

1 AN ACT concerning government.

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

4 Section 5. The State Employees Group Insurance Act of 1971
5 is amended by adding Section 6.11A as follows:

6 (5 ILCS 375/6.11A new)

7 Sec. 6.11A. Physical therapy and occupational therapy.

8 (a) The program of health benefits provided under this Act
9 shall provide coverage for medically necessary physical
10 therapy and occupational therapy ordered or referred by a
11 physician licensed under the Medical Practice Act of 1987, a
12 physician's assistant licensed under the Physician's Assistant
13 Practice Act of 1987, or an advanced practice nurse licensed
14 under the Nurse Practice Act.

15 (b) For the purpose of this Section, "medically necessary"
16 means any care, treatment, intervention, service, or item that
17 will or is reasonably expected to:

18 (i) prevent the onset of an illness,
19 condition, injury, disease, or disability;

20 (ii) reduce or ameliorate the physical,
21 mental, or developmental effects of an illness,
22 condition, injury, disease, or disability; or

23 (iii) assist the achievement or maintenance of

1 maximum functional activity in performing daily
2 activities.

3 (c) The coverage required under this Section shall be
4 subject to the same deductible, coinsurance, waiting period,
5 cost sharing limitation, treatment limitation, calendar year
6 maximum, or other limitations as provided for other physical or
7 rehabilitative or occupational therapy benefits covered by the
8 policy.

9 (d) Upon request of the reimbursing insurer, the provider
10 of the physical therapy or occupational therapy shall furnish
11 medical records, clinical notes, or other necessary data that
12 substantiate that initial or continued treatment is medically
13 necessary and is resulting in approved clinical status. When
14 treatment is anticipated to require continued services to
15 achieve demonstrable progress, the insurer may request a
16 treatment plan consisting of the diagnosis, proposed treatment
17 by type, proposed frequency of treatment, anticipated duration
18 of treatment, anticipated outcomes stated as goals, and
19 proposed frequency of updating the treatment plan.

20 (e) When making a determination of medical necessity for
21 treatment, an insurer must make the determination in a manner
22 consistent with the manner in which that determination is made
23 with respect to other diseases or illnesses covered under the
24 policy, including an appeals process. During the appeals
25 process, any challenge to medical necessity may be viewed as
26 reasonable only if the review includes a licensed health care

1 professional with the same category of license as the
2 professional who ordered or referred the service in question
3 and with expertise in the most current and effective treatment.