a unique number to each completed test, which the Technician and the employee can read before each test and that is printed on each copy of the result;

D) prints, on each copy of the result, the manufacturer's name for the device, its serial number, and the time of the test;

E) distinguishes alcohol from acetone at the 0.08 alcohol concentration level;

F) tests an air blank; and

G) performs an external calibration check.

f) Use and Care of Devices for Alcohol Testing

1) Evidential Breath Testing Devices. Users of an Evidential Breath Testing Device must:

A) follow the manufacturer's instructions, including performance of external calibration checks at the intervals the instructions specify.

B) in conducting external calibration checks, use only calibration devices appearing on NHTSA's Conforming Products List for Calibrating Units for Breath Alcohol Tests.

C) maintain records of the inspection, maintenance and calibration of Evidential Breath Testing Device for two years; and

D) ensure that inspection, maintenance and calibration of the Evidential Breath Testing Device are performed by its manufacturer or a maintenance representative certified either by the manufacturer or by a state health agency or other appropriate state agency. If an Evidential Breath Testing Device fails an external check of calibration, the Evidential Breath Testing Device must be taken out of service. The Evidential Breath Testing Device

may not be used again for alcohol testing until it is repaired and passes an external calibration check.

2) Alcohol Screening Device.

A) Users of an Alcohol Screening Device must:

i) follow the quality assurance plan instructions created by the manufacturer of the Alcohol Screening Device; and

ii) follow all device and care requirements for Evidential Breath Testing Devices.

B) An Alcohol Screening Device that does not pass the specified quality control checks or has passed its expiration date shall not be used.

g) Alcohol Screening Test Procedures

1) Initial Procedures. The Breath Alcohol Technician or Screening Test Technician shall take the following steps to begin all alcohol screening tests, regardless of the type of testing device used:

A) The Technician shall ensure that, when the employee enters the alcohol testing site, the alcohol testing process begins without undue delay.

B) If the employee is also going to provide a urine or blood specimen, the Technician shall, to the greatest extent practicable, ensure that the alcohol test is completed before the urine or blood collection process begins.

C) If the employee needs medical attention, this treatment shall not be delayed to conduct an Alcohol Screening Test.

D) The employee shall provide the Technician with positive identification.

E) The Technician shall explain the testing procedure to the employee.

2) Evidential Breath Testing Device or Non-evidential Breath Alcohol Screening Device. For an alcohol screening test using an Evidential

Breath Testing Device or non-evidential breath Alcohol Screening Device, the Technician shall execute the following procedure:

A) Select, or allow the employee to select, an individually wrapped or sealed mouthpiece from the testing materials.

B) Open the individually wrapped or sealed mouthpiece in view of the employee and insert it into the device in accordance with the manufacturer's instructions.

C) Instruct the employee to blow steadily and forcefully into the mouthpiece for at least six seconds or until the device indicates that an adequate amount of breath has been obtained.

D) Show the employee the displayed test result.

E) If the device is one that prints the test number, testing device name and serial number, time and result directly onto the collection form, the Technician shall ensure that the information has been printed correctly onto the collection form.

F) If the device is one that prints the test number, testing device name and serial number, time and result, but on a separate printout rather than directly onto the collection form, the Technician shall affix the printout of the information to the collection form with tamper-evident tape or use a self-adhesive label that is tamper-evident.

G) If the device is one that does not print the test number, testing device name and serial number, time and result, or is a device not being used with a printer, the Technician shall record this information on the collection form.

3) Procedure for an Alcohol Screening Test using a Saliva Alcohol Screening Device or a Breath Tube Alcohol Screening Device. The Technician shall execute the following procedure when using the saliva Alcohol Screening Device:

A) Check the expiration date on the device or on the package containing the device and show it to the employee. The device shall not be used after its expiration date.

B) Open an individually wrapped or sealed package containing the device in the presence of the employee.

C) Offer the employee the opportunity to use the device. If the employee uses it, the Technician shall instruct the employee to insert it into his or her mouth and use it in a manner described by the device's manufacturer.

D) If the employee chooses not to use the device, or in all cases in which a new test is necessary because the device did not activate, the Technician shall insert the device into the employee's mouth and gather saliva in the manner described by the device's manufacturer. The Technician shall wear single-use examination or similar gloves while doing so and change them following each test.

E) When the device is removed from the employee's mouth, the Technician shall follow the manufacturer's instructions regarding necessary next steps in ensuring that the device has activated.

F) If the Technician is unable to successfully follow these procedures, he or she shall discard the device and conduct a new test using a new device. The new device must be one that has been under the control of the Technician. The Technician shall note on the remarks section of the collection form the reason for the new test. The Technician shall offer the employee the choice of using the device or having the Technician use it unless the employee was responsible for the new test needing to be conducted.

G) If the Technician is unable to successfully follow the required procedures on the new test, he or she shall end the collection and include an explanation on the remarks section of the collection form. The Technician shall then direct the employee to take a new test immediately, using an Evidential Breath Testing Device for the screening test.

H) If the Technician is able to successfully follow the procedures, but the device does not activate, he or she shall discard the device and conduct a new test. In this case, the Technician shall place the device into the employee's mouth to collect saliva for the new test.

I) The Technician shall read the result displayed on the device no sooner than the device's manufacturer instructs. In all cases, the result displayed must be read within 15 minutes after the test. The Technician shall then show the device and its reading to the employee and enter the result on the collection form.

J) The Technician shall not re-use devices, swabs, gloves or other materials used in saliva testing.

4) Procedure for Breath Tube Alcohol Screening Device. The Technician shall execute the following procedure when using the breath tube Alcohol Screening Device:

A) Check the expiration date on the detector device and the electronic analyzer or on the package containing the device and the analyzer and show it to the employee. The Technician shall not use the device or the analyzer after its expiration date. The Technician shall not use an analyzer that is not specifically pre-calibrated for the device being used in the collection.

B) Remove the device from the package and secure an inflation bag onto the appropriate end of the device, as directed by the manufacturer on the device's instructions.

C) Break the tube's ampoule in the presence of the employee.

D) Offer the employee the opportunity to use the device. If the employee chooses to use the device, instruct the employee to blow forcefully and steadily into the blowing end of device until the inflation bag fills with air.

E) If the employee chooses not to hold the device, the Technician shall hold the device.

F) When the employee completes the breath process, take the device from the employee, remove the inflation bag, and prepare the device to be read by the analyzer in accordance with the manufacturer's directions.

G) If the Technician was unable to successfully complete these procedures, he or she shall discard the device and conduct a new test using a new one. The new device must be one that has been under the control of the Technician before the test. The Technician shall note on the remarks section of the collection form the reason for the new test.

H) The Technician shall offer the employee the choice of holding the device or having the Technician hold it, unless the employee was responsible for the new test needing to be conducted.

I) If the Technician is unable to successfully follow the required procedures on the new test, he or she shall end the collection and put an explanation in the remarks section of the collection form.

J) The Technician shall then direct the employee to take a new test immediately, using another type of Alcohol Screening Device or an Evidential Breath Testing Device.

K) If the Technician was able to successfully follow the required procedures, and after having waited the required amount of time directed by the manufacturer for the detector device to incubate, the Technician shall place the device in the analyzer in accordance with the manufacturer's directions. The result must be read from the analyzer no earlier than the required incubation time of the device. In all cases, the result shall be read within 15 minutes after the test.

L) The Technician shall follow the manufacturer's instructions for determining the result of the test. He or she shall show the analyzer result to the employee and record it on the collection form.

M) The Technician shall never re-use detector devices or any gloves used in breath tube testing. The inflation bag must be voided of air following removal from a device. Inflation bags and electronic analyzers may be re-used but only in accordance with the manufacturer's directions.

5) Procedures Following an Alcohol Screening Test Result

A) The Breath Alcohol Technician or the Screening Test Technician shall complete and sign the collection form.

B) If the test result is an alcohol concentration of less than 0.08, the Technician, must complete the collection form and transmit the result to the DER in a confidential manner.

C) If the test result is an alcohol concentration of 0.08 or higher, the Technician shall direct the employee to take an Alcohol Confirmation Test.

D) If the test result is any other result, the Technician shall note this result in the remarks section of the collection form.

h) Alcohol Confirmation Test Procedures

1) Initial Procedures. Before starting the Alcohol Confirmation Test, the Breath Alcohol Technician shall execute the following procedure:

A) Ensure that the employee waits at least 15 minutes before taking an alcohol confirmation test, starting with the completion of the Alcohol Screening Test. After the waiting period has elapsed, the Breath Alcohol Technician shall begin the Alcohol Confirmation Test as soon as possible, but not more than 30 minutes after the completion of the Alcohol Screening Test.

B) The Breath Alcohol Technician shall observe the employee during the waiting period.

C) The employee shall be given the following instructions before beginning the waiting period:

i) Not to eat, drink, put anything, such as a cigarette or chewing gum, into his or her mouth, or belch;

ii) That the reason for the waiting period is to prevent inaccurate reading;

iii) That following the instructions concerning the waiting period is to the employee's benefit; and

iv) That the confirmation test will be conducted at the end of the waiting period, even if the instructions have not been followed.

D) If the Breath Alcohol Technician is aware that the employee has not followed the instructions, this should be noted in the remarks section of the collection form.

E) If the Breath Alcohol Technician did not conduct the Alcohol Screening Test for the employee, the Breath Alcohol Technician performing the Alcohol Confirmation Test shall require positive identification of the employee, explain the confirmation

procedures, and use a new collection form. The Breath Alcohol Technician performing the Alcohol Confirmation Test must note on the remarks section of the collection form that a different Breath Alcohol Technician or Screening Test Technician conducted the Alcohol Screening Test.

F) Even if more than 30 minutes have passed since the screening test result was obtained, the Breath Alcohol Technician shall begin the Alcohol Confirmation Test, not another Alcohol Screening Test.

G) The Breath Alcohol Technician performing the Alcohol Confirmation Test shall note in the remarks section of the collection form the time that elapsed between the two events and, if the Alcohol Confirmation Test could not begin within 30 minutes after the screening test, the reason why.

2) Alcohol Confirmation Test Procedures. The Breath Alcohol Technician conducting the Alcohol Confirmation Test must execute the following procedures to complete the Alcohol Confirmation Test process:

A) In the presence of the employee, conduct an air blank on the Evidential Breath Testing Device to be used for the Alcohol Confirmation Test before beginning the confirmation test and show the reading to the employee.

i) If the reading is 0.00, the test may proceed. If the reading is greater than 0.00, another air blank shall be conducted.

ii) If the reading on the second air blank is 0.00, the test may proceed. If the reading is greater than 0.00, the Breath Alcohol Technician must take the Evidential Breath Testing Device out of service. If the Evidential Breath Testing Device is taken out of service for an air blank reading greater than 0.00, the Evidential Breath Testing Device shall not be used until it is found to be within tolerance limits on an external check of calibration.

B) Open a new individually wrapped or sealed mouthpiece in view of the employee and insert it into the device in accordance with the manufacturer's instructions.

C) The Breath Alcohol Technician and the employee shall both read the unique test number displayed on the Evidential Breath Testing Device.

D) Instruct the employee to blow steadily and forcefully into the mouthpiece for at least six seconds or until the device indicates that an adequate amount of breath has been obtained.

E) Show the employee the result displayed on the Evidential Breath Testing Device.

F) Show the employee the result and unique test number that the Evidential Breath Testing Device prints out.

G) If the Evidential Breath Testing Device provides a separate printout of the result, attach the printout to the collection form with tamper-evident tape, or use a self-adhesive label that is tamper-evident.

3) Procedures Following an Alcohol Confirmation Test Result. After the Evidential Breath Testing Device has printed the result of an alcohol confirmation test, the Breath Alcohol Technician shall execute the following procedures:

A) Indicate the alcohol reading from the Evidential Breath Testing Device on the collection form and sign the collection form.

B) If the test produces any other results, indicate these results in the remarks section of the collection form.

C) Immediately transmit the collection form with the reported result directly to the DER and the employee in a confidential manner.

Section 9140.70 Preservation of Specimens and Records

a) Laboratories testing a primary specimen of blood or urine that was reported with a verified positive, adulterated or substituted result must retain the primary specimen for a minimum of three years. The specimen shall be kept in secure, long-term, frozen storage in accordance with requirements set forth by HHS.

b) Within the three-year period, the MRO, the employee, or the DER may request in writing that the laboratory retain a specimen for an additional period of time, not to exceed one additional year.

c) If a laboratory has not sent the split specimen to another laboratory for testing, the laboratory must retain the split specimen for the same period of time as the primary specimen and under the same storage conditions.

d) Laboratories testing the split specimen must preserve the split specimen in accordance with subsections (a) and (b).

e) Laboratories must retain all records pertaining to the testing of each employee specimen for a minimum of two years. Within this two-year period, the MRO, the employee or the DER may request in writing that the laboratory retain the records for an additional period of time, not to exceed two additional years.

f) The employer shall maintain all collection forms for breath and saliva testing for a minimum of three years. Within this three-year period, the employee may request in writing that the employer retain the records for an additional period of time, not to exceed one additional year.

g) Laboratories testing a specimen of blood or urine that was reported with a verified negative result shall discard both the primary and the split specimen as soon as possible.

Section 9140.80 Materials Incorporated by Reference

Copies of the incorporated material are available from the Illinois Workers' Compensation Commission, 100 West Randolph, Suite 8-200, Chicago, Illinois 60601 or on the Commission's Internet website, http://www.iwcc.il.gov/