LRB10005727KTG43234a

Sen. Michael E. Hastings

Filed: 11/13/2018

1 AMENDMENT TO HOUSE BILL 3452

2 AMENDMENT NO. ______. Amend House Bill 3452 by replacing
3 everything after the enacting clause with the following:

4 "Section 5. If and only if Senate Bill 904 of the 100th
5 General Assembly becomes law in the form in which it passed
6 both houses on May 31, 2018, then the Workers' Compensation Act
7 is amended by changing Section 8.2 as follows:

8 (820 ILCS 305/8.2)
9 Sec. 8.2. Fee schedule.
10 (a) Except as provided for in subsection (c), for
11 procedures, treatments, or services covered under this Act and
12 rendered or to be rendered on and after February 1, 2006, the
13 maximum allowable payment shall be 90% of the 80th percentile
14 of charges and fees as determined by the Commission utilizing
15 information provided by employers' and insurers' national
16 databases, with a minimum of 12,000,000 Illinois line item

1 charges and fees comprised of health care provider and hospital
2 charges and fees as of August 1, 2004 but not earlier than
3 August 1, 2002. These charges and fees are provider billed
4 amounts and shall not include discounted charges. The 80th
5 percentile is the point on an ordered data set from low to high
6 such that 80% of the cases are below or equal to that point and
7 at most 20% are above or equal to that point. The Commission
8 shall adjust these historical charges and fees as of August 1,
9 2004 by the Consumer Price Index-U for the period August 1,
10 2004 through September 30, 2005. The Commission shall establish
11 fee schedules for procedures, treatments, or services for
12 hospital inpatient, hospital outpatient, emergency room and
13 trauma, ambulatory surgical treatment centers, and
14 professional services. These charges and fees shall be
15 designated by geozip or any smaller geographic unit. The data
16 shall in no way identify or tend to identify any patient,
17 employer, or health care provider. As used in this Section,
18 "geozip" means a three-digit zip code based on data
19 similarities, geographical similarities, and frequencies. A
20 geozip does not cross state boundaries. As used in this
21 Section, "three-digit zip code" means a geographic area in
22 which all zip codes have the same first 3 digits. If a geozip
23 does not have the necessary number of charges and fees to
24 calculate a valid percentile for a specific procedure,
25 treatment, or service, the Commission may combine data from the
26 geozip with up to 4 other geozips that are demographically and

1 economically similar and exhibit similarities in data and
2 frequencies until the Commission reaches 9 charges or fees for
3 that specific procedure, treatment, or service. In cases where
4 the compiled data contains less than 9 charges or fees for a
5 procedure, treatment, or service, reimbursement shall occur at
6 76% of charges and fees as determined by the Commission in a
7 manner consistent with the provisions of this paragraph.
8 Providers of out-of-state procedures, treatments, services,
9 products, or supplies shall be reimbursed at the lesser of that
10 state's fee schedule amount or the fee schedule amount for the
11 region in which the employee resides. If no fee schedule exists
12 in that state, the provider shall be reimbursed at the lesser
13 of the actual charge or the fee schedule amount for the region
14 in which the employee resides. Not later than September 30 in
15 2006 and each year thereafter, the Commission shall
16 automatically increase or decrease the maximum allowable
17 payment for a procedure, treatment, or service established and
18 in effect on January 1 of that year by the percentage change in
19 the Consumer Price Index-U for the 12 month period ending
20 August 31 of that year. The increase or decrease shall become
21 effective on January 1 of the following year. As used in this
22 Section, "Consumer Price Index-U" means the index published by
23 the Bureau of Labor Statistics of the U.S. Department of Labor,
24 that measures the average change in prices of all goods and
25 services purchased by all urban consumers, U.S. city average,
26 all items, 1982-84=100.

1 (a-1) Notwithstanding the provisions of subsection (a) and
2 unless otherwise indicated, the following provisions shall
3 apply to the medical fee schedule starting on September 1,
4 2011:
5 (1) The Commission shall establish and maintain fee
6 schedules for procedures, treatments, products, services,
7 or supplies for hospital inpatient, hospital outpatient,
8 emergency room, ambulatory surgical treatment centers,
9 accredited ambulatory surgical treatment facilities,
10 prescriptions filled and dispensed outside of a licensed
11 pharmacy, dental services, and professional services. This
12 fee schedule shall be based on the fee schedule amounts
13 already established by the Commission pursuant to
14 subsection (a) of this Section. However, starting on
15 January 1, 2012, these fee schedule amounts shall be
16 grouped into geographic regions in the following manner:
17 (A) Four regions for non-hospital fee schedule
18 amounts shall be utilized:
19 (i) Cook County;
20 (ii) DuPage, Kane, Lake, and Will Counties;
21 (iii) Bond, Calhoun, Clinton, Jersey,
22 Macoupin, Madison, Monroe, Montgomery, Randolph,
23 St. Clair, and Washington Counties; and
24 (iv) All other counties of the State.
25 (B) Fourteen regions for hospital fee schedule
26 amounts shall be utilized:

1 (i) Cook, DuPage, Will, Kane, McHenry, DeKalb,
2 Kendall, and Grundy Counties;
3 (ii) Kankakee County;
4 (iii) Madison, St. Clair, Macoupin, Clinton,
5 Monroe, Jersey, Bond, and Calhoun Counties;
6 (iv) Winnebago and Boone Counties;
7 (v) Peoria, Tazewell, Woodford, Marshall, and
8 Stark Counties;
9 (vi) Champaign, Piatt, and Ford Counties;
10 (vii) Rock Island, Henry, and Mercer Counties;
11 (viii) Sangamon and Menard Counties;
12 (ix) McLean County;
13 (x) Lake County;
14 (xi) Macon County;
15 (xii) Vermilion County;
16 (xiii) Alexander County; and
17 (xiv) All other counties of the State.
18 (2) If a geozip, as defined in subsection (a) of this
19 Section, overlaps into one or more of the regions set forth
20 in this Section, then the Commission shall average or
21 repeat the charges and fees in a geozip in order to
22 designate charges and fees for each region.
23 (3) In cases where the compiled data contains less than
24 9 charges or fees for a procedure, treatment, product,
25 supply, or service or where the fee schedule amount cannot
26 be determined by the non-discounted charge data,

1 non-Medicare relative values and conversion factors
2 derived from established fee schedule amounts, coding
3 crosswalks, or other data as determined by the Commission,
4 reimbursement shall occur at 76% of charges and fees until
5 September 1, 2011 and 53.2% of charges and fees thereafter
6 as determined by the Commission in a manner consistent with
7 the provisions of this paragraph.
8 (4) To establish additional fee schedule amounts, the
9 Commission shall utilize provider non-discounted charge
10 data, non-Medicare relative values and conversion factors
11 derived from established fee schedule amounts, and coding
12 crosswalks. The Commission may establish additional fee
13 schedule amounts based on either the charge or cost of the
14 procedure, treatment, product, supply, or service.
15 (5) Implants shall be reimbursed at 25% above the net
16 manufacturer's invoice price less rebates, plus actual
17 reasonable and customary shipping charges whether or not
18 the implant charge is submitted by a provider in
19 conjunction with a bill for all other services associated
20 with the implant, submitted by a provider on a separate
21 claim form, submitted by a distributor, or submitted by the
22 manufacturer of the implant. "Implants" include the
23 following codes or any substantially similar updated code
24 as determined by the Commission: 0274
25 (prosthetics/orthotics); 0275 (pacemaker); 0276 (lens
26 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 Medispan.

(b) Notwithstanding the provisions of subsection (a), if the Commission finds that there is a significant limitation on access to quality health care in either a specific field of

1 health care services or a specific geographic limitation on
2 access to health care, it may change the Consumer Price Index-U
3 increase or decrease for that specific field or specific
4 geographic limitation on access to health care to address that
5 limitation.

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

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

22 (1) All payments to providers for treatment provided
23 pursuant to this Act shall be made within 30 days of
24 receipt of the bills as long as the bill contains
25 substantially all the required data elements necessary to
26 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 ~~not later than~~ 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) ~~this subsection (d)~~, the provider may bring an action in circuit court for the sole purpose of seeking payment of interest pursuant to paragraph (3) ~~enforce the provisions of this subsection (d)~~ against the employer or its insurer responsible for insuring the employer's liability pursuant to item (3) of subsection (a) of Section 4. The circuit court's jurisdiction shall be limited to enforcing payment of interest pursuant to paragraph (3). Interest under paragraph (3) ~~this subsection (d)~~ is only payable to the provider. An employee is not responsible for the payment of interest under this Section. The right to interest under paragraph (3) ~~this subsection (d)~~ shall not delay, diminish, restrict, or alter in any way the benefits to which the employee or his or her dependents are entitled under this Act.

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

(e) Except as provided in subsections (e-5), (e-10), and (e-15), a provider shall not hold an employee liable for costs related to a non-disputed procedure, treatment, or service rendered in connection with a compensable injury. The provisions of subsections (e-5), (e-10), (e-15), and (e-20) shall not apply if an employee provides information to the

1 provider regarding participation in a group health plan. If the
2 employee participates in a group health plan, the provider may
3 submit a claim for services to the group health plan. If the
4 claim for service is covered by the group health plan, the
5 employee's responsibility shall be limited to applicable
6 deductibles, co-payments, or co-insurance. Except as provided
7 under subsections (e-5), (e-10), (e-15), and (e-20), a provider
8 shall not bill or otherwise attempt to recover from the
9 employee the difference between the provider's charge and the
10 amount paid by the employer or the insurer on a compensable
11 injury, or for medical services or treatment determined by the
12 Commission to be excessive or unnecessary.

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

1 (e-10) If an employer notifies a provider that the employer
2 will pay only a portion of a bill for any procedure, treatment,
3 or service rendered in connection with a compensable illness or
4 disease, the provider may seek payment from the employee for
5 the remainder of the amount of the bill up to the lesser of the
6 actual charge, negotiated rate, if applicable, or the payment
7 level set by the Commission in the fee schedule established in
8 this Section. Once an employee informs the provider that there
9 is an application filed with the Commission to resolve a
10 dispute over payment of such charges, the provider shall cease
11 any and all efforts to collect payment for the services that
12 are the subject of the dispute. Any statute of limitations or
13 statute of repose applicable to the provider's efforts to
14 collect payment from the employee shall be tolled from the date
15 that the employee files the application with the Commission
16 until the date that the provider is permitted to resume
17 collection efforts under the provisions of this Section.
18 (e-15) When there is a dispute over the compensability of
19 or amount of payment for a procedure, treatment, or service,
20 and a case is pending or proceeding before an Arbitrator or the
21 Commission, the provider may mail the employee reminders that
22 the employee will be responsible for payment of any procedure,
23 treatment or service rendered by the provider. The reminders
24 must state that they are not bills, to the extent practicable
25 include itemized information, and state that the employee need
26 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

1 responsibility of the employee unless a provider and employee
2 have agreed otherwise in writing. Services not covered or not
3 compensable under this Act are not subject to the fee schedule
4 in this Section.
5 (f) Nothing in this Act shall prohibit an employer or
6 insurer from contracting with a health care provider or group
7 of health care providers for reimbursement levels for benefits
8 under this Act different from those provided in this Section.
9 (g) On or before January 1, 2010 the Commission shall
10 provide to the Governor and General Assembly a report regarding
11 the implementation of the medical fee schedule and the index
12 used for annual adjustment to that schedule as described in
13 this Section.
14 (Source: 10000SB0904enr.)

15 Section 99. Effective date. This Act takes effect upon
16 becoming law or on the date Senate Bill 904 of the 100th
17 General Assembly takes effect, whichever is later.".