Sen. Christine Radogno

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AMENDMENT TO SENATE BILL 12

AMENDMENT NO. _____. Amend Senate Bill 12 on page 10, line 15, after "pursuant", by inserting "to"; and

on page 10, by replacing lines 23 and 24 with the following: "changing Sections 1, 8, 8.1b, 8.2, 8.2a, 14, 19, 25.5, and 29.2 as follows:"; and

by replacing line 4 on page 17 through line 13 on page 19 with the following:

"In determining whether an employee is required to travel for the performance of job duties, the following factors shall be considered: whether the employer had knowledge that the employee may be required to travel to perform the job; whether the employer furnished any mode of transportation to or from the employee; whether the employee received, or the employer paid or agreed to pay, any remuneration or reimbursement for costs or expenses of any form of travel; whether the employer

in any way directed the course or method of travel; whether the employer in any way assisted the employee in making any travel arrangements; whether the employer furnished lodging or in any way reimbursed the employee for lodging; and whether the employer received any benefit from the employee traveling."; and

on page 26, by replacing lines 1 and 2 with the following: "lasts more than 5 scheduled ~~3~~ working days for the claimant, weekly compensation as hereinafter provided shall be paid beginning on the 6th ~~4th~~ day"; and

on page 29, line 20, by changing "$755.22" to "$775.18"; and

on page 45, by replacing lines 16 and 17 with the following: "fingers, leg, foot, or any toes, or loss under Section 8(d)2 due to accidental injuries to the same part of the spine, such loss or partial loss of any such member or loss under Section 8(d)2 due to accidental injuries to the same part of the spine shall be deducted from any award made"; and

on page 45, line 20, by replacing "eye" with "eye or loss under Section 8(d)2 due to accidental injuries to the same part of the spine"; and

on page 45, line 22, by inserting immediately following the

period the following:

"For purposes of this subdivision (e)17 only, "same part of the spine" means: (1) cervical spine and thoracic spine from vertebra C1 through T12 and (2) lumbar and sacral spine and coccyx from vertebra L1 through S5."; and

on page 46, by replacing lines 6 through 21 with the following:

"members, and in a subsequent independent accident loses another or suffers the permanent and complete loss of the use of any one of such members the employer for whom the injured employee is working at the time of the last independent accident is liable to pay compensation only for the loss or permanent and complete loss of the use of the member occasioned by the last independent accident."; and

on page 58, by replacing lines 2 through 22 with the following:

"(b) Where an impairment report pursuant to subsection (a) exists, it must be considered by the Commission in its determination of the level of permanent partial disability.

In determining the level of permanent partial disability, the Commission shall base its determination on the reported level of impairment pursuant to subsection (a). In addition to any impairment report submitted, the Commission shall, by a preponderance of credible evidence, consider the following additional factors to determine disability: (i) the occupation of the injured employee; (ii) the age of the employee at the

time of the injury; (iii) the employee's future earning capacity; and (iv) evidence of disability at maximum medical improvement corroborated by findings in the treating medical records and independent medical exams. In determining the level of permanent partial disability, the Commission may base its determination on a report of impairment, after considering by a preponderance of credible evidence, the additional factors to determine disability. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

(c) A report of impairment prepared pursuant to subsection (a) is not required for the arbitrator or Commission to approve a Settlement Contract Lump Sum Petition.

~~(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the~~

~~physician must be explained in a written order.~~"; and

on page 61, by inserting after line 7 the following:

"The provisions of this subsection (a), other than this sentence, are inoperative after August 31, 2017."; and

on page 64, by inserting after line 18 the following:

"The provisions of this subsection (a-1), other than this sentence, are inoperative after August 31, 2017.

(a-1.5) The following provisions apply to procedures, treatments, services, products, and supplies covered under this Act and rendered or to be rendered on or after September 1, 2017:

(1) In this Section:

"CPT code" means each Current Procedural Terminology code, for each geographic region specified in subsection (b) of this Section, included on the most recent medical fee schedule established by the Commission pursuant to this Section.

"DRG code" means each current diagnosis related group code, for each geographic region specified in subsection (b) of this Section, included on the most recent medical fee schedule established by the Commission pursuant to this Section.

"Geozip" means a three-digit zip code based on data similarities, geographical similarities, and frequencies.

"Health care services" means those CPT and DRG codes for procedures, treatments, products, services or supplies for hospital inpatient, hospital outpatient, emergency room, ambulatory surgical treatment centers, accredited ambulatory surgical treatment facilities, and professional services. It does not include codes classified as healthcare common procedure coding systems or dental.

"Medicare maximum fee" means, for each CPT and DRG code, the current maximum fee for that CPT or DRG code allowed to be charged by the Centers for Medicare and Medicaid Services for Medicare patients in that geographic region. The Medicare maximum fee shall be the greater of (i) the current maximum fee allowed to be charged by the Centers for Medicare and Medicaid Services for Medicare patients in the geographic region or (ii) the maximum fee charged by the Centers for Medicare and Medicaid Services for Medicare patients in the geographic region on January 1, 2017.

"Medicare percentage amount" means, for each CPT and DRG code, the workers' compensation maximum fee as a percentage of the Medicare maximum fee.

"Workers' compensation maximum fee" means, for each CPT and DRG code, the current maximum fee allowed to be charged under the medical fee schedule established by the Commission for that CPT or DRG code in that geographic region.

(2) 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. 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.

If a geozip 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) The initial workers' compensation maximum fee for each CPT and DRG code as of September 1, 2017 shall be determined as follows:

(A) Within 45 days after the effective date of this amendatory Act of the 100th General Assembly, the Commission shall determine the Medicare percentage amount for each CPT and DRG code using the most recent data available.

CPT or DRG codes which have a value, but are not covered expenses under Medicare, are still compensable under the medical fee schedule according to the rate described in Section (B).

(B) Within 30 days after the Commission makes the determinations required by subdivision (3)(A) of this subsection (a-1.5), the Commission shall determine an adjustment to be made to the workers' compensation maximum fee for each CPT and DRG code as follows:

(i) If the Medicare percentage amount for that CPT or DRG code is equal to or less than 125%, then the workers' compensation maximum fee for that CPT or DRG code shall be adjusted so that it equals 125% of the most recent Medicare maximum fee for that CPT or DRG code.

(ii) If the Medicare percentage amount for that CPT or DRG code is greater than 125% but less than 150%, then the workers' compensation maximum fee for that CPT or DRG code shall not be adjusted.

(iii) If the Medicare percentage amount for that CPT or DRG code is greater than 150% but less than or equal to 225%, then the workers' compensation maximum fee for that CPT or DRG code shall be adjusted so that it equals the greater of (I) 150% of the most recent Medicare maximum fee for that CPT or DRG code or (II) 85% of the most recent workers' compensation maximum amount for that CPT or DRG code.

(iv) If the Medicare percentage amount for that CPT or DRG code is greater than 225% but less

than or equal to 428.57%, then the workers' compensation maximum fee for that CPT or DRG code shall be adjusted so that it equals the greater of (I) 191.25% of the most recent Medicare maximum fee for that CPT or DRG code or (II) 70% of the most recent workers' compensation maximum amount for that CPT or DRG code.

(v) If the Medicare percentage amount for that CPT or DRG code is greater than 428.57%, then the workers' compensation maximum fee for that CPT or DRG code shall be adjusted so that it equals 300% of the most recent Medicare maximum fee for that CPT or DRG code.

The Commission shall promptly publish the adjustments determined pursuant to this subdivision (3)(B) on its website.

(C) The initial workers' compensation maximum fee for each CPT and DRG code as of September 1, 2017 shall be equal to the workers' compensation maximum fee for that code as determined and adjusted pursuant to subdivision (3)(B) of this subsection, subject to any further adjustments pursuant to subdivision (5) of this subsection.

(4) The Commission, as of September 1, 2018 and September 1 of each year thereafter, shall adjust the workers' compensation maximum fee for each CPT or DRG code

to exactly half of the most recent annual increase in the Consumer Price Index-U.

(5) A person who believes that the workers' compensation maximum fee for a CPT or DRG code, as otherwise determined pursuant to this subsection, creates or would create upon implementation 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 may petition the Commission to modify the workers' compensation maximum fee for that CPT or DRG code so as to not create that significant limitation.

The petitioner bears the burden of demonstrating, by a preponderance of the credible evidence, that the workers' compensation maximum fee that would otherwise apply would create 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. Petitions shall be made publicly available. Such credible evidence shall include empirical data demonstrating a significant limitation on access to quality health care. Other interested persons may file comments or responses to a petition within 30 days of the filing of a petition.

The Commission shall take final action on each petition within 180 days of filing. The Commission may, but is not required to, seek the recommendation of the Medical Fee

Advisory Board to assist with this determination. If the Commission grants the petition, the Commission shall further increase the workers' compensation maximum fee for that CPT or DRG code by the amount minimally necessary to avoid creating 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. The increased workers' compensation maximum fee shall take effect upon entry of the Commission's final action."; and

on page 64, line 24, by inserting after the period the following:

"The provisions of this subsection (a-2), other than this sentence, are inoperative after August 31, 2017."; and

by deleting lines 25 and 26 of page 64 and all of page 65; and

by deleting lines 22 through 25 of page 73, all of pages 74 through 80, and lines 1 through 12 of page 81; and

by deleting lines 18 through 25 of page 86, all of pages 87 and 88, and lines 1 through 7 of page 89; and

by replacing lines 20 through 26 of page 92 and lines 1 through 23 of page 93 with the following:

"Whether the employee is working or not, if the employee is not receiving or has not received medical, surgical, or hospital services or other services or compensation as provided in paragraph (a) of Section 8, or compensation as provided in paragraph (b) of Section 8, or if the employer has refused or failed to respond to a written request for authorization of medical care and treatment, the employee may at any time petition for an expedited hearing by an Arbitrator on the issue of whether or not he or she is entitled to receive payment of the services or compensation or authorization of medical care. Provided the employer continues to pay compensation pursuant to paragraph (b) of Section 8, the employer may at any time petition for an expedited hearing on the issue of whether or not the employee is entitled to receive medical, surgical, or hospital services or other services or compensation as provided in paragraph (a) of Section 8, whether or not the employee is entitled to authorization of medical care and treatment, or compensation as provided in paragraph (b) of Section 8. When an employer has petitioned for an expedited hearing, the employer shall continue to pay compensation as provided in paragraph (b) of Section 8 unless the arbitrator renders a decision that the employee is not entitled to the benefits that are the subject of the expedited hearing or unless the employee's treating physician has released the employee to return to work at his or her regular job with the employer or the employee actually returns to work at any other job. If the arbitrator renders a

decision that the employee is not entitled to the benefits or medical care that is ~~are~~ the subject of the expedited hearing, a petition for review filed by the employee shall receive the same priority as if the employee had filed a petition for an expedited hearing by an Arbitrator. Neither party shall be entitled to an expedited hearing when the employee has returned to work and the sole issue in dispute amounts to less than 12 weeks of unpaid compensation pursuant to paragraph (b) of Section 8."; and

on page 113, by replacing lines 7 through 18 with the following:

"(k) In a case where there has been any unreasonable or vexatious delay of payment or intentional underpayment of compensation, or proceedings have been instituted or carried on by the one liable to pay the compensation, which do not present a real controversy, but are merely frivolous or for delay, then the Commission may award compensation additional to that otherwise payable under this Act equal to 50% of the amount payable at the time of such award. Failure to pay compensation in accordance with the provisions of Section 8, paragraph (b) of this Act, shall be considered unreasonable delay."; and

on page 122, line 6, after "pursuant", by inserting "to"; and

by replacing line 23 on page 131 through line 13 on page 132

with the following:

"(5) The growth of total paid indemnity benefits by temporary total disability, scheduled and non-scheduled permanent partial disability, and total disability.

(6) Illinois' rank, relative to other states, for:

(i) the maximum and minimum temporary total disability benefit levels;

(ii) the maximum and minimum scheduled and non-scheduled permanent partial disability benefit levels;

(iii) the maximum and minimum total disability benefit levels; and

(iv) the maximum and minimum death benefit levels.

(7) The aggregate growth of medical benefit payouts by non-hospital providers and hospitals."; and

on page 134, by replacing lines 14 through 17 with the following:

"Section 99. Effective date. This Act takes effect upon becoming law, but this Act does not take effect at all unless Senate Bills 1, 3, 4, 5, 6, 7, 8, 9, 10, 13, and 16 of the 100th General Assembly become law.".