

1 AN ACT concerning employment.

2 **Be it enacted by the People of the State of Illinois,**
3 **represented in the General Assembly:**

4 Section 5. The Workers' Compensation Act is amended by
5 changing Section 8.2 as follows:

6 (820 ILCS 305/8.2)

7 Sec. 8.2. Fee schedule.

8 (a) Except as provided for in subsection (c), for
9 procedures, treatments, or services covered under this Act and
10 rendered or to be rendered on and after February 1, 2006, the
11 maximum allowable payment shall be 90% of the 80th percentile
12 of charges and fees as determined by the Commission utilizing
13 information provided by employers' and insurers' national
14 databases, with a minimum of 12,000,000 Illinois line item
15 charges and fees comprised of health care provider and hospital
16 charges and fees as of August 1, 2004 but not earlier than
17 August 1, 2002. These charges and fees are provider billed
18 amounts and shall not include discounted charges. The 80th
19 percentile is the point on an ordered data set from low to high
20 such that 80% of the cases are below or equal to that point and
21 at most 20% are above or equal to that point. The Commission
22 shall adjust these historical charges and fees as of August 1,
23 2004 by the Consumer Price Index-U for the period August 1,

1 2004 through September 30, 2005. The Commission shall establish
2 fee schedules for procedures, treatments, or services for
3 hospital inpatient, hospital outpatient, emergency room and
4 trauma, ambulatory surgical treatment centers, and
5 professional services. These charges and fees shall be
6 designated by geozip or any smaller geographic unit. The data
7 shall in no way identify or tend to identify any patient,
8 employer, or health care provider. As used in this Section,
9 "geozip" means a three-digit zip code based on data
10 similarities, geographical similarities, and frequencies. A
11 geozip does not cross state boundaries. As used in this
12 Section, "three-digit zip code" means a geographic area in
13 which all zip codes have the same first 3 digits. If a geozip
14 does not have the necessary number of charges and fees to
15 calculate a valid percentile for a specific procedure,
16 treatment, or service, the Commission may combine data from the
17 geozip with up to 4 other geozips that are demographically and
18 economically similar and exhibit similarities in data and
19 frequencies until the Commission reaches 9 charges or fees for
20 that specific procedure, treatment, or service. In cases where
21 the compiled data contains less than 9 charges or fees for a
22 procedure, treatment, or service, reimbursement shall occur at
23 76% of charges and fees as determined by the Commission in a
24 manner consistent with the provisions of this paragraph.
25 Providers of out-of-state procedures, treatments, services,
26 products, or supplies shall be reimbursed at the lesser of that

1 state's fee schedule amount or the fee schedule amount for the
2 region in which the employee resides. If no fee schedule exists
3 in that state, the provider shall be reimbursed at the lesser
4 of the actual charge or the fee schedule amount for the region
5 in which the employee resides. Not later than September 30 in
6 2006 and each year thereafter, the Commission shall
7 automatically increase or decrease the maximum allowable
8 payment for a procedure, treatment, or service established and
9 in effect on January 1 of that year by the percentage change in
10 the Consumer Price Index-U for the 12 month period ending
11 August 31 of that year. The increase or decrease shall become
12 effective on January 1 of the following year. As used in this
13 Section, "Consumer Price Index-U" means the index published by
14 the Bureau of Labor Statistics of the U.S. Department of Labor,
15 that measures the average change in prices of all goods and
16 services purchased by all urban consumers, U.S. city average,
17 all items, 1982-84=100.

18 (a-1) Notwithstanding the provisions of subsection (a) and
19 unless otherwise indicated, the following provisions shall
20 apply to the medical fee schedule starting on September 1,
21 2011:

22 (1) The Commission shall establish and maintain fee
23 schedules for procedures, treatments, products, services,
24 or supplies for hospital inpatient, hospital outpatient,
25 emergency room, ambulatory surgical treatment centers,
26 accredited ambulatory surgical treatment facilities,

1 prescriptions filled and dispensed outside of a licensed
2 pharmacy, dental services, and professional services. This
3 fee schedule shall be based on the fee schedule amounts
4 already established by the Commission pursuant to
5 subsection (a) of this Section. However, starting on
6 January 1, 2012, these fee schedule amounts shall be
7 grouped into geographic regions in the following manner:

8 (A) Four regions for non-hospital fee schedule
9 amounts shall be utilized:

10 (i) Cook County;

11 (ii) DuPage, Kane, Lake, and Will Counties;

12 (iii) Bond, Calhoun, Clinton, Jersey,
13 Macoupin, Madison, Monroe, Montgomery, Randolph,
14 St. Clair, and Washington Counties; and

15 (iv) All other counties of the State.

16 (B) Fourteen regions for hospital fee schedule
17 amounts shall be utilized:

18 (i) Cook, DuPage, Will, Kane, McHenry, DeKalb,
19 Kendall, and Grundy Counties;

20 (ii) Kankakee County;

21 (iii) Madison, St. Clair, Macoupin, Clinton,
22 Monroe, Jersey, Bond, and Calhoun Counties;

23 (iv) Winnebago and Boone Counties;

24 (v) Peoria, Tazewell, Woodford, Marshall, and
25 Stark Counties;

26 (vi) Champaign, Piatt, and Ford Counties;

- 1 (vii) Rock Island, Henry, and Mercer Counties;
2 (viii) Sangamon and Menard Counties;
3 (ix) McLean County;
4 (x) Lake County;
5 (xi) Macon County;
6 (xii) Vermilion County;
7 (xiii) Alexander County; and
8 (xiv) All other counties of the State.

9 (2) If a geozip, as defined in subsection (a) of this
10 Section, overlaps into one or more of the regions set forth
11 in this Section, then the Commission shall average or
12 repeat the charges and fees in a geozip in order to
13 designate charges and fees for each region.

14 (3) In cases where the compiled data contains less than
15 9 charges or fees for a procedure, treatment, product,
16 supply, or service or where the fee schedule amount cannot
17 be determined by the non-discounted charge data,
18 non-Medicare relative values and conversion factors
19 derived from established fee schedule amounts, coding
20 crosswalks, or other data as determined by the Commission,
21 reimbursement shall occur at 76% of charges and fees until
22 September 1, 2011 and 53.2% of charges and fees thereafter
23 as determined by the Commission in a manner consistent with
24 the provisions of this paragraph.

25 (4) To establish additional fee schedule amounts, the
26 Commission shall utilize provider non-discounted charge

1 data, non-Medicare relative values and conversion factors
2 derived from established fee schedule amounts, and coding
3 crosswalks. The Commission may establish additional fee
4 schedule amounts based on either the charge or cost of the
5 procedure, treatment, product, supply, or service.

6 (5) Implants shall be reimbursed at 25% above the net
7 manufacturer's invoice price less rebates, plus actual
8 reasonable and customary shipping charges whether or not
9 the implant charge is submitted by a provider in
10 conjunction with a bill for all other services associated
11 with the implant, submitted by a provider on a separate
12 claim form, submitted by a distributor, or submitted by the
13 manufacturer of the implant. "Implants" include the
14 following codes or any substantially similar updated code
15 as determined by the Commission: 0274
16 (prosthetics/orthotics); 0275 (pacemaker); 0276 (lens
17 implant); 0278 (implants); 0540 and 0545 (ambulance); 0624
18 (investigational devices); and 0636 (drugs requiring
19 detailed coding). Non-implantable devices or supplies
20 within these codes shall be reimbursed at 65% of actual
21 charge, which is the provider's normal rates under its
22 standard chargemaster. A standard chargemaster is the
23 provider's list of charges for procedures, treatments,
24 products, supplies, or services used to bill payers in a
25 consistent manner.

26 (6) The Commission shall automatically update all

1 codes and associated rules with the version of the codes
2 and rules valid on January 1 of that year.

3 (a-2) For procedures, treatments, services, or supplies
4 covered under this Act and rendered or to be rendered on or
5 after September 1, 2011, the maximum allowable payment shall be
6 70% of the fee schedule amounts, which shall be adjusted yearly
7 by the Consumer Price Index-U, as described in subsection (a)
8 of this Section.

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

15 (b) Notwithstanding the provisions of subsection (a), if
16 the Commission finds that there is a significant limitation on
17 access to quality health care in either a specific field of
18 health care services or a specific geographic limitation on
19 access to health care, it may change the Consumer Price Index-U
20 increase or decrease for that specific field or specific
21 geographic limitation on access to health care to address that
22 limitation.

23 (c) The Commission shall establish by rule a process to
24 review those medical cases or outliers that involve
25 extra-ordinary treatment to determine whether to make an
26 additional adjustment to the maximum payment within a fee

1 schedule for a procedure, treatment, or service.

2 (d) When a patient notifies a provider that the treatment,
3 procedure, or service being sought is for a work-related
4 illness or injury and furnishes the provider the name and
5 address of the responsible employer, the provider shall bill
6 the employer directly. The employer shall make payment and
7 providers shall submit bills and records in accordance with the
8 provisions of this Section.

9 (1) All payments to providers for treatment provided
10 pursuant to this Act shall be made within 30 days of
11 receipt of the bills as long as the claim contains
12 substantially all the required data elements necessary to
13 adjudicate the bills.

14 (2) If the claim does not contain substantially all the
15 required data elements necessary to adjudicate the bill, or
16 the claim is denied for any other reason, in whole or in
17 part, the employer or insurer shall provide written
18 notification to the provider and to the employee or his or
19 her designee in the form of an explanation of benefits,
20 explaining the basis for the denial and describing any
21 additional necessary data elements, to the provider within
22 30 days of receipt of the bill.

23 (3) In the case of nonpayment to a provider within 30
24 days of receipt of the bill which contained substantially
25 all of the required data elements necessary to adjudicate
26 the bill or nonpayment to a provider of a portion of such a

1 bill up to the lesser of the actual charge or the payment
2 level set by the Commission in the fee schedule established
3 in this Section, the bill, or portion of the bill, shall
4 incur interest at a rate of 1% per month payable to the
5 provider. Any required interest payments shall be made
6 within 30 days after payment.

7 (e) Except as provided in subsections (e-5), (e-10), and
8 (e-15), a provider shall not hold an employee liable for costs
9 related to a non-disputed procedure, treatment, or service
10 rendered in connection with a compensable injury. The
11 provisions of subsections (e-5), (e-10), (e-15), and (e-20)
12 shall not apply if an employee provides information to the
13 provider regarding participation in a group health plan. If the
14 employee participates in a group health plan, the provider may
15 submit a claim for services to the group health plan. If the
16 claim for service is covered by the group health plan, the
17 employee's responsibility shall be limited to applicable
18 deductibles, co-payments, or co-insurance. Except as provided
19 under subsections (e-5), (e-10), (e-15), and (e-20), a provider
20 shall not bill or otherwise attempt to recover from the
21 employee the difference between the provider's charge and the
22 amount paid by the employer or the insurer on a compensable
23 injury, or for medical services or treatment determined by the
24 Commission to be excessive or unnecessary.

25 (e-5) If an employer notifies a provider that the employer
26 does not consider the illness or injury to be compensable under

1 this Act, the provider may seek payment of the provider's
2 actual charges from the employee for any procedure, treatment,
3 or service rendered. Once an employee informs the provider that
4 there is an application filed with the Commission to resolve a
5 dispute over payment of such charges, the provider shall cease
6 any and all efforts to collect payment for the services that
7 are the subject of the dispute. Any statute of limitations or
8 statute of repose applicable to the provider's efforts to
9 collect payment from the employee shall be tolled from the date
10 that the employee files the application with the Commission
11 until the date that the provider is permitted to resume
12 collection efforts under the provisions of this Section.

13 (e-10) If an employer notifies a provider that the employer
14 will pay only a portion of a bill for any procedure, treatment,
15 or service rendered in connection with a compensable illness or
16 disease, the provider may seek payment from the employee for
17 the remainder of the amount of the bill up to the lesser of the
18 actual charge, negotiated rate, if applicable, or the payment
19 level set by the Commission in the fee schedule established in
20 this Section. Once an employee informs the provider that there
21 is an application filed with the Commission to resolve a
22 dispute over payment of such charges, the provider shall cease
23 any and all efforts to collect payment for the services that
24 are the subject of the dispute. Any statute of limitations or
25 statute of repose applicable to the provider's efforts to
26 collect payment from the employee shall be tolled from the date

1 that the employee files the application with the Commission
2 until the date that the provider is permitted to resume
3 collection efforts under the provisions of this Section.

4 (e-15) When there is a dispute over the compensability of
5 or amount of payment for a procedure, treatment, or service,
6 and a case is pending or proceeding before an Arbitrator or the
7 Commission, the provider may mail the employee reminders that
8 the employee will be responsible for payment of any procedure,
9 treatment or service rendered by the provider. The reminders
10 must state that they are not bills, to the extent practicable
11 include itemized information, and state that the employee need
12 not pay until such time as the provider is permitted to resume
13 collection efforts under this Section. The reminders shall not
14 be provided to any credit rating agency. The reminders may
15 request that the employee furnish the provider with information
16 about the proceeding under this Act, such as the file number,
17 names of parties, and status of the case. If an employee fails
18 to respond to such request for information or fails to furnish
19 the information requested within 90 days of the date of the
20 reminder, the provider is entitled to resume any and all
21 efforts to collect payment from the employee for the services
22 rendered to the employee and the employee shall be responsible
23 for payment of any outstanding bills for a procedure,
24 treatment, or service rendered by a provider.

25 (e-20) Upon a final award or judgment by an Arbitrator or
26 the Commission, or a settlement agreed to by the employer and

1 the employee, a provider may resume any and all efforts to
2 collect payment from the employee for the services rendered to
3 the employee and the employee shall be responsible for payment
4 of any outstanding bills for a procedure, treatment, or service
5 rendered by a provider as well as the interest awarded under
6 subsection (d) of this Section. In the case of a procedure,
7 treatment, or service deemed compensable, the provider shall
8 not require a payment rate, excluding the interest provisions
9 under subsection (d), greater than the lesser of the actual
10 charge or the payment level set by the Commission in the fee
11 schedule established in this Section. Payment for services
12 deemed not covered or not compensable under this Act is the
13 responsibility of the employee unless a provider and employee
14 have agreed otherwise in writing. Services not covered or not
15 compensable under this Act are not subject to the fee schedule
16 in this Section.

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

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

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