HB2587

LRB101 08368 JLS 53437 b

101ST GENERAL ASSEMBLY

State of Illinois

2019 and 2020

HB2587

by Rep. Thomas M. Bennett

SYNOPSIS AS INTRODUCED:

820 ILCS 305/8.2

Amends the Workers' Compensation Act. Requires a recipient of certain pain management medication to sign a written agreement with the prescribing physician agreeing to comply with the conditions of the prescription. Prohibits additional prescriptions while the recipient is noncompliant. Limits the applicability of the lack of pain management as a consideration in awarding benefits. Provides for the disclosure of violations of the agreement upon request by the employer. Requires a prescribing physician to file quarterly reports to obtain payment. Effective immediately.

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A BILL FOR

AN ACT concerning employment.

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

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

(820 ILCS 305/8.2)

Sec. 8.2. Fee schedule.

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

2004 through September 30, 2005. The Commission shall establish fee schedules for procedures, treatments, or services for hospital inpatient, hospital outpatient, emergency room and trauma, ambulatory surgical treatment centers, and professional services. These charges and fees shall be designated by geozip or any smaller geographic unit. The data shall in no way identify or tend to identify any patient, employer, or health care provider. As used in this Section, "geozip" means a three-digit zip code based on data similarities, geographical similarities, and frequencies. A geozip does not cross state boundaries. As used in this Section, "three-digit zip code" means a geographic area in which all zip codes have the same first 3 digits. If a geozip does not have the necessary number of charges and fees to calculate a valid percentile for a specific procedure, treatment, or service, the Commission may combine data from the geozip with up to 4 other geozips that are demographically and economically similar and exhibit similarities in data and frequencies until the Commission reaches 9 charges or fees for that specific procedure, treatment, or service. In cases where the compiled data contains less than 9 charges or fees for a procedure, treatment, or service, reimbursement shall occur at 76% of charges and fees as determined by the Commission in a manner consistent with the provisions of this paragraph. 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. Not later than September 30 in 2006 and each year thereafter, the Commission shall automatically increase or decrease the maximum allowable payment for a procedure, treatment, or service established and in effect on January 1 of that year by the percentage change in the Consumer Price Index-U for the 12 month period ending August 31 of that year. The increase or decrease shall become effective on January 1 of the following year. As used in this Section, "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.

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

(1) The Commission shall establish and maintain fee schedules for procedures, treatments, 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. This fee schedule shall be based on the fee schedule amounts already established by the Commission pursuant to subsection (a) of this Section. However, starting on January 1, 2012, these fee schedule amounts shall be grouped into geographic regions in the following manner:

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

(i) Cook County;

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

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

(iv) All other counties of the State.

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

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

(ii) Kankakee County;

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

(iv) Winnebago and Boone Counties;

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

(vi) Champaign, Piatt, and Ford Counties;

(vii) Rock Island, Henry, and Mercer Counties;

(viii) Sangamon and Menard Counties;

(ix) McLean County;

(x) Lake County;

(xi) Macon County;

(xii) Vermilion County;

(xiii) Alexander County; and

(xiv) All other counties of the State.

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

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

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

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

(5) Implants 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. "Implants" include the following codes or any substantially similar updated code as determined by the Commission: 0274 (prosthetics/orthotics); 0275 (pacemaker); 0276 (lens implant); 0278 (implants); 0540 and 0545 (ambulance); 0624 (investigational devices); and 0636 (drugs requiring detailed coding). Non-implantable devices or supplies within these codes shall be reimbursed at 65% of actual charge, which is the provider's normal rates under its standard chargemaster. 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.

(6) The Commission shall automatically update all

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

(a-2) For procedures, treatments, services, or supplies covered under this 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, as described in subsection (a) of this Section.

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

(a-4) As a condition of receiving pain management that requires prescribing a Schedule II, III, or IV controlled substance, as provided in the Illinois Controlled Substances Act, the injured worker shall sign a formal written agreement with the physician prescribing the Schedule II, III, or IV controlled substance acknowledging the conditions under which the injured worker shall continue to be prescribed a Schedule II, III, or IV controlled substance and agreeing to comply with those conditions. The pain management agreement shall outline the risks and benefits of opioid use, the conditions under which opioids will be prescribed, and the responsibilities of the prescribing physician and the injured worker.

An agreement made pursuant to this subsection shall be reviewed, updated, and renewed every 6 months.

(a-4.1) If the injured worker violates any of the conditions of the agreement on more than one occasion, the injured worker's right to pain management through the prescription of a Schedule II, III, or IV controlled substance under this Act shall be suspended pursuant to subsection (d) of Section 19 of this Act until the injured worker becomes compliant with the pain management agreement.

(a-4.2) A physician may disclose the employee's violation of the formal written agreement on the physician's own initiative. Upon request of the employer, a physician shall disclose the employee's violation of the formal written agreement provided in this Section.

(a-4.3) The formal written agreement shall include a notice disclosing to the employee in capitalized, conspicuous lettering on the face of the agreement the consequences for violating the terms of the agreement as provided for in this Section.

(a-4.4) If an injured worker's pain management benefits are terminated pursuant to alleged violations of the formal agreement as provided in this Section, the employee may file a request for an expedited hearing pursuant to subsection (b) of Section 19 of this Act.

(a-4.5) Any prescribing physician requiring a written agreement with an injured worker pursuant to this Section shall

have a rebuttable presumption of non-liability under Part 17 of Article II of the Code of Civil Procedure for injuries caused by the lack of access to Schedule II, III, or IV controlled substances if a violation of the agreement results in termination of pain management benefits pursuant to this Section.

(a-5) As used in this Section, "chronic pain" means pain that is unrelated to cancer, that is incident to surgery, and that persists beyond the period of expected healing after an acute injury episode or is pain that persists beyond 180 days following the onset of the pain.

(a-5.1) To receive reimbursement for a Schedule II, III, or IV controlled substance for chronic pain, the physician seeking reimbursement shall submit a written report to the payer not later than 90 days after the initial Schedule II, III, or IV controlled substance prescription fill for chronic pain and every 90 days thereafter. The written report shall include all of the following:

(1) A review and analysis of the relevant prior medical history, including any consultations that have been obtained and a review of data received from an automated prescription drug monitoring program in the treating jurisdiction for identification of past history of narcotic use and any concurrent prescriptions.

(2) A summary of conservative care rendered to the injured worker that focused on increased function and

return to work.

(3) A statement on why prior or alternative conservative measures were ineffective or contraindicated.

(4) A statement that the attending physician has considered the results obtained from appropriate industry-accepted screening tools to detect factors that may significantly increase the risk of abuse or adverse outcomes including a history of alcohol or other substance abuse.

(5) A treatment plan which includes all of the following:

(A) Overall treatment goals, functional progress, and demonstrated progress.

(B) Periodic urine drug screens.

(C) A conscientious effort to reduce pain through the use of non-opioid medications, alternative non-pharmaceutical strategies, or both.

(D) Consideration of weaning the injured or disabled patient from opioid use including, but not limited to, detoxification.

(a-5.2) A provider may bill the additional services required for compliance with this Section utilizing CPT procedure code 99215 for the initial 90-day report and all subsequent follow-up reports at 90-day intervals.

(a-5.3) A payor is not required to reimburse and the injured worker is not liable for the chronic pain services if

the physician reporting and treatment plan requirements pursuant to subsection (a-5.1) are not met. If the injured worker is in the process of weaning or weaning has been approved by the payor, denial of reimbursement shall occur only after a period of time, as established by evidence-based medicine and national guidelines, is provided for the weaning of the injured worker from the Schedule II, III, or IV controlled substance medication or alternative means of pain management have been offered.

(a-6) A payor who denies benefits in compliance with subsection (a-4.1) or subsection (a-5.3), performs utilization review as provided in Section 8.7, and finds the care to be inconsistent with national guidelines and protocols and that the prescriber failed to respond to the utilization review determination with a variance from the standards of care used in the utilization review that justifies the care is reasonably required and necessary to cure or relieve the effects of his or her injury, is rebuttably presumed to have acted in good faith and not subject to penalties under subsections (k) and (l) of Section 19.

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

geographic limitation on access to health care to address that limitation.

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

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

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

(2) If the bill does not contain substantially all the required data elements necessary to adjudicate the bill, or the claim is denied for any other reason, in whole or in

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

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

(4) If the employer or its insurer fails to pay interest within 30 days after payment of the bill as required pursuant to paragraph (3), the provider may bring an action in circuit court for the sole purpose of seeking payment of interest pursuant to paragraph (3) against the

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

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

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

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

(e-5) If an employer notifies a provider that the employer does not consider the illness or injury to be compensable under this Act, the provider may seek payment of the provider's actual charges from the employee for any procedure, treatment, or service rendered. Once an employee informs the provider that there is an application filed with the Commission to resolve a dispute over payment of such charges, the provider shall cease any and all efforts to collect payment for the services that are the subject of the dispute. Any statute of limitations or statute of repose applicable to the provider's efforts to collect payment from the employee shall be tolled from the date that the employee files the application with the Commission until the date that the provider is permitted to resume collection efforts under the provisions of this Section.

(e-10) If an employer notifies a provider that the employer will pay only a portion of a bill for any procedure, treatment, or service rendered in connection with a compensable illness or disease, the provider may seek payment from the employee for the remainder of the amount of the bill up to the lesser of the

actual charge, negotiated rate, if applicable, or the payment level set by the Commission in the fee schedule established in this Section. Once an employee informs the provider that there is an application filed with the Commission to resolve a dispute over payment of such charges, the provider shall cease any and all efforts to collect payment for the services that are the subject of the dispute. Any statute of limitations or statute of repose applicable to the provider's efforts to collect payment from the employee shall be tolled from the date that the employee files the application with the Commission until the date that the provider is permitted to resume collection efforts under the provisions of this Section.

(e-15) When there is a dispute over the compensability of or amount of payment for a procedure, treatment, or service, and a case is pending or proceeding before an Arbitrator or the Commission, the provider may mail the employee reminders that the employee will be responsible for payment of any procedure, treatment or service rendered by the provider. The reminders must state that they are not bills, to the extent practicable include itemized information, and state that the employee need not pay until such time as the provider is permitted to resume collection efforts under this Section. The reminders shall not be provided to any credit rating agency. The reminders may request that the employee furnish the provider with information about the proceeding under this Act, such as the file number, names of parties, and status of the case. If an employee fails

to respond to such request for information or fails to furnish the information requested within 90 days of the date of the reminder, the provider is entitled to resume any and all efforts to collect payment from the employee for the services rendered to the employee and the employee shall be responsible for payment of any outstanding bills for a procedure, treatment, or service rendered by a provider.

(e-20) Upon a final award or judgment by an Arbitrator or the Commission, or a settlement agreed to by the employer and the employee, a provider may resume any and all efforts to collect payment from the employee for the services rendered to the employee and the employee shall be responsible for payment of any outstanding bills for a procedure, treatment, or service rendered by a provider as well as the interest awarded under subsection (d) of this Section. In the case of a procedure, treatment, or service deemed compensable, the provider shall not require a payment rate, excluding the interest provisions under subsection (d), greater than the lesser of the actual charge or the payment level set by the Commission in the fee schedule established in this Section. Payment for services deemed not covered or not compensable under this Act is the responsibility of the employee unless a provider and employee have agreed otherwise in writing. Services not covered or not compensable under this Act are not subject to the fee schedule in this Section.

(f) Nothing in this Act shall prohibit an employer or

insurer from contracting with a health care provider or group of health care providers for reimbursement levels for benefits under this Act different from those provided in this Section.

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

(Source: P.A. 100-1117, eff. 11-27-18; 100-1175, eff. 1-11-19.)

Section 99. Effective date. This Act takes effect upon becoming law.