Sen. Kwame Raoul

Filed: 5/16/2017

1 AMENDMENT TO SENATE BILL 198

2 AMENDMENT NO. ______. Amend Senate Bill 198 by replacing
3 everything after the enacting clause with the following:

4 "Section 1. The Freedom of Information Act is amended by
5 changing Section 7.5 as follows:

6 (5 ILCS 140/7.5)
7 Sec. 7.5. Statutory exemptions. To the extent provided for
8 by the statutes referenced below, the following shall be exempt
9 from inspection and copying:
10 (a) All information determined to be confidential
11 under Section 4002 of the Technology Advancement and
12 Development Act.
13 (b) Library circulation and order records identifying
14 library users with specific materials under the Library
15 Records Confidentiality Act.
16 (c) Applications, related documents, and medical

1 records received by the Experimental Organ Transplantation
2 Procedures Board and any and all documents or other records
3 prepared by the Experimental Organ Transplantation
4 Procedures Board or its staff relating to applications it
5 has received.
6 (d) Information and records held by the Department of
7 Public Health and its authorized representatives relating
8 to known or suspected cases of sexually transmissible
9 disease or any information the disclosure of which is
10 restricted under the Illinois Sexually Transmissible
11 Disease Control Act.
12 (e) Information the disclosure of which is exempted
13 under Section 30 of the Radon Industry Licensing Act.
14 (f) Firm performance evaluations under Section 55 of
15 the Architectural, Engineering, and Land Surveying
16 Qualifications Based Selection Act.
17 (g) Information the disclosure of which is restricted
18 and exempted under Section 50 of the Illinois Prepaid
19 Tuition Act.
20 (h) Information the disclosure of which is exempted
21 under the State Officials and Employees Ethics Act, and
22 records of any lawfully created State or local inspector
23 general's office that would be exempt if created or
24 obtained by an Executive Inspector General's office under
25 that Act.
26 (i) Information contained in a local emergency energy

1 plan submitted to a municipality in accordance with a local
2 emergency energy plan ordinance that is adopted under
3 Section 11-21.5-5 of the Illinois Municipal Code.
4 (j) Information and data concerning the distribution
5 of surcharge moneys collected and remitted by wireless
6 carriers under the Wireless Emergency Telephone Safety
7 Act.
8 (k) Law enforcement officer identification information
9 or driver identification information compiled by a law
10 enforcement agency or the Department of Transportation
11 under Section 11-212 of the Illinois Vehicle Code.
12 (l) Records and information provided to a residential
13 health care facility resident sexual assault and death
14 review team or the Executive Council under the Abuse
15 Prevention Review Team Act.
16 (m) Information provided to the predatory lending
17 database created pursuant to Article 3 of the Residential
18 Real Property Disclosure Act, except to the extent
19 authorized under that Article.
20 (n) Defense budgets and petitions for certification of
21 compensation and expenses for court appointed trial
22 counsel as provided under Sections 10 and 15 of the Capital
23 Crimes Litigation Act. This subsection (n) shall apply
24 until the conclusion of the trial of the case, even if the
25 prosecution chooses not to pursue the death penalty prior
26 to trial or sentencing.

1 (o) Information that is prohibited from being
2 disclosed under Section 4 of the Illinois Health and
3 Hazardous Substances Registry Act.
4 (p) Security portions of system safety program plans,
5 investigation reports, surveys, schedules, lists, data, or
6 information compiled, collected, or prepared by or for the
7 Regional Transportation Authority under Section 2.11 of
8 the Regional Transportation Authority Act or the St. Clair
9 County Transit District under the Bi-State Transit Safety
10 Act.
11 (q) Information prohibited from being disclosed by the
12 Personnel Records Review Act.
13 (r) Information prohibited from being disclosed by the
14 Illinois School Student Records Act.
15 (s) Information the disclosure of which is restricted
16 under Section 5-108 of the Public Utilities Act.
17 (t) All identified or deidentified health information
18 in the form of health data or medical records contained in,
19 stored in, submitted to, transferred by, or released from
20 the Illinois Health Information Exchange, and identified
21 or deidentified health information in the form of health
22 data and medical records of the Illinois Health Information
23 Exchange in the possession of the Illinois Health
24 Information Exchange Authority due to its administration
25 of the Illinois Health Information Exchange. The terms
26 "identified" and "deidentified" shall be given the same

meaning as in the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, or any subsequent amendments thereto, and any regulations promulgated thereunder.

(u) Records and information provided to an independent team of experts under Brian's Law.

(v) Names and information of people who have applied for or received Firearm Owner's Identification Cards under the Firearm Owners Identification Card Act or applied for or received a concealed carry license under the Firearm Concealed Carry Act, unless otherwise authorized by the Firearm Concealed Carry Act; and databases under the Firearm Concealed Carry Act, records of the Concealed Carry Licensing Review Board under the Firearm Concealed Carry Act, and law enforcement agency objections under the Firearm Concealed Carry Act.

(w) Personally identifiable information which is exempted from disclosure under subsection (g) of Section 19.1 of the Toll Highway Act.

(x) Information which is exempted from disclosure under Section 5-1014.3 of the Counties Code or Section 8-11-21 of the Illinois Municipal Code.

(y) Confidential information under the Adult Protective Services Act and its predecessor enabling statute, the Elder Abuse and Neglect Act, including information about the identity and administrative finding

against any caregiver of a verified and substantiated decision of abuse, neglect, or financial exploitation of an eligible adult maintained in the Registry established under Section 7.5 of the Adult Protective Services Act.

(z) Records and information provided to a fatality review team or the Illinois Fatality Review Team Advisory Council under Section 15 of the Adult Protective Services Act.

(aa) Information which is exempted from disclosure under Section 2.37 of the Wildlife Code.

(bb) Information which is or was prohibited from disclosure by the Juvenile Court Act of 1987.

(cc) Recordings made under the Law Enforcement Officer-Worn Body Camera Act, except to the extent authorized under that Act.

(dd) Information that is prohibited from being disclosed under Section 45 of the Condominium and Common Interest Community Ombudsperson Act.

(ee) ~~(dd)~~ Information that is exempted from disclosure under Section 30.1 of the Pharmacy Practice Act.

(ff) Information the disclosure of which is restricted and exempted under Sections 25.5 and 29.2 of the Workers' Compensation Act.

(Source: P.A. 98-49, eff. 7-1-13; 98-63, eff. 7-9-13; 98-756, eff. 7-16-14; 98-1039, eff. 8-25-14; 98-1045, eff. 8-25-14; 99-78, eff. 7-20-15; 99-298, eff. 8-6-15; 99-352, eff. 1-1-16;

1 99-642, eff. 7-28-16; 99-776, eff. 8-12-16; 99-863, eff.
2 8-19-16; revised 9-1-16.)

3 Section 3. The Criminal Code of 2012 is amended by adding
4 Section 17-10.4 as follows:

5 (720 ILCS 5/17-10.4 new)
6 Sec. 17-10.4. Workers' compensation fraud.
7 (a) It is unlawful for any person, company, corporation,
8 insurance carrier, health care provider, or other entity to:
9 (1) Intentionally present or cause to be presented any
10 false or fraudulent claim for the payment of any workers'
11 compensation benefit.
12 (2) Intentionally make or cause to be made any false or
13 fraudulent material statement or material representation
14 for the purpose of obtaining or denying any workers'
15 compensation benefit.
16 (3) Intentionally make or cause to be made any false or
17 fraudulent statements with regard to entitlement to
18 workers' compensation benefits with the intent to prevent
19 an injured worker from making a legitimate claim for any
20 workers' compensation benefit.
21 (4) Intentionally prepare or provide an invalid,
22 false, or counterfeit certificate of insurance as proof of
23 workers' compensation insurance.
24 (5) Intentionally make or cause to be made any false or

1 fraudulent material statement or material representation
2 for the purpose of obtaining workers' compensation
3 insurance at less than the proper amount for that
4 insurance.
5 (6) Intentionally make or cause to be made any false or
6 fraudulent material statement or material representation
7 on an initial or renewal self-insurance application or
8 accompanying financial statement for the purpose of
9 obtaining self-insurance status or reducing the amount of
10 security that may be required to be furnished pursuant to
11 Section 4 of the Workers' Compensation Act.
12 (7) Intentionally make or cause to be made any false or
13 fraudulent material statement to the Department of
14 Insurance's fraud and insurance non-compliance unit in the
15 course of an investigation of fraud or insurance
16 non-compliance.
17 (8) Intentionally present a bill or statement for the
18 payment for medical services that were not provided.
19 (9) Intentionally assist, abet, solicit, or conspire
20 with any person, company, or other entity to commit any of
21 the acts in paragraph (1), (2), (3), (4), (5), (6), (7), or
22 (8) of this subsection (a).
23 As used in paragraphs (2), (3), (5), (6), (7), and (8),
24 "statement" includes any writing, notice, proof of injury, bill
25 for services, hospital and doctor records and reports, and
26 X-ray and test results.

1 (b) Sentence.
2 (1) A violation of paragraph (a)(3) is a Class 4
3 felony.
4 (2) A violation of paragraph (a)(4) or (a)(7) is a
5 Class 3 felony.
6 (3) A violation of paragraph (a)(1), (a)(2), (a)(5),
7 (a)(6), or (a)(8) in which the value of the property
8 obtained or attempted to be obtained is $500 or less is a
9 Class A misdemeanor.
10 (4) A violation of paragraph (a)(1), (a)(2), (a)(5),
11 (a)(6), or (a)(8) in which the value of the property
12 obtained or attempted to be obtained is more than $500 but
13 not more than $10,000 is a Class 3 felony.
14 (5) A violation of paragraph (a)(1), (a)(2), (a)(5),
15 (a)(6), or (a)(8) in which the value of the property
16 obtained or attempted to be obtained is more than $10,000
17 but not more than $100,000 is a Class 2 felony.
18 (6) A violation of paragraph (a)(1), (a)(2), (a)(5),
19 (a)(6), or (a)(8) in which the value of the property
20 obtained or attempted to be obtained is more than $100,000
21 is a Class 1 felony.
22 (7) A violation of paragraph (9) of subsection (a)
23 shall be punishable as the Class of offense for which the
24 person convicted assisted, abetted, solicited, or
25 conspired to commit, as set forth in paragraphs (1) through
26 (6) of this subsection.

1 (8) A person convicted under this Section shall be
2 ordered to pay monetary restitution to the insurance
3 company or self-insured entity or any other person for any
4 financial loss sustained as a result of a violation of this
5 Section, including any court costs and attorney fees. An
6 order of restitution also includes expenses incurred and
7 paid by the State of Illinois or an insurance company or
8 self-insured entity in connection with any medical
9 evaluation or treatment services.
10 For a violation of paragraph (a)(1) or (a)(2), the value of
11 the property obtained or attempted to be obtained includes
12 payments pursuant to the provisions of the Workers'
13 Compensation Act as well as the amount paid for medical
14 expenses. For a violation of paragraph (a)(5), the value of the
15 property obtained or attempted to be obtained is the difference
16 between the proper amount for the coverage sought or provided
17 and the actual amount billed for workers' compensation
18 insurance. For a violation of paragraph (a)(6), the value of
19 the property obtained or attempted to be obtained is the
20 difference between the proper amount of security required
21 pursuant to Section 4 of the Workers' Compensation Act and the
22 amount furnished pursuant to the false or fraudulent statements
23 or representations. Notwithstanding the foregoing, an
24 insurance company, self-insured entity, or any other person
25 suffering financial loss sustained as a result of violation of
26 this Section may seek restitution, including court costs and

1 attorney's fees, in a civil action in a court of competent
2 jurisdiction.

3 Section 5. The Workers' Compensation Act is amended by
4 changing Sections 8, 8.1b, 8.2, 8.2a, 14, 19, 25.5, and 29.2 as
5 follows:

6 (820 ILCS 305/8) (from Ch. 48, par. 138.8)
7 Sec. 8. The amount of compensation which shall be paid to
8 the employee for an accidental injury not resulting in death
9 is:
10 (a) The employer shall provide and pay the negotiated rate,
11 if applicable, or the lesser of the health care provider's
12 actual charges or according to a fee schedule, subject to
13 Section 8.2, in effect at the time the service was rendered for
14 all the necessary first aid, medical and surgical services, and
15 all necessary medical, surgical and hospital services
16 thereafter incurred, limited, however, to that which is
17 reasonably required to cure or relieve from the effects of the
18 accidental injury, even if a health care provider sells,
19 transfers, or otherwise assigns an account receivable for
20 procedures, treatments, or services covered under this Act. If
21 the employer does not dispute payment of first aid, medical,
22 surgical, and hospital services, the employer shall make such
23 payment to the provider on behalf of the employee. The employer
24 shall also pay for treatment, instruction and training

1 necessary for the physical, mental and vocational
2 rehabilitation of the employee, including all maintenance
3 costs and expenses incidental thereto. If as a result of the
4 injury the employee is unable to be self-sufficient the
5 employer shall further pay for such maintenance or
6 institutional care as shall be required.

7 The employee may at any time elect to secure his own
8 physician, surgeon and hospital services at the employer's
9 expense, or,

10 Upon agreement between the employer and the employees, or
11 the employees' exclusive representative, and subject to the
12 approval of the Illinois Workers' Compensation Commission, the
13 employer shall maintain a list of physicians, to be known as a
14 Panel of Physicians, who are accessible to the employees. The
15 employer shall post this list in a place or places easily
16 accessible to his employees. The employee shall have the right
17 to make an alternative choice of physician from such Panel if
18 he is not satisfied with the physician first selected. If, due
19 to the nature of the injury or its occurrence away from the
20 employer's place of business, the employee is unable to make a
21 selection from the Panel, the selection process from the Panel
22 shall not apply. The physician selected from the Panel may
23 arrange for any consultation, referral or other specialized
24 medical services outside the Panel at the employer's expense.
25 Provided that, in the event the Commission shall find that a
26 doctor selected by the employee is rendering improper or

1 inadequate care, the Commission may order the employee to
2 select another doctor certified or qualified in the medical
3 field for which treatment is required. If the employee refuses
4 to make such change the Commission may relieve the employer of
5 his obligation to pay the doctor's charges from the date of
6 refusal to the date of compliance.

7 Any vocational rehabilitation counselors who provide
8 service under this Act shall have appropriate certifications
9 which designate the counselor as qualified to render opinions
10 relating to vocational rehabilitation. Vocational
11 rehabilitation may include, but is not limited to, counseling
12 for job searches, supervising a job search program, and
13 vocational retraining including education at an accredited
14 learning institution. The employee or employer may petition to
15 the Commission to decide disputes relating to vocational
16 rehabilitation and the Commission shall resolve any such
17 dispute, including payment of the vocational rehabilitation
18 program by the employer.

19 The maintenance benefit shall not be less than the
20 temporary total disability rate determined for the employee. In
21 addition, maintenance shall include costs and expenses
22 incidental to the vocational rehabilitation program.

23 When the employee is working light duty on a part-time
24 basis or full-time basis and earns less than he or she would be
25 earning if employed in the full capacity of the job or jobs,
26 then the employee shall be entitled to temporary partial

1 disability benefits. Temporary partial disability benefits
2 shall be equal to two-thirds of the difference between the
3 average amount that the employee would be able to earn in the
4 full performance of his or her duties in the occupation in
5 which he or she was engaged at the time of accident and the
6 gross amount which he or she is earning in the modified job
7 provided to the employee by the employer or in any other job
8 that the employee is working.

9 Every hospital, physician, surgeon or other person
10 rendering treatment or services in accordance with the
11 provisions of this Section shall upon written request furnish
12 full and complete reports thereof to, and permit their records
13 to be copied by, the employer, the employee or his dependents,
14 as the case may be, or any other party to any proceeding for
15 compensation before the Commission, or their attorneys.

16 Notwithstanding the foregoing, the employer's liability to
17 pay for such medical services selected by the employee shall be
18 limited to:

19 (1) all first aid and emergency treatment; plus

20 (2) all medical, surgical and hospital services
21 provided by the physician, surgeon or hospital initially
22 chosen by the employee or by any other physician,
23 consultant, expert, institution or other provider of
24 services recommended by said initial service provider or
25 any subsequent provider of medical services in the chain of
26 referrals from said initial service provider; plus

1 (3) all medical, surgical and hospital services
2 provided by any second physician, surgeon or hospital
3 subsequently chosen by the employee or by any other
4 physician, consultant, expert, institution or other
5 provider of services recommended by said second service
6 provider or any subsequent provider of medical services in
7 the chain of referrals from said second service provider.
8 Thereafter the employer shall select and pay for all
9 necessary medical, surgical and hospital treatment and the
10 employee may not select a provider of medical services at
11 the employer's expense unless the employer agrees to such
12 selection. At any time the employee may obtain any medical
13 treatment he desires at his own expense. This paragraph
14 shall not affect the duty to pay for rehabilitation
15 referred to above.
16 (4) The following shall apply for injuries occurring on
17 or after June 28, 2011 (the effective date of Public Act
18 97-18) and only when an employer has an approved preferred
19 provider program pursuant to Section 8.1a on the date the
20 employee sustained his or her accidental injuries:
21 (A) The employer shall, in writing, on a form
22 promulgated by the Commission, inform the employee of
23 the preferred provider program;
24 (B) Subsequent to the report of an injury by an
25 employee, the employee may choose in writing at any
26 time to decline the preferred provider program, in

1 which case that would constitute one of the two choices
2 of medical providers to which the employee is entitled
3 under subsection (a)(2) or (a)(3); and
4 (C) Prior to the report of an injury by an
5 employee, when an employee chooses non-emergency
6 treatment from a provider not within the preferred
7 provider program, that would constitute the employee's
8 one choice of medical providers to which the employee
9 is entitled under subsection (a)(2) or (a)(3).
10 When an employer and employee so agree in writing, nothing
11 in this Act prevents an employee whose injury or disability has
12 been established under this Act, from relying in good faith, on
13 treatment by prayer or spiritual means alone, in accordance
14 with the tenets and practice of a recognized church or
15 religious denomination, by a duly accredited practitioner
16 thereof, and having nursing services appropriate therewith,
17 without suffering loss or diminution of the compensation
18 benefits under this Act. However, the employee shall submit to
19 all physical examinations required by this Act. The cost of
20 such treatment and nursing care shall be paid by the employee
21 unless the employer agrees to make such payment.
22 Where the accidental injury results in the amputation of an
23 arm, hand, leg or foot, or the enucleation of an eye, or the
24 loss of any of the natural teeth, the employer shall furnish an
25 artificial of any such members lost or damaged in accidental
26 injury arising out of and in the course of employment, and

shall also furnish the necessary braces in all proper and necessary cases. In cases of the loss of a member or members by amputation, the employer shall, whenever necessary, maintain in good repair, refit or replace the artificial limbs during the lifetime of the employee. Where the accidental injury accompanied by physical injury results in damage to a denture, eye glasses or contact eye lenses, or where the accidental injury results in damage to an artificial member, the employer shall replace or repair such denture, glasses, lenses, or artificial member.

The furnishing by the employer of any such services or appliances is not an admission of liability on the part of the employer to pay compensation.

The furnishing of any such services or appliances or the servicing thereof by the employer is not the payment of compensation.

(b) If the period of temporary total incapacity for work 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 of such temporary total incapacity and continuing as long as the total temporary incapacity lasts. In cases where the temporary total incapacity for work continues for a period of 14 days or more from the day of the accident compensation shall commence on the day after the accident.

1. The compensation rate for temporary total

1 incapacity under this paragraph (b) of this Section shall
2 be equal to 66 2/3% of the employee's average weekly wage
3 computed in accordance with Section 10, provided that it
4 shall be not less than 66 2/3% of the sum of the Federal
5 minimum wage under the Fair Labor Standards Act, or the
6 Illinois minimum wage under the Minimum Wage Law, whichever
7 is more, multiplied by 40 hours. This percentage rate shall
8 be increased by 10% for each spouse and child, not to
9 exceed 100% of the total minimum wage calculation, nor
10 exceed the employee's average weekly wage computed in
11 accordance with the provisions of Section 10, whichever is
12 less.

13 2. The compensation rate in all cases other than for
14 temporary total disability under this paragraph (b), and
15 other than for serious and permanent disfigurement under
16 paragraph (c) and other than for permanent partial
17 disability under subparagraph (2) of paragraph (d) or under
18 paragraph (e), of this Section shall be equal to 66 2/3% of
19 the employee's average weekly wage computed in accordance
20 with the provisions of Section 10, provided that it shall
21 be not less than 66 2/3% of the sum of the Federal minimum
22 wage under the Fair Labor Standards Act, or the Illinois
23 minimum wage under the Minimum Wage Law, whichever is more,
24 multiplied by 40 hours. This percentage rate shall be
25 increased by 10% for each spouse and child, not to exceed
26 100% of the total minimum wage calculation, nor exceed the

1 employee's average weekly wage computed in accordance with
2 the provisions of Section 10, whichever is less.
3 2.1. The compensation rate in all cases of serious and
4 permanent disfigurement under paragraph (c) and of
5 permanent partial disability under subparagraph (2) of
6 paragraph (d) or under paragraph (e) of this Section shall
7 be equal to 60% of the employee's average weekly wage
8 computed in accordance with the provisions of Section 10,
9 provided that it shall be not less than 66 2/3% of the sum
10 of the Federal minimum wage under the Fair Labor Standards
11 Act, or the Illinois minimum wage under the Minimum Wage
12 Law, whichever is more, multiplied by 40 hours. This
13 percentage rate shall be increased by 10% for each spouse
14 and child, not to exceed 100% of the total minimum wage
15 calculation, nor exceed the employee's average weekly wage
16 computed in accordance with the provisions of Section 10,
17 whichever is less.
18 3. As used in this Section the term "child" means a
19 child of the employee including any child legally adopted
20 before the accident or whom at the time of the accident the
21 employee was under legal obligation to support or to whom
22 the employee stood in loco parentis, and who at the time of
23 the accident was under 18 years of age and not emancipated.
24 The term "children" means the plural of "child".
25 4. All weekly compensation rates provided under
26 subparagraphs 1, 2 and 2.1 of this paragraph (b) of this

1 Section shall be subject to the following limitations:
2 The maximum weekly compensation rate from July 1, 1975,
3 except as hereinafter provided, shall be 100% of the
4 State's average weekly wage in covered industries under the
5 Unemployment Insurance Act, that being the wage that most
6 closely approximates the State's average weekly wage.
7 The maximum weekly compensation rate, for the period
8 July 1, 1984, through June 30, 1987, except as hereinafter
9 provided, shall be $293.61. Effective July 1, 1987 and on
10 July 1 of each year thereafter the maximum weekly
11 compensation rate, except as hereinafter provided, shall
12 be determined as follows: if during the preceding 12 month
13 period there shall have been an increase in the State's
14 average weekly wage in covered industries under the
15 Unemployment Insurance Act, the weekly compensation rate
16 shall be proportionately increased by the same percentage
17 as the percentage of increase in the State's average weekly
18 wage in covered industries under the Unemployment
19 Insurance Act during such period.
20 The maximum weekly compensation rate, for the period
21 January 1, 1981 through December 31, 1983, except as
22 hereinafter provided, shall be 100% of the State's average
23 weekly wage in covered industries under the Unemployment
24 Insurance Act in effect on January 1, 1981. Effective
25 January 1, 1984 and on January 1, of each year thereafter
26 the maximum weekly compensation rate, except as

1 hereinafter provided, shall be determined as follows: if
2 during the preceding 12 month period there shall have been
3 an increase in the State's average weekly wage in covered
4 industries under the Unemployment Insurance Act, the
5 weekly compensation rate shall be proportionately
6 increased by the same percentage as the percentage of
7 increase in the State's average weekly wage in covered
8 industries under the Unemployment Insurance Act during
9 such period.

10 The maximum compensation rate for the period July 1,
11 2017 through June 30, 2021, except as hereinafter provided,
12 shall be $775.18. Effective July 1, 2021 and on July 1 of
13 each year thereafter the maximum weekly compensation rate,
14 except as hereinafter provided, shall be determined as
15 follows: if during the preceding 12-month period there
16 shall have been an increase in the State's average weekly
17 wage in covered industries under the Unemployment
18 Insurance Act, the weekly compensation rate shall be
19 proportionately increased by the same percentage as the
20 percentage of increase in the State's average weekly wage
21 in covered industries under the Unemployment Insurance Act
22 during such period.

23 From July 1, 1977 and thereafter such maximum weekly
24 compensation rate in death cases under Section 7, and
25 permanent total disability cases under paragraph (f) or
26 subparagraph 18 of paragraph (3) of this Section and for

1 temporary total disability under paragraph (b) of this
2 Section and for amputation of a member or enucleation of an
3 eye under paragraph (e) of this Section shall be increased
4 to 133-1/3% of the State's average weekly wage in covered
5 industries under the Unemployment Insurance Act.

6 For injuries occurring on or after February 1, 2006,
7 the maximum weekly benefit under paragraph (d)1 of this
8 Section shall be 100% of the State's average weekly wage in
9 covered industries under the Unemployment Insurance Act.

10 4.1. Any provision herein to the contrary
11 notwithstanding, the weekly compensation rate for
12 compensation payments under subparagraph 18 of paragraph
13 (e) of this Section and under paragraph (f) of this Section
14 and under paragraph (a) of Section 7 and for amputation of
15 a member or enucleation of an eye under paragraph (e) of
16 this Section, shall in no event be less than 50% of the
17 State's average weekly wage in covered industries under the
18 Unemployment Insurance Act.

19 4.2. Any provision to the contrary notwithstanding,
20 the total compensation payable under Section 7 shall not
21 exceed the greater of $500,000 or 25 years.

22 5. For the purpose of this Section this State's average
23 weekly wage in covered industries under the Unemployment
24 Insurance Act on July 1, 1975 is hereby fixed at $228.16
25 per week and the computation of compensation rates shall be
26 based on the aforesaid average weekly wage until modified

1 as hereinafter provided.
2 6. The Department of Employment Security of the State
3 shall on or before the first day of December, 1977, and on
4 or before the first day of June, 1978, and on the first day
5 of each December and June of each year thereafter, publish
6 the State's average weekly wage in covered industries under
7 the Unemployment Insurance Act and the Illinois Workers'
8 Compensation Commission shall on the 15th day of January,
9 1978 and on the 15th day of July, 1978 and on the 15th day
10 of each January and July of each year thereafter, post and
11 publish the State's average weekly wage in covered
12 industries under the Unemployment Insurance Act as last
13 determined and published by the Department of Employment
14 Security. The amount when so posted and published shall be
15 conclusive and shall be applicable as the basis of
16 computation of compensation rates until the next posting
17 and publication as aforesaid.
18 7. The payment of compensation by an employer or his
19 insurance carrier to an injured employee shall not
20 constitute an admission of the employer's liability to pay
21 compensation.
22 (c) For any serious and permanent disfigurement to the
23 hand, head, face, neck, arm, leg below the knee or the chest
24 above the axillary line, the employee is entitled to
25 compensation for such disfigurement, the amount determined by
26 agreement at any time or by arbitration under this Act, at a

1 hearing not less than 6 months after the date of the accidental
2 injury, which amount shall not exceed 150 weeks (if the
3 accidental injury occurs on or after the effective date of this
4 amendatory Act of the 94th General Assembly but before February
5 1, 2006) or 162 weeks (if the accidental injury occurs on or
6 after February 1, 2006) at the applicable rate provided in
7 subparagraph 2.1 of paragraph (b) of this Section.
8 No compensation is payable under this paragraph where
9 compensation is payable under paragraphs (d), (e) or (f) of
10 this Section.
11 A duly appointed member of a fire department in a city, the
12 population of which exceeds 500,000 according to the last
13 federal or State census, is eligible for compensation under
14 this paragraph only where such serious and permanent
15 disfigurement results from burns.
16 (d) 1. If, after the accidental injury has been sustained,
17 the employee as a result thereof becomes partially
18 incapacitated from pursuing his usual and customary line of
19 employment, he shall, except in cases compensated under the
20 specific schedule set forth in paragraph (e) of this Section,
21 receive compensation for the duration of his disability,
22 subject to the limitations as to maximum amounts fixed in
23 paragraph (b) of this Section, equal to 66-2/3% of the
24 difference between the average amount which he would be able to
25 earn in the full performance of his duties in the occupation in
26 which he was engaged at the time of the accident and the

1 average amount which he is earning or is able to earn in some
2 suitable employment or business after the accident. For
3 accidental injuries that occur on or after September 1, 2011,
4 an award for wage differential under this subsection shall be
5 effective only until the employee reaches the age of 67 or 5
6 years from the date the award becomes final, whichever is
7 later.
8 2. If, as a result of the accident, the employee sustains
9 serious and permanent injuries not covered by paragraphs (c)
10 and (e) of this Section or having sustained injuries covered by
11 the aforesaid paragraphs (c) and (e), he shall have sustained
12 in addition thereto other injuries which injuries do not
13 incapacitate him from pursuing the duties of his employment but
14 which would disable him from pursuing other suitable
15 occupations, or which have otherwise resulted in physical
16 impairment; or if such injuries partially incapacitate him from
17 pursuing the duties of his usual and customary line of
18 employment but do not result in an impairment of earning
19 capacity, or having resulted in an impairment of earning
20 capacity, the employee elects to waive his right to recover
21 under the foregoing subparagraph 1 of paragraph (d) of this
22 Section then in any of the foregoing events, he shall receive
23 in addition to compensation for temporary total disability
24 under paragraph (b) of this Section, compensation at the rate
25 provided in subparagraph 2.1 of paragraph (b) of this Section
26 for that percentage of 500 weeks that the partial disability

1 resulting from the injuries covered by this paragraph bears to
2 total disability. If the employee shall have sustained a
3 fracture of one or more vertebra or fracture of the skull, the
4 amount of compensation allowed under this Section shall be not
5 less than 6 weeks for a fractured skull and 6 weeks for each
6 fractured vertebra, and in the event the employee shall have
7 sustained a fracture of any of the following facial bones:
8 nasal, lachrymal, vomer, zygoma, maxilla, palatine or
9 mandible, the amount of compensation allowed under this Section
10 shall be not less than 2 weeks for each such fractured bone,
11 and for a fracture of each transverse process not less than 3
12 weeks. In the event such injuries shall result in the loss of a
13 kidney, spleen or lung, the amount of compensation allowed
14 under this Section shall be not less than 10 weeks for each
15 such organ. Compensation awarded under this subparagraph 2
16 shall not take into consideration injuries covered under
17 paragraphs (c) and (e) of this Section and the compensation
18 provided in this paragraph shall not affect the employee's
19 right to compensation payable under paragraphs (b), (c) and (e)
20 of this Section for the disabilities therein covered.

21 (e) For accidental injuries in the following schedule, the
22 employee shall receive compensation for the period of temporary
23 total incapacity for work resulting from such accidental
24 injury, under subparagraph 1 of paragraph (b) of this Section,
25 and shall receive in addition thereto compensation for a
26 further period for the specific loss herein mentioned, but

shall not receive any compensation under any other provisions of this Act. The following listed amounts apply to either the loss of or the permanent and complete loss of use of the member specified, such compensation for the length of time as follows:

1. Thumb-

70 weeks if the accidental injury occurs on or after the effective date of this amendatory Act of the 94th General Assembly but before February 1, 2006.

76 weeks if the accidental injury occurs on or after February 1, 2006.

2. First, or index finger-

40 weeks if the accidental injury occurs on or after the effective date of this amendatory Act of the 94th General Assembly but before February 1, 2006.

43 weeks if the accidental injury occurs on or after February 1, 2006.

3. Second, or middle finger-

35 weeks if the accidental injury occurs on or after the effective date of this amendatory Act of the 94th General Assembly but before February 1, 2006.

38 weeks if the accidental injury occurs on or after February 1, 2006.

4. Third, or ring finger-

25 weeks if the accidental injury occurs on or after the effective date of this amendatory Act of the 94th General Assembly but before February 1, 2006.

1 27 weeks if the accidental injury occurs on or
2 after February 1, 2006.
3 5. Fourth, or little finger-
4 20 weeks if the accidental injury occurs on or
5 after the effective date of this amendatory Act of the
6 94th General Assembly but before February 1, 2006.
7 22 weeks if the accidental injury occurs on or
8 after February 1, 2006.
9 6. Great toe-
10 35 weeks if the accidental injury occurs on or
11 after the effective date of this amendatory Act of the
12 94th General Assembly but before February 1, 2006.
13 38 weeks if the accidental injury occurs on or
14 after February 1, 2006.
15 7. Each toe other than great toe-
16 12 weeks if the accidental injury occurs on or
17 after the effective date of this amendatory Act of the
18 94th General Assembly but before February 1, 2006.
19 13 weeks if the accidental injury occurs on or
20 after February 1, 2006.
21 8. The loss of the first or distal phalanx of the thumb
22 or of any finger or toe shall be considered to be equal to
23 the loss of one-half of such thumb, finger or toe and the
24 compensation payable shall be one-half of the amount above
25 specified. The loss of more than one phalanx shall be
26 considered as the loss of the entire thumb, finger or toe.

1 In no case shall the amount received for more than one
2 finger exceed the amount provided in this schedule for the
3 loss of a hand.
4 9. Hand-
5 190 weeks if the accidental injury occurs on or
6 after the effective date of this amendatory Act of the
7 94th General Assembly but before February 1, 2006.
8 205 weeks if the accidental injury occurs on or
9 after February 1, 2006.
10 190 weeks if the accidental injury occurs on or
11 after June 28, 2011 (the effective date of Public Act
12 97-18) and if the accidental injury involves carpal
13 tunnel syndrome due to repetitive or cumulative
14 trauma, in which case the permanent partial disability
15 shall not exceed 15% loss of use of the hand, except
16 for cause shown by clear and convincing evidence and in
17 which case the award shall not exceed 30% loss of use
18 of the hand.
19 The loss of 2 or more digits, or one or more phalanges
20 of 2 or more digits, of a hand may be compensated on the
21 basis of partial loss of use of a hand, provided, further,
22 that the loss of 4 digits, or the loss of use of 4 digits,
23 in the same hand shall constitute the complete loss of a
24 hand.
25 10. Arm-
26 235 weeks if the accidental injury occurs on or

1 after the effective date of this amendatory Act of the
2 94th General Assembly but before February 1, 2006.
3 253 weeks if the accidental injury occurs on or
4 after February 1, 2006.
5 Where an accidental injury results in the amputation of
6 an arm below the elbow, such injury shall be compensated as
7 a loss of an arm. Where an accidental injury results in the
8 amputation of an arm above the elbow, compensation for an
9 additional 15 weeks (if the accidental injury occurs on or
10 after the effective date of this amendatory Act of the 94th
11 General Assembly but before February 1, 2006) or an
12 additional 17 weeks (if the accidental injury occurs on or
13 after February 1, 2006) shall be paid, except where the
14 accidental injury results in the amputation of an arm at
15 the shoulder joint, or so close to shoulder joint that an
16 artificial arm cannot be used, or results in the
17 disarticulation of an arm at the shoulder joint, in which
18 case compensation for an additional 65 weeks (if the
19 accidental injury occurs on or after the effective date of
20 this amendatory Act of the 94th General Assembly but before
21 February 1, 2006) or an additional 70 weeks (if the
22 accidental injury occurs on or after February 1, 2006)
23 shall be paid.
24 For purposes of awards under this subdivision (e),
25 injuries to the shoulder shall be considered injuries to
26 part of the arm. The foregoing change made by this

amendatory Act of the 100th General Assembly to this subdivision (e)10 of this Section 8 is declarative of existing law and is not a new enactment.

11. Foot-

155 weeks if the accidental injury occurs on or after the effective date of this amendatory Act of the 94th General Assembly but before February 1, 2006.

167 weeks if the accidental injury occurs on or after February 1, 2006.

12. Leg-

200 weeks if the accidental injury occurs on or after the effective date of this amendatory Act of the 94th General Assembly but before February 1, 2006.

215 weeks if the accidental injury occurs on or after February 1, 2006.

Where an accidental injury results in the amputation of a leg below the knee, such injury shall be compensated as loss of a leg. Where an accidental injury results in the amputation of a leg above the knee, compensation for an additional 25 weeks (if the accidental injury occurs on or after the effective date of this amendatory Act of the 94th General Assembly but before February 1, 2006) or an additional 27 weeks (if the accidental injury occurs on or after February 1, 2006) shall be paid, except where the accidental injury results in the amputation of a leg at the hip joint, or so close to the hip joint that an artificial

leg cannot be used, or results in the disarticulation of a leg at the hip joint, in which case compensation for an additional 75 weeks (if the accidental injury occurs on or after the effective date of this amendatory Act of the 94th General Assembly but before February 1, 2006) or an additional 81 weeks (if the accidental injury occurs on or after February 1, 2006) shall be paid.

For purposes of awards under this subdivision (e), injuries to the hip shall be considered injuries to part of the leg. The foregoing change made by this amendatory Act of the 100th General Assembly to this subdivision (e)12 of this Section 8 is declarative of existing law and is not a new enactment.

13. Eye-

150 weeks if the accidental injury occurs on or after the effective date of this amendatory Act of the 94th General Assembly but before February 1, 2006.

162 weeks if the accidental injury occurs on or after February 1, 2006.

Where an accidental injury results in the enucleation of an eye, compensation for an additional 10 weeks (if the accidental injury occurs on or after the effective date of this amendatory Act of the 94th General Assembly but before February 1, 2006) or an additional 11 weeks (if the accidental injury occurs on or after February 1, 2006) shall be paid.

1 14. Loss of hearing of one ear-
2 50 weeks if the accidental injury occurs on or
3 after the effective date of this amendatory Act of the
4 94th General Assembly but before February 1, 2006.
5 54 weeks if the accidental injury occurs on or
6 after February 1, 2006.
7 Total and permanent loss of hearing of both ears-
8 200 weeks if the accidental injury occurs on or
9 after the effective date of this amendatory Act of the
10 94th General Assembly but before February 1, 2006.
11 215 weeks if the accidental injury occurs on or
12 after February 1, 2006.
13 15. Testicle-
14 50 weeks if the accidental injury occurs on or
15 after the effective date of this amendatory Act of the
16 94th General Assembly but before February 1, 2006.
17 54 weeks if the accidental injury occurs on or
18 after February 1, 2006.
19 Both testicles-
20 150 weeks if the accidental injury occurs on or
21 after the effective date of this amendatory Act of the
22 94th General Assembly but before February 1, 2006.
23 162 weeks if the accidental injury occurs on or
24 after February 1, 2006.
25 16. For the permanent partial loss of use of a member
26 or sight of an eye, or hearing of an ear, compensation

1 during that proportion of the number of weeks in the
2 foregoing schedule provided for the loss of such member or
3 sight of an eye, or hearing of an ear, which the partial
4 loss of use thereof bears to the total loss of use of such
5 member, or sight of eye, or hearing of an ear.
6 (a) Loss of hearing for compensation purposes
7 shall be confined to the frequencies of 1,000, 2,000
8 and 3,000 cycles per second. Loss of hearing ability
9 for frequency tones above 3,000 cycles per second are
10 not to be considered as constituting disability for
11 hearing.
12 (b) The percent of hearing loss, for purposes of
13 the determination of compensation claims for
14 occupational deafness, shall be calculated as the
15 average in decibels for the thresholds of hearing for
16 the frequencies of 1,000, 2,000 and 3,000 cycles per
17 second. Pure tone air conduction audiometric
18 instruments, approved by nationally recognized
19 authorities in this field, shall be used for measuring
20 hearing loss. If the losses of hearing average 30
21 decibels or less in the 3 frequencies, such losses of
22 hearing shall not then constitute any compensable
23 hearing disability. If the losses of hearing average 85
24 decibels or more in the 3 frequencies, then the same
25 shall constitute and be total or 100% compensable
26 hearing loss.

1 (c) In measuring hearing impairment, the lowest
2 measured losses in each of the 3 frequencies shall be
3 added together and divided by 3 to determine the
4 average decibel loss. For every decibel of loss
5 exceeding 30 decibels an allowance of 1.82% shall be
6 made up to the maximum of 100% which is reached at 85
7 decibels.

8 (d) If a hearing loss is established to have
9 existed on July 1, 1975 by audiometric testing the
10 employer shall not be liable for the previous loss so
11 established nor shall he be liable for any loss for
12 which compensation has been paid or awarded.

13 (e) No consideration shall be given to the question
14 of whether or not the ability of an employee to
15 understand speech is improved by the use of a hearing
16 aid.

17 (f) No claim for loss of hearing due to industrial
18 noise shall be brought against an employer or allowed
19 unless the employee has been exposed for a period of
20 time sufficient to cause permanent impairment to noise
21 levels in excess of the following:

22 Sound Level DBA

23 Slow Response	Hours Per Day
24 90	8
25 92	6
26 95	4

97	3
100	2
102	1-1/2
105	1
110	1/2
115	1/4

This subparagraph (f) shall not be applied in cases of hearing loss resulting from trauma or explosion.

17. In computing the compensation to be paid to any employee who, before the accident for which he claims compensation, had before that time sustained an injury resulting in the loss by amputation or partial loss by amputation of any member, including hand, arm, thumb or 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 for the subsequent injury. For the permanent loss of use or the permanent partial loss of use of any such member or the partial loss of sight of an eye or loss under Section 8(d)2 due to accidental injuries to the same part of the spine, for which compensation has been paid, then such loss shall be taken into consideration and deducted from any award for the subsequent injury. 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.

18. The specific case of loss of both hands, both arms, or both feet, or both legs, or both eyes, or of any two thereof, or the permanent and complete loss of the use thereof, constitutes total and permanent disability, to be compensated according to the compensation fixed by paragraph (f) of this Section. These specific cases of total and permanent disability do not exclude other cases.

Any employee who has previously suffered the loss or permanent and complete loss of the use of any of such 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.

19. In a case of specific loss and the subsequent death of such injured employee from other causes than such injury leaving a widow, widower, or dependents surviving before payment or payment in full for such injury, then the amount due for such injury is payable to the widow or widower and, if there be no widow or widower, then to such dependents, in the proportion which such dependency bears to total

1 dependency.
2 Beginning July 1, 1980, and every 6 months thereafter, the
3 Commission shall examine the Second Injury Fund and when, after
4 deducting all advances or loans made to such Fund, the amount
5 therein is $500,000 then the amount required to be paid by
6 employers pursuant to paragraph (f) of Section 7 shall be
7 reduced by one-half. When the Second Injury Fund reaches the
8 sum of $600,000 then the payments shall cease entirely.
9 However, when the Second Injury Fund has been reduced to
10 $400,000, payment of one-half of the amounts required by
11 paragraph (f) of Section 7 shall be resumed, in the manner
12 herein provided, and when the Second Injury Fund has been
13 reduced to $300,000, payment of the full amounts required by
14 paragraph (f) of Section 7 shall be resumed, in the manner
15 herein provided. The Commission shall make the changes in
16 payment effective by general order, and the changes in payment
17 become immediately effective for all cases coming before the
18 Commission thereafter either by settlement agreement or final
19 order, irrespective of the date of the accidental injury.
20 On August 1, 1996 and on February 1 and August 1 of each
21 subsequent year, the Commission shall examine the special fund
22 designated as the "Rate Adjustment Fund" and when, after
23 deducting all advances or loans made to said fund, the amount
24 therein is $4,000,000, the amount required to be paid by
25 employers pursuant to paragraph (f) of Section 7 shall be
26 reduced by one-half. When the Rate Adjustment Fund reaches the

1 sum of $5,000,000 the payment therein shall cease entirely.
2 However, when said Rate Adjustment Fund has been reduced to
3 $3,000,000 the amounts required by paragraph (f) of Section 7
4 shall be resumed in the manner herein provided.

5 (f) In case of complete disability, which renders the
6 employee wholly and permanently incapable of work, or in the
7 specific case of total and permanent disability as provided in
8 subparagraph 18 of paragraph (e) of this Section, compensation
9 shall be payable at the rate provided in subparagraph 2 of
10 paragraph (b) of this Section for life.

11 An employee entitled to benefits under paragraph (f) of
12 this Section shall also be entitled to receive from the Rate
13 Adjustment Fund provided in paragraph (f) of Section 7 of the
14 supplementary benefits provided in paragraph (g) of this
15 Section 8.

16 If any employee who receives an award under this paragraph
17 afterwards returns to work or is able to do so, and earns or is
18 able to earn as much as before the accident, payments under
19 such award shall cease. If such employee returns to work, or is
20 able to do so, and earns or is able to earn part but not as much
21 as before the accident, such award shall be modified so as to
22 conform to an award under paragraph (d) of this Section. If
23 such award is terminated or reduced under the provisions of
24 this paragraph, such employees have the right at any time
25 within 30 months after the date of such termination or
26 reduction to file petition with the Commission for the purpose

1 of determining whether any disability exists as a result of the
2 original accidental injury and the extent thereof.
3 Disability as enumerated in subdivision 18, paragraph (e)
4 of this Section is considered complete disability.
5 If an employee who had previously incurred loss or the
6 permanent and complete loss of use of one member, through the
7 loss or the permanent and complete loss of the use of one hand,
8 one arm, one foot, one leg, or one eye, incurs permanent and
9 complete disability through the loss or the permanent and
10 complete loss of the use of another member, he shall receive,
11 in addition to the compensation payable by the employer and
12 after such payments have ceased, an amount from the Second
13 Injury Fund provided for in paragraph (f) of Section 7, which,
14 together with the compensation payable from the employer in
15 whose employ he was when the last accidental injury was
16 incurred, will equal the amount payable for permanent and
17 complete disability as provided in this paragraph of this
18 Section.
19 The custodian of the Second Injury Fund provided for in
20 paragraph (f) of Section 7 shall be joined with the employer as
21 a party respondent in the application for adjustment of claim.
22 The application for adjustment of claim shall state briefly and
23 in general terms the approximate time and place and manner of
24 the loss of the first member.
25 In its award the Commission or the Arbitrator shall
26 specifically find the amount the injured employee shall be

weekly paid, the number of weeks compensation which shall be paid by the employer, the date upon which payments begin out of the Second Injury Fund provided for in paragraph (f) of Section 7 of this Act, the length of time the weekly payments continue, the date upon which the pension payments commence and the monthly amount of the payments. The Commission shall 30 days after the date upon which payments out of the Second Injury Fund have begun as provided in the award, and every month thereafter, prepare and submit to the State Comptroller a voucher for payment for all compensation accrued to that date at the rate fixed by the Commission. The State Comptroller shall draw a warrant to the injured employee along with a receipt to be executed by the injured employee and returned to the Commission. The endorsed warrant and receipt is a full and complete acquittance to the Commission for the payment out of the Second Injury Fund. No other appropriation or warrant is necessary for payment out of the Second Injury Fund. The Second Injury Fund is appropriated for the purpose of making payments according to the terms of the awards.

As of July 1, 1980 to July 1, 1982, all claims against and obligations of the Second Injury Fund shall become claims against and obligations of the Rate Adjustment Fund to the extent there is insufficient money in the Second Injury Fund to pay such claims and obligations. In that case, all references to "Second Injury Fund" in this Section shall also include the Rate Adjustment Fund.

1 (g) Every award for permanent total disability entered by
2 the Commission on and after July 1, 1965 under which
3 compensation payments shall become due and payable after the
4 effective date of this amendatory Act, and every award for
5 death benefits or permanent total disability entered by the
6 Commission on and after the effective date of this amendatory
7 Act shall be subject to annual adjustments as to the amount of
8 the compensation rate therein provided. Such adjustments shall
9 first be made on July 15, 1977, and all awards made and entered
10 prior to July 1, 1975 and on July 15 of each year thereafter.
11 In all other cases such adjustment shall be made on July 15 of
12 the second year next following the date of the entry of the
13 award and shall further be made on July 15 annually thereafter.
14 If during the intervening period from the date of the entry of
15 the award, or the last periodic adjustment, there shall have
16 been an increase in the State's average weekly wage in covered
17 industries under the Unemployment Insurance Act, the weekly
18 compensation rate shall be proportionately increased by the
19 same percentage as the percentage of increase in the State's
20 average weekly wage in covered industries under the
21 Unemployment Insurance Act. The increase in the compensation
22 rate under this paragraph shall in no event bring the total
23 compensation rate to an amount greater than the prevailing
24 maximum rate at the time that the annual adjustment is made.
25 Such increase shall be paid in the same manner as herein
26 provided for payments under the Second Injury Fund to the

1 injured employee, or his dependents, as the case may be, out of
2 the Rate Adjustment Fund provided in paragraph (f) of Section 7
3 of this Act. Payments shall be made at the same intervals as
4 provided in the award or, at the option of the Commission, may
5 be made in quarterly payment on the 15th day of January, April,
6 July and October of each year. In the event of a decrease in
7 such average weekly wage there shall be no change in the then
8 existing compensation rate. The within paragraph shall not
9 apply to cases where there is disputed liability and in which a
10 compromise lump sum settlement between the employer and the
11 injured employee, or his dependents, as the case may be, has
12 been duly approved by the Illinois Workers' Compensation
13 Commission.

14 Provided, that in cases of awards entered by the Commission
15 for injuries occurring before July 1, 1975, the increases in
16 the compensation rate adjusted under the foregoing provision of
17 this paragraph (g) shall be limited to increases in the State's
18 average weekly wage in covered industries under the
19 Unemployment Insurance Act occurring after July 1, 1975.

20 For every accident occurring on or after July 20, 2005 but
21 before the effective date of this amendatory Act of the 94th
22 General Assembly (Senate Bill 1283 of the 94th General
23 Assembly), the annual adjustments to the compensation rate in
24 awards for death benefits or permanent total disability, as
25 provided in this Act, shall be paid by the employer. The
26 adjustment shall be made by the employer on July 15 of the

second year next following the date of the entry of the award and shall further be made on July 15 annually thereafter. If during the intervening period from the date of the entry of the award, or the last periodic adjustment, there shall have been an increase in the State's average weekly wage in covered industries under the Unemployment Insurance Act, the employer shall increase the weekly compensation rate proportionately by the same percentage as the percentage of increase in the State's average weekly wage in covered industries under the Unemployment Insurance Act. The increase in the compensation rate under this paragraph shall in no event bring the total compensation rate to an amount greater than the prevailing maximum rate at the time that the annual adjustment is made. In the event of a decrease in such average weekly wage there shall be no change in the then existing compensation rate. Such increase shall be paid by the employer in the same manner and at the same intervals as the payment of compensation in the award. This paragraph shall not apply to cases where there is disputed liability and in which a compromise lump sum settlement between the employer and the injured employee, or his or her dependents, as the case may be, has been duly approved by the Illinois Workers' Compensation Commission.

The annual adjustments for every award of death benefits or permanent total disability involving accidents occurring before July 20, 2005 and accidents occurring on or after the effective date of this amendatory Act of the 94th General

Assembly (Senate Bill 1283 of the 94th General Assembly) shall continue to be paid from the Rate Adjustment Fund pursuant to this paragraph and Section 7(f) of this Act.

(h) In case death occurs from any cause before the total compensation to which the employee would have been entitled has been paid, then in case the employee leaves any widow, widower, child, parent (or any grandchild, grandparent or other lineal heir or any collateral heir dependent at the time of the accident upon the earnings of the employee to the extent of 50% or more of total dependency) such compensation shall be paid to the beneficiaries of the deceased employee and distributed as provided in paragraph (g) of Section 7.

(h-1) In case an injured employee is under legal disability at the time when any right or privilege accrues to him or her under this Act, a guardian may be appointed pursuant to law, and may, on behalf of such person under legal disability, claim and exercise any such right or privilege with the same effect as if the employee himself or herself had claimed or exercised the right or privilege. No limitations of time provided by this Act run so long as the employee who is under legal disability is without a conservator or guardian.

(i) In case the injured employee is under 16 years of age at the time of the accident and is illegally employed, the amount of compensation payable under paragraphs (b), (c), (d), (e) and (f) of this Section is increased 50%.

However, where an employer has on file an employment

certificate issued pursuant to the Child Labor Law or work permit issued pursuant to the Federal Fair Labor Standards Act, as amended, or a birth certificate properly and duly issued, such certificate, permit or birth certificate is conclusive evidence as to the age of the injured minor employee for the purposes of this Section.

Nothing herein contained repeals or amends the provisions of the Child Labor Law relating to the employment of minors under the age of 16 years.

(j) 1. In the event the injured employee receives benefits, including medical, surgical or hospital benefits under any group plan covering non-occupational disabilities contributed to wholly or partially by the employer, which benefits should not have been payable if any rights of recovery existed under this Act, then such amounts so paid to the employee from any such group plan as shall be consistent with, and limited to, the provisions of paragraph 2 hereof, shall be credited to or against any compensation payment for temporary total incapacity for work or any medical, surgical or hospital benefits made or to be made under this Act. In such event, the period of time for giving notice of accidental injury and filing application for adjustment of claim does not commence to run until the termination of such payments. This paragraph does not apply to payments made under any group plan which would have been payable irrespective of an accidental injury under this Act. Any employer receiving such credit shall keep such

employee safe and harmless from any and all claims or liabilities that may be made against him by reason of having received such payments only to the extent of such credit.

Any excess benefits paid to or on behalf of a State employee by the State Employees' Retirement System under Article 14 of the Illinois Pension Code on a death claim or disputed disability claim shall be credited against any payments made or to be made by the State of Illinois to or on behalf of such employee under this Act, except for payments for medical expenses which have already been incurred at the time of the award. The State of Illinois shall directly reimburse the State Employees' Retirement System to the extent of such credit.

2. Nothing contained in this Act shall be construed to give the employer or the insurance carrier the right to credit for any benefits or payments received by the employee other than compensation payments provided by this Act, and where the employee receives payments other than compensation payments, whether as full or partial salary, group insurance benefits, bonuses, annuities or any other payments, the employer or insurance carrier shall receive credit for each such payment only to the extent of the compensation that would have been payable during the period covered by such payment.

3. The extension of time for the filing of an Application for Adjustment of Claim as provided in paragraph 1 above shall not apply to those cases where the time for such filing had

1 expired prior to the date on which payments or benefits
2 enumerated herein have been initiated or resumed. Provided
3 however that this paragraph 3 shall apply only to cases wherein
4 the payments or benefits hereinabove enumerated shall be
5 received after July 1, 1969.
6 (Source: P.A. 97-18, eff. 6-28-11; 97-268, eff. 8-8-11; 97-813,
7 eff. 7-13-12.)

8 (820 ILCS 305/8.1b)
9 Sec. 8.1b. Determination of permanent partial disability.
10 For accidental injuries that occur on or after September 1,
11 2011, permanent partial disability shall be established using
12 the following criteria:
13 (a) A physician licensed to practice medicine in all of its
14 branches preparing a permanent partial disability impairment
15 report shall report the level of impairment in writing. The
16 report shall include an evaluation of medically defined and
17 professionally appropriate measurements of impairment that
18 include, but are not limited to: loss of range of motion; loss
19 of strength; measured atrophy of tissue mass consistent with
20 the injury; and any other measurements that establish the
21 nature and extent of the impairment. The most current edition
22 of the American Medical Association's "Guides to the Evaluation
23 of Permanent Impairment" shall be used by the physician in
24 determining the level of impairment. A report under this
25 subsection may be waived by joint written agreement of the

parties.

(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.

(c) A report of impairment prepared pursuant to subsection (a) is not required for an arbitrator or the Commission to make an award for permanent partial disability or permanent total disability benefits or any award for benefits under subsection (c) of Section 8 or subsection (d) of Section 8 of this Act or to approve a Settlement Contract Lump Sum Petition.

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

(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

1 does not have the necessary number of charges and fees to
2 calculate a valid percentile for a specific procedure,
3 treatment, or service, the Commission may combine data from the
4 geozip with up to 4 other geozips that are demographically and
5 economically similar and exhibit similarities in data and
6 frequencies until the Commission reaches 9 charges or fees for
7 that specific procedure, treatment, or service. In cases where
8 the compiled data contains less than 9 charges or fees for a
9 procedure, treatment, or service, reimbursement shall occur at
10 76% of charges and fees as determined by the Commission in a
11 manner consistent with the provisions of this paragraph.
12 Providers of out-of-state procedures, treatments, services,
13 products, or supplies shall be reimbursed at the lesser of that
14 state's fee schedule amount or the fee schedule amount for the
15 region in which the employee resides. If no fee schedule exists
16 in that state, the provider shall be reimbursed at the lesser
17 of the actual charge or the fee schedule amount for the region
18 in which the employee resides. Not later than September 30 in
19 2006 and each year thereafter, the Commission shall
20 automatically increase or decrease the maximum allowable
21 payment for a procedure, treatment, or service established and
22 in effect on January 1 of that year by the percentage change in
23 the Consumer Price Index-U for the 12 month period ending
24 August 31 of that year. The increase or decrease shall become
25 effective on January 1 of the following year. As used in this
26 Section, "Consumer Price Index-U" means the index published by

1 the Bureau of Labor Statistics of the U.S. Department of Labor,
2 that measures the average change in prices of all goods and
3 services purchased by all urban consumers, U.S. city average,
4 all items, 1982-84=100.

5 The provisions of this subsection (a), other than this
6 sentence, are inoperative after August 31, 2017.

7 (a-1) Notwithstanding the provisions of subsection (a) and
8 unless otherwise indicated, the following provisions shall
9 apply to the medical fee schedule starting on September 1,
10 2011:

11 (1) The Commission shall establish and maintain fee
12 schedules for procedures, treatments, products, services,
13 or supplies for hospital inpatient, hospital outpatient,
14 emergency room, ambulatory surgical treatment centers,
15 accredited ambulatory surgical treatment facilities,
16 prescriptions filled and dispensed outside of a licensed
17 pharmacy, dental services, and professional services. This
18 fee schedule shall be based on the fee schedule amounts
19 already established by the Commission pursuant to
20 subsection (a) of this Section. However, starting on
21 January 1, 2012, these fee schedule amounts shall be
22 grouped into geographic regions in the following manner:

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

25 (i) Cook County;

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

1 (iii) Bond, Calhoun, Clinton, Jersey,
2 Macoupin, Madison, Monroe, Montgomery, Randolph,
3 St. Clair, and Washington Counties; and
4 (iv) All other counties of the State.
5 (B) Fourteen regions for hospital fee schedule
6 amounts shall be utilized:
7 (i) Cook, DuPage, Will, Kane, McHenry, DeKalb,
8 Kendall, and Grundy Counties;
9 (ii) Kankakee County;
10 (iii) Madison, St. Clair, Macoupin, Clinton,
11 Monroe, Jersey, Bond, and Calhoun Counties;
12 (iv) Winnebago and Boone Counties;
13 (v) Peoria, Tazewell, Woodford, Marshall, and
14 Stark Counties;
15 (vi) Champaign, Piatt, and Ford Counties;
16 (vii) Rock Island, Henry, and Mercer Counties;
17 (viii) Sangamon and Menard Counties;
18 (ix) McLean County;
19 (x) Lake County;
20 (xi) Macon County;
21 (xii) Vermilion County;
22 (xiii) Alexander County; and
23 (xiv) All other counties of the State.
24 (2) If a geozip, as defined in subsection (a) of this
25 Section, overlaps into one or more of the regions set forth
26 in this Section, then the Commission shall average or

1 repeat the charges and fees in a geozip in order to
2 designate charges and fees for each region.
3 (3) In cases where the compiled data contains less than
4 9 charges or fees for a procedure, treatment, product,
5 supply, or service or where the fee schedule amount cannot
6 be determined by the non-discounted charge data,
7 non-Medicare relative values and conversion factors
8 derived from established fee schedule amounts, coding
9 crosswalks, or other data as determined by the Commission,
10 reimbursement shall occur at 76% of charges and fees until
11 September 1, 2011 and 53.2% of charges and fees thereafter
12 as determined by the Commission in a manner consistent with
13 the provisions of this paragraph.
14 (4) To establish additional fee schedule amounts, the
15 Commission shall utilize provider non-discounted charge
16 data, non-Medicare relative values and conversion factors
17 derived from established fee schedule amounts, and coding
18 crosswalks. The Commission may establish additional fee
19 schedule amounts based on either the charge or cost of the
20 procedure, treatment, product, supply, or service.
21 (5) Implants shall be reimbursed at 25% above the net
22 manufacturer's invoice price less rebates, plus actual
23 reasonable and customary shipping charges whether or not
24 the implant charge is submitted by a provider in
25 conjunction with a bill for all other services associated
26 with the implant, submitted by a provider on a separate

1 claim form, submitted by a distributor, or submitted by the
2 manufacturer of the implant. "Implants" include the
3 following codes or any substantially similar updated code
4 as determined by the Commission: 0274
5 (prosthetics/orthotics); 0275 (pacemaker); 0276 (lens
6 implant); 0278 (implants); 0540 and 0545 (ambulance); 0624
7 (investigational devices); and 0636 (drugs requiring
8 detailed coding). Non-implantable devices or supplies
9 within these codes shall be reimbursed at 65% of actual
10 charge, which is the provider's normal rates under its
11 standard chargemaster. A standard chargemaster is the
12 provider's list of charges for procedures, treatments,
13 products, supplies, or services used to bill payers in a
14 consistent manner.

15 (6) The Commission shall automatically update all
16 codes and associated rules with the version of the codes
17 and rules valid on January 1 of that year.

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

20 (a-1.5) The following provisions apply to procedures,
21 treatments, services, products, and supplies covered under
22 this Act and rendered or to be rendered on or after September
23 1, 2017:

24 (1) In this Section:

25 "CPT code" means each Current Procedural Terminology
26 code, for each geographic region specified in subsection

1 (b) of this Section, included on the most recent medical
2 fee schedule established by the Commission pursuant to this
3 Section.
4 "DRG code" means each current diagnosis related group
5 code, for each geographic region specified in subsection
6 (b) of this Section, included on the most recent medical
7 fee schedule established by the Commission pursuant to this
8 Section.
9 "Geozip" means a three-digit zip code based on data
10 similarities, geographical similarities, and frequencies.
11 "Health care services" means those CPT and DRG codes
12 for procedures, treatments, products, services or supplies
13 for hospital inpatient, hospital outpatient, emergency
14 room, ambulatory surgical treatment centers, accredited
15 ambulatory surgical treatment facilities, and professional
16 services. It does not include codes classified as
17 healthcare common procedure coding systems or dental.
18 "Medicare maximum fee" means, for each CPT and DRG
19 code, the current maximum fee for that CPT or DRG code
20 allowed to be charged by the Centers for Medicare and
21 Medicaid Services for Medicare patients in that geographic
22 region. The Medicare maximum fee shall be the greater of
23 (i) the current maximum fee allowed to be charged by the
24 Centers for Medicare and Medicaid Services for Medicare
25 patients in the geographic region or (ii) the maximum fee
26 charged by the Centers for Medicare and Medicaid Services

1 for Medicare patients in the geographic region on January
2 1, 2017.

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

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

11 (2) The Commission shall establish and maintain fee
12 schedules for procedures, treatments, products, services,
13 or supplies for hospital inpatient, hospital outpatient,
14 emergency room, ambulatory surgical treatment centers,
15 accredited ambulatory surgical treatment facilities,
16 prescriptions filled and dispensed outside of a licensed
17 pharmacy, dental services, and professional services.
18 These fee schedule amounts shall be grouped into geographic
19 regions in the following manner:

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

22 (i) Cook County;

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

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

1 (iv) All other counties of the State.
2 (B) Fourteen regions for hospital fee schedule
3 amounts shall be utilized:
4 (i) Cook, DuPage, Will, Kane, McHenry, DeKalb,
5 Kendall, and Grundy Counties;
6 (ii) Kankakee County;
7 (iii) Madison, St. Clair, Macoupin, Clinton,
8 Monroe, Jersey, Bond, and Calhoun Counties;
9 (iv) Winnebago and Boone Counties;
10 (v) Peoria, Tazewell, Woodford, Marshall, and
11 Stark Counties;
12 (vi) Champaign, Piatt, and Ford Counties;
13 (vii) Rock Island, Henry, and Mercer Counties;
14 (viii) Sangamon and Menard Counties;
15 (ix) McLean County;
16 (x) Lake County;
17 (xi) Macon County;
18 (xii) Vermilion County;
19 (xiii) Alexander County; and
20 (xiv) All other counties of the State.
21 If a geozip overlaps into one or more of the regions
22 set forth in this Section, then the Commission shall
23 average or repeat the charges and fees in a geozip in order
24 to designate charges and fees for each region.
25 (3) The initial workers' compensation maximum fee for
26 each CPT and DRG code as of September 1, 2017 shall be

1 determined as follows:
2 (A) Within 45 days after the effective date of this
3 amendatory Act of the 100th General Assembly, the
4 Commission shall determine the Medicare percentage
5 amount for each CPT and DRG code using the most recent
6 data available.
7 CPT or DRG codes which have a value, but are not
8 covered expenses under Medicare, are still compensable
9 under the medical fee schedule according to the rate
10 described in Section (B).
11 (B) Within 30 days after the Commission makes the
12 determinations required by subdivision (3)(A) of this
13 subsection (a-1.5), the Commission shall determine an
14 adjustment to be made to the workers' compensation
15 maximum fee for each CPT and DRG code as follows:
16 (i) If the Medicare percentage amount for that
17 CPT or DRG code is equal to or less than 125%, then
18 the workers' compensation maximum fee for that CPT
19 or DRG code shall be adjusted so that it equals
20 125% of the most recent Medicare maximum fee for
21 that CPT or DRG code.
22 (ii) If the Medicare percentage amount for
23 that CPT or DRG code is greater than 125% but less
24 than 150%, then the workers' compensation maximum
25 fee for that CPT or DRG code shall not be adjusted.
26 (iii) If the Medicare percentage amount for

1 that CPT or DRG code is greater than 150% but less
2 than or equal to 225%, then the workers'
3 compensation maximum fee for that CPT or DRG code
4 shall be adjusted so that it equals the greater of
5 (I) 150% of the most recent Medicare maximum fee
6 for that CPT or DRG code or (II) 85% of the most
7 recent workers' compensation maximum amount for
8 that CPT or DRG code.
9 (iv) If the Medicare percentage amount for
10 that CPT or DRG code is greater than 225% but less
11 than or equal to 428.57%, then the workers'
12 compensation maximum fee for that CPT or DRG code
13 shall be adjusted so that it equals the greater of
14 (I) 191.25% of the most recent Medicare maximum fee
15 for that CPT or DRG code or (II) 70% of the most
16 recent workers' compensation maximum amount for
17 that CPT or DRG code.
18 (v) If the Medicare percentage amount for that
19 CPT or DRG code is greater than 428.57%, then the
20 workers' compensation maximum fee for that CPT or
21 DRG code shall be adjusted so that it equals 300%
22 of the most recent Medicare maximum fee for that
23 CPT or DRG code.
24 The Commission shall promptly publish the
25 adjustments determined pursuant to this subdivision
26 (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.

(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. The provisions of this subsection (a-2), other

1 than this sentence, are inoperative after August 31, 2017.
2 (a-3) Prescriptions filled and dispensed outside of a
3 licensed pharmacy shall be subject to a fee schedule that shall
4 not exceed the Average Wholesale Price (AWP) plus a dispensing
5 fee of $4.18. AWP or its equivalent as registered by the
6 National Drug Code shall be set forth for that drug on that
7 date as published in Medispan.
8 (a-4) The Commission, in consultation with the Workers'
9 Compensation Medical Fee Advisory Board, shall promulgate by
10 rule an evidence-based drug formulary and any rules necessary
11 for its administration. Prescriptions prescribed for workers'
12 compensation cases shall be limited to those prescription drugs
13 and doses on the closed formulary.
14 A request for a prescription that is not on the closed
15 formulary shall be reviewed pursuant to Section 8.7 of this
16 Act.
17 (a-5) Notwithstanding any other provision of this Section,
18 on or before March 1, 2018 and on or before March 1 of each
19 subsequent year, the Commission must investigate all
20 procedures, treatments, and services covered under this Act for
21 ambulatory surgical treatment centers and accredited
22 ambulatory surgical treatment facilities and establish fee
23 schedule amounts for procedures, treatments, and services for
24 which fee schedule amounts have not been established. The
25 Commission must adopt, in a timely and ongoing manner, all
26 rules necessary to ensure that its responsibilities under this

subsection are carried out.

(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 directly. The employer shall make payment and 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 claim contains substantially all the required data elements necessary to adjudicate the bills.

1 (2) If the claim does not contain substantially all the
2 required data elements necessary to adjudicate the bill, or
3 the claim is denied for any other reason, in whole or in
4 part, the employer or insurer shall provide written
5 notification, explaining the basis for the denial and
6 describing any additional necessary data elements, to the
7 provider within 30 days of receipt of the bill.

8 (3) In the case of nonpayment to a provider within 30
9 days of receipt of the bill which contained substantially
10 all of the required data elements necessary to adjudicate
11 the bill or nonpayment to a provider of a portion of such a
12 bill up to the lesser of the actual charge or the payment
13 level set by the Commission in the fee schedule established
14 in this Section, the bill, or portion of the bill, shall
15 incur interest at a rate of 1% per month payable to the
16 provider. Any required interest payments shall be made
17 within 30 days after payment.

18 (e) Except as provided in subsections (e-5), (e-10), and
19 (e-15), a provider shall not hold an employee liable for costs
20 related to a non-disputed procedure, treatment, or service
21 rendered in connection with a compensable injury. The
22 provisions of subsections (e-5), (e-10), (e-15), and (e-20)
23 shall not apply if an employee provides information to the
24 provider regarding participation in a group health plan. If the
25 employee participates in a group health plan, the provider may
26 submit a claim for services to the group health plan. If the

1 claim for service is covered by the group health plan, the
2 employee's responsibility shall be limited to applicable
3 deductibles, co-payments, or co-insurance. Except as provided
4 under subsections (e-5), (e-10), (e-15), and (e-20), a provider
5 shall not bill or otherwise attempt to recover from the
6 employee the difference between the provider's charge and the
7 amount paid by the employer or the insurer on a compensable
8 injury, or for medical services or treatment determined by the
9 Commission to be excessive or unnecessary.
10 (e-5) If an employer notifies a provider that the employer
11 does not consider the illness or injury to be compensable under
12 this Act, the provider may seek payment of the provider's
13 actual charges from the employee for any procedure, treatment,
14 or service rendered. Once an employee informs the provider that
15 there is an application filed with the Commission to resolve a
16 dispute over payment of such charges, the provider shall cease
17 any and all efforts to collect payment for the services that
18 are the subject of the dispute. Any statute of limitations or
19 statute of repose applicable to the provider's efforts to
20 collect payment from the employee shall be tolled from the date
21 that the employee files the application with the Commission
22 until the date that the provider is permitted to resume
23 collection efforts under the provisions of this Section.
24 (e-10) If an employer notifies a provider that the employer
25 will pay only a portion of a bill for any procedure, treatment,
26 or service rendered in connection with a compensable illness or

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

1 about the proceeding under this Act, such as the file number,
2 names of parties, and status of the case. If an employee fails
3 to respond to such request for information or fails to furnish
4 the information requested within 90 days of the date of the
5 reminder, the provider is entitled to resume any and all
6 efforts to collect payment from the employee for the services
7 rendered to the employee and the employee shall be responsible
8 for payment of any outstanding bills for a procedure,
9 treatment, or service rendered by a provider.
10 (e-20) Upon a final award or judgment by an Arbitrator or
11 the Commission, or a settlement agreed to by the employer and
12 the employee, a provider may resume any and all efforts to
13 collect payment from the employee for the services rendered to
14 the employee and the employee shall be responsible for payment
15 of any outstanding bills for a procedure, treatment, or service
16 rendered by a provider as well as the interest awarded under
17 subsection (d) of this Section. In the case of a procedure,
18 treatment, or service deemed compensable, the provider shall
19 not require a payment rate, excluding the interest provisions
20 under subsection (d), greater than the lesser of the actual
21 charge or the payment level set by the Commission in the fee
22 schedule established in this Section. Payment for services
23 deemed not covered or not compensable under this Act is the
24 responsibility of the employee unless a provider and employee
25 have agreed otherwise in writing. Services not covered or not
26 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. 97-18, eff. 6-28-11.)

(820 ILCS 305/8.2a)

Sec. 8.2a. Electronic claims.

(a) The Director of Insurance shall adopt rules to do all of the following:

(1) Ensure that all health care providers and facilities submit medical bills for payment on standardized forms.

(2) Require acceptance by employers and insurers of electronic claims for payment of medical services.

(3) Ensure confidentiality of medical information submitted on electronic claims for payment of medical services.

(4) Ensure that health care providers have at least 15 business days to comply with records requested by employers

and insurers for the authorization of the payment of workers' compensation claims.

(5) Ensure that health care providers are responsible for supplying only those medical records pertaining to the provider's own claims that are minimally necessary.

(6) Provide that any electronically submitted bill determined to be complete but not paid or objected to within 30 days shall be subject to penalties pursuant to Section 8.2(d)(3) of this Act to be entered by the Commission.

(7) Provide that the Department of Insurance may impose an administrative fine if it determines that an employer or insurer has failed to comply with the electronic claims acceptance and response process. The amount of the administrative fine shall be no greater than $1,000 per each violation, but shall not exceed $10,000 for identical violations during a calendar year.

(b) To the extent feasible, standards adopted pursuant to subdivision (a) shall be consistent with existing standards under the federal Health Insurance Portability and Accountability Act of 1996 and standards adopted under the Illinois Health Information Exchange and Technology Act.

(c) The rules requiring employers and insurers to accept electronic claims for payment of medical services shall be proposed on or before September 1, 2017 ~~January 1, 2012~~, and shall require all employers and insurers to accept electronic

claims for payment of medical services on or before January 1, 2018 ~~June 30, 2012~~.

(d) The Director of Insurance shall by rule establish criteria for granting exceptions to employers, insurance carriers, and health care providers who are unable to submit or accept medical bills electronically.

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

(820 ILCS 305/14) (from Ch. 48, par. 138.14)

Sec. 14. The Commission shall appoint a secretary, an assistant secretary, and arbitrators and shall employ such assistants and clerical help as may be necessary. Arbitrators shall be appointed pursuant to this Section, notwithstanding any provision of the Personnel Code.

Each arbitrator appointed after June 28, 2011 shall be required to demonstrate in writing his or her knowledge of and expertise in the law of and judicial processes of the Workers' Compensation Act and the Workers' Occupational Diseases Act.

A formal training program for newly-hired arbitrators shall be implemented. The training program shall include the following:

(a) substantive and procedural aspects of the arbitrator position;

(b) current issues in workers' compensation law and practice;

(c) medical lectures by specialists in areas such as

orthopedics, ophthalmology, psychiatry, rehabilitation counseling;

(d) orientation to each operational unit of the Illinois Workers' Compensation Commission;

(e) observation of experienced arbitrators conducting hearings of cases, combined with the opportunity to discuss evidence presented and rulings made;

(f) the use of hypothetical cases requiring the trainee to issue judgments as a means to evaluating knowledge and writing ability;

(g) writing skills;

(h) professional and ethical standards pursuant to Section 1.1 of this Act;

(i) detection of workers' compensation fraud and reporting obligations of Commission employees and appointees;

(j) standards of evidence-based medical treatment and best practices for measuring and improving quality and health care outcomes in the workers' compensation system, including but not limited to the use of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" and the practice of utilization review; and

(k) substantive and procedural aspects of coal workers' pneumoconiosis (black lung) cases.

A formal and ongoing professional development program

including, but not limited to, the above-noted areas shall be implemented to keep arbitrators informed of recent developments and issues and to assist them in maintaining and enhancing their professional competence. Each arbitrator shall complete 20 hours of training in the above-noted areas during every 2 years such arbitrator shall remain in office.

Each arbitrator shall devote full time to his or her duties and shall serve when assigned as an acting Commissioner when a Commissioner is unavailable in accordance with the provisions of Section 13 of this Act. Any arbitrator who is an attorney-at-law shall not engage in the practice of law, nor shall any arbitrator hold any other office or position of profit under the United States or this State or any municipal corporation or political subdivision of this State. Notwithstanding any other provision of this Act to the contrary, an arbitrator who serves as an acting Commissioner in accordance with the provisions of Section 13 of this Act shall continue to serve in the capacity of Commissioner until a decision is reached in every case heard by that arbitrator while serving as an acting Commissioner.

Notwithstanding any other provision of this Section, the term of all arbitrators serving on June 28, 2011 (the effective date of Public Act 97-18), including any arbitrators on administrative leave, shall terminate at the close of business on July 1, 2011, but the incumbents shall continue to exercise all of their duties until they are reappointed or their

successors are appointed.

On and after June 28, 2011 (the effective date of Public Act 97-18), arbitrators shall be appointed to 3-year terms as follows:

(1) All appointments shall be made by the Governor with the advice and consent of the Senate.

(2) For their initial appointments, 12 arbitrators shall be appointed to terms expiring July 1, 2012; 12 arbitrators shall be appointed to terms expiring July 1, 2013; and all additional arbitrators shall be appointed to terms expiring July 1, 2014. Thereafter, all arbitrators shall be appointed to 3-year terms.

Upon the expiration of a term, the Chairman shall evaluate the performance of the arbitrator and may recommend to the Governor that he or she be reappointed to a second or subsequent term by the Governor with the advice and consent of the Senate.

Each arbitrator appointed on or after June 28, 2011 (the effective date of Public Act 97-18) and who has not previously served as an arbitrator for the Commission shall be required to be authorized to practice law in this State by the Supreme Court, and to maintain this authorization throughout his or her term of employment.

The performance of all arbitrators shall be reviewed by the Chairman on an annual basis. The Chairman shall allow input from the Commissioners in all such reviews.

The Commission shall assign no fewer than 3 arbitrators to each hearing site. The Commission shall establish a procedure to ensure that the arbitrators assigned to each hearing site are assigned cases on a random basis. <u>The Chairman of the Workers' Compensation Commission shall have discretion to assign and reassign arbitrators to each hearing site as needed.</u> ~~No arbitrator shall hear cases in any county, other than Cook County, for more than 2 years in each 3-year term.~~

The Secretary and each arbitrator shall receive a per annum salary of $4,000 less than the per annum salary of members of The Illinois Workers' Compensation Commission as provided in Section 13 of this Act, payable in equal monthly installments.

The members of the Commission, Arbitrators and other employees whose duties require them to travel, shall have reimbursed to them their actual traveling expenses and disbursements made or incurred by them in the discharge of their official duties while away from their place of residence in the performance of their duties.

The Commission shall provide itself with a seal for the authentication of its orders, awards and proceedings upon which shall be inscribed the name of the Commission and the words "Illinois--Seal".

The Secretary or Assistant Secretary, under the direction of the Commission, shall have charge and custody of the seal of the Commission and also have charge and custody of all records, files, orders, proceedings, decisions, awards and other

documents on file with the Commission. He shall furnish certified copies, under the seal of the Commission, of any such records, files, orders, proceedings, decisions, awards and other documents on file with the Commission as may be required. Certified copies so furnished by the Secretary or Assistant Secretary shall be received in evidence before the Commission or any Arbitrator thereof, and in all courts, provided that the original of such certified copy is otherwise competent and admissible in evidence. The Secretary or Assistant Secretary shall perform such other duties as may be prescribed from time to time by the Commission.

(Source: P.A. 98-40, eff. 6-28-13; 99-642, eff. 7-28-16.)

(820 ILCS 305/19) (from Ch. 48, par. 138.19)

Sec. 19. Any disputed questions of law or fact shall be determined as herein provided.

(a) It shall be the duty of the Commission upon notification that the parties have failed to reach an agreement, to designate an Arbitrator.

1. Whenever any claimant misconceives his remedy and files an application for adjustment of claim under this Act and it is subsequently discovered, at any time before final disposition of such cause, that the claim for disability or death which was the basis for such application should properly have been made under the Workers' Occupational Diseases Act, then the provisions of Section 19, paragraph

(a-1) of the Workers' Occupational Diseases Act having reference to such application shall apply.

2. Whenever any claimant misconceives his remedy and files an application for adjustment of claim under the Workers' Occupational Diseases Act and it is subsequently discovered, at any time before final disposition of such cause that the claim for injury or death which was the basis for such application should properly have been made under this Act, then the application so filed under the Workers' Occupational Diseases Act may be amended in form, substance or both to assert claim for such disability or death under this Act and it shall be deemed to have been so filed as amended on the date of the original filing thereof, and such compensation may be awarded as is warranted by the whole evidence pursuant to this Act. When such amendment is submitted, further or additional evidence may be heard by the Arbitrator or Commission when deemed necessary. Nothing in this Section contained shall be construed to be or permit a waiver of any provisions of this Act with reference to notice but notice if given shall be deemed to be a notice under the provisions of this Act if given within the time required herein.

3. When an Arbitrator conducts a status call of cases that appear on the Arbitrator's docket in accordance with the rules of the Commission, parties or their attorneys may appear by telephone, video conference, or other remote

1 electronic means as prescribed by the Commission.
2 (b) The Arbitrator shall make such inquiries and
3 investigations as he or they shall deem necessary and may
4 examine and inspect all books, papers, records, places, or
5 premises relating to the questions in dispute and hear such
6 proper evidence as the parties may submit.
7 The hearings before the Arbitrator shall be held in the
8 vicinity where the injury occurred after 10 days' notice of the
9 time and place of such hearing shall have been given to each of
10 the parties or their attorneys of record.
11 The Arbitrator may find that the disabling condition is
12 temporary and has not yet reached a permanent condition and may
13 order the payment of compensation up to the date of the
14 hearing, which award shall be reviewable and enforceable in the
15 same manner as other awards, and in no instance be a bar to a
16 further hearing and determination of a further amount of
17 temporary total compensation or of compensation for permanent
18 disability, but shall be conclusive as to all other questions
19 except the nature and extent of said disability.
20 The decision of the Arbitrator shall be filed with the
21 Commission which Commission shall immediately send to each
22 party or his attorney a copy of such decision, together with a
23 notification of the time when it was filed. As of the effective
24 date of this amendatory Act of the 94th General Assembly, all
25 decisions of the Arbitrator shall set forth in writing findings
26 of fact and conclusions of law, separately stated, if requested

1 by either party. Unless a petition for review is filed by
2 either party within 30 days after the receipt by such party of
3 the copy of the decision and notification of time when filed,
4 and unless such party petitioning for a review shall within 35
5 days after the receipt by him of the copy of the decision, file
6 with the Commission either an agreed statement of the facts
7 appearing upon the hearing before the Arbitrator, or if such
8 party shall so elect a correct transcript of evidence of the
9 proceedings at such hearings, then the decision shall become
10 the decision of the Commission and in the absence of fraud
11 shall be conclusive. The Petition for Review shall contain a
12 statement of the petitioning party's specific exceptions to the
13 decision of the arbitrator. The jurisdiction of the Commission
14 to review the decision of the arbitrator shall not be limited
15 to the exceptions stated in the Petition for Review. The
16 Commission, or any member thereof, may grant further time not
17 exceeding 30 days, in which to file such agreed statement or
18 transcript of evidence. Such agreed statement of facts or
19 correct transcript of evidence, as the case may be, shall be
20 authenticated by the signatures of the parties or their
21 attorneys, and in the event they do not agree as to the
22 correctness of the transcript of evidence it shall be
23 authenticated by the signature of the Arbitrator designated by
24 the Commission.

25 Whether the employee is working or not, if the employee is
26 not receiving or has not received medical, surgical, or

1 hospital services or other services or compensation as provided
2 in paragraph (a) of Section 8, or compensation as provided in
3 paragraph (b) of Section 8, or if the employer has refused or
4 failed to respond to a written request for authorization of
5 medical care and treatment, the employee may at any time
6 petition for an expedited hearing by an Arbitrator on the issue
7 of whether or not he or she is entitled to receive payment of
8 the services or compensation or authorization of medical care.
9 Provided the employer continues to pay compensation pursuant to
10 paragraph (b) of Section 8, the employer may at any time
11 petition for an expedited hearing on the issue of whether or
12 not the employee is entitled to receive medical, surgical, or
13 hospital services or other services or compensation as provided
14 in paragraph (a) of Section 8, whether or not the employee is
15 entitled to authorization of medical care and treatment, or
16 compensation as provided in paragraph (b) of Section 8. When an
17 employer has petitioned for an expedited hearing, the employer
18 shall continue to pay compensation as provided in paragraph (b)
19 of Section 8 unless the arbitrator renders a decision that the
20 employee is not entitled to the benefits that are the subject
21 of the expedited hearing or unless the employee's treating
22 physician has released the employee to return to work at his or
23 her regular job with the employer or the employee actually
24 returns to work at any other job. If the arbitrator renders a
25 decision that the employee is not entitled to the benefits or
26 medical care that is ~~are~~ the subject of the expedited hearing,

1 a petition for review filed by the employee shall receive the
2 same priority as if the employee had filed a petition for an
3 expedited hearing by an Arbitrator. Neither party shall be
4 entitled to an expedited hearing when the employee has returned
5 to work and the sole issue in dispute amounts to less than 12
6 weeks of unpaid compensation pursuant to paragraph (b) of
7 Section 8.

8 Expedited hearings shall have priority over all other
9 petitions and shall be heard by the Arbitrator and Commission
10 with all convenient speed. Any party requesting an expedited
11 hearing shall give notice of a request for an expedited hearing
12 under this paragraph. A copy of the Application for Adjustment
13 of Claim shall be attached to the notice. The Commission shall
14 adopt rules and procedures under which the final decision of
15 the Commission under this paragraph is filed not later than 180
16 days from the date that the Petition for Review is filed with
17 the Commission.

18 Where 2 or more insurance carriers, private self-insureds,
19 or a group workers' compensation pool under Article V 3/4 of
20 the Illinois Insurance Code dispute coverage for the same
21 injury, any such insurance carrier, private self-insured, or
22 group workers' compensation pool may request an expedited
23 hearing pursuant to this paragraph to determine the issue of
24 coverage, provided coverage is the only issue in dispute and
25 all other issues are stipulated and agreed to and further
26 provided that all compensation benefits including medical

1 benefits pursuant to Section 8(a) continue to be paid to or on
2 behalf of petitioner. Any insurance carrier, private
3 self-insured, or group workers' compensation pool that is
4 determined to be liable for coverage for the injury in issue
5 shall reimburse any insurance carrier, private self-insured,
6 or group workers' compensation pool that has paid benefits to
7 or on behalf of petitioner for the injury.

8 (b-1) If the employee is not receiving medical, surgical or
9 hospital services as provided in paragraph (a) of Section 8 or
10 compensation as provided in paragraph (b) of Section 8, the
11 employee, in accordance with Commission Rules, may file a
12 petition for an emergency hearing by an Arbitrator on the issue
13 of whether or not he is entitled to receive payment of such
14 compensation or services as provided therein. Such petition
15 shall have priority over all other petitions and shall be heard
16 by the Arbitrator and Commission with all convenient speed.

17 Such petition shall contain the following information and
18 shall be served on the employer at least 15 days before it is
19 filed:

20 (i) the date and approximate time of accident;

21 (ii) the approximate location of the accident;

22 (iii) a description of the accident;

23 (iv) the nature of the injury incurred by the employee;

24 (v) the identity of the person, if known, to whom the
25 accident was reported and the date on which it was
26 reported;

1 (vi) the name and title of the person, if known,
2 representing the employer with whom the employee conferred
3 in any effort to obtain compensation pursuant to paragraph
4 (b) of Section 8 of this Act or medical, surgical or
5 hospital services pursuant to paragraph (a) of Section 8 of
6 this Act and the date of such conference;
7 (vii) a statement that the employer has refused to pay
8 compensation pursuant to paragraph (b) of Section 8 of this
9 Act or for medical, surgical or hospital services pursuant
10 to paragraph (a) of Section 8 of this Act;
11 (viii) the name and address, if known, of each witness
12 to the accident and of each other person upon whom the
13 employee will rely to support his allegations;
14 (ix) the dates of treatment related to the accident by
15 medical practitioners, and the names and addresses of such
16 practitioners, including the dates of treatment related to
17 the accident at any hospitals and the names and addresses
18 of such hospitals, and a signed authorization permitting
19 the employer to examine all medical records of all
20 practitioners and hospitals named pursuant to this
21 paragraph;
22 (x) a copy of a signed report by a medical
23 practitioner, relating to the employee's current inability
24 to return to work because of the injuries incurred as a
25 result of the accident or such other documents or
26 affidavits which show that the employee is entitled to

receive compensation pursuant to paragraph (b) of Section 8 of this Act or medical, surgical or hospital services pursuant to paragraph (a) of Section 8 of this Act. Such reports, documents or affidavits shall state, if possible, the history of the accident given by the employee, and describe the injury and medical diagnosis, the medical services for such injury which the employee has received and is receiving, the physical activities which the employee cannot currently perform as a result of any impairment or disability due to such injury, and the prognosis for recovery;

(xi) complete copies of any reports, records, documents and affidavits in the possession of the employee on which the employee will rely to support his allegations, provided that the employer shall pay the reasonable cost of reproduction thereof;

(xii) a list of any reports, records, documents and affidavits which the employee has demanded by subpoena and on which he intends to rely to support his allegations;

(xiii) a certification signed by the employee or his representative that the employer has received the petition with the required information 15 days before filing.

Fifteen days after receipt by the employer of the petition with the required information the employee may file said petition and required information and shall serve notice of the filing upon the employer. The employer may file a motion

1 addressed to the sufficiency of the petition. If an objection
2 has been filed to the sufficiency of the petition, the
3 arbitrator shall rule on the objection within 2 working days.
4 If such an objection is filed, the time for filing the final
5 decision of the Commission as provided in this paragraph shall
6 be tolled until the arbitrator has determined that the petition
7 is sufficient.

8 The employer shall, within 15 days after receipt of the
9 notice that such petition is filed, file with the Commission
10 and serve on the employee or his representative a written
11 response to each claim set forth in the petition, including the
12 legal and factual basis for each disputed allegation and the
13 following information: (i) complete copies of any reports,
14 records, documents and affidavits in the possession of the
15 employer on which the employer intends to rely in support of
16 his response, (ii) a list of any reports, records, documents
17 and affidavits which the employer has demanded by subpoena and
18 on which the employer intends to rely in support of his
19 response, (iii) the name and address of each witness on whom
20 the employer will rely to support his response, and (iv) the
21 names and addresses of any medical practitioners selected by
22 the employer pursuant to Section 12 of this Act and the time
23 and place of any examination scheduled to be made pursuant to
24 such Section.

25 Any employer who does not timely file and serve a written
26 response without good cause may not introduce any evidence to

1 dispute any claim of the employee but may cross examine the
2 employee or any witness brought by the employee and otherwise
3 be heard.

4 No document or other evidence not previously identified by
5 either party with the petition or written response, or by any
6 other means before the hearing, may be introduced into evidence
7 without good cause. If, at the hearing, material information is
8 discovered which was not previously disclosed, the Arbitrator
9 may extend the time for closing proof on the motion of a party
10 for a reasonable period of time which may be more than 30 days.
11 No evidence may be introduced pursuant to this paragraph as to
12 permanent disability. No award may be entered for permanent
13 disability pursuant to this paragraph. Either party may
14 introduce into evidence the testimony taken by deposition of
15 any medical practitioner.

16 The Commission shall adopt rules, regulations and
17 procedures whereby the final decision of the Commission is
18 filed not later than 90 days from the date the petition for
19 review is filed but in no event later than 180 days from the
20 date the petition for an emergency hearing is filed with the
21 Illinois Workers' Compensation Commission.

22 All service required pursuant to this paragraph (b-1) must
23 be by personal service or by certified mail and with evidence
24 of receipt. In addition for the purposes of this paragraph, all
25 service on the employer must be at the premises where the
26 accident occurred if the premises are owned or operated by the

1 employer. Otherwise service must be at the employee's principal
2 place of employment by the employer. If service on the employer
3 is not possible at either of the above, then service shall be
4 at the employer's principal place of business. After initial
5 service in each case, service shall be made on the employer's
6 attorney or designated representative.

7 (c)(1) At a reasonable time in advance of and in connection
8 with the hearing under Section 19(e) or 19(h), the Commission
9 may on its own motion order an impartial physical or mental
10 examination of a petitioner whose mental or physical condition
11 is in issue, when in the Commission's discretion it appears
12 that such an examination will materially aid in the just
13 determination of the case. The examination shall be made by a
14 member or members of a panel of physicians chosen for their
15 special qualifications by the Illinois State Medical Society.
16 The Commission shall establish procedures by which a physician
17 shall be selected from such list.

18 (2) Should the Commission at any time during the hearing
19 find that compelling considerations make it advisable to have
20 an examination and report at that time, the commission may in
21 its discretion so order.

22 (3) A copy of the report of examination shall be given to
23 the Commission and to the attorneys for the parties.

24 (4) Either party or the Commission may call the examining
25 physician or physicians to testify. Any physician so called
26 shall be subject to cross-examination.

1 (5) The examination shall be made, and the physician or
2 physicians, if called, shall testify, without cost to the
3 parties. The Commission shall determine the compensation and
4 the pay of the physician or physicians. The compensation for
5 this service shall not exceed the usual and customary amount
6 for such service.
7 (6) The fees and payment thereof of all attorneys and
8 physicians for services authorized by the Commission under this
9 Act shall, upon request of either the employer or the employee
10 or the beneficiary affected, be subject to the review and
11 decision of the Commission.
12 (d) If any employee shall persist in insanitary or
13 injurious practices which tend to either imperil or retard his
14 recovery or shall refuse to submit to such medical, surgical,
15 or hospital treatment as is reasonably essential to promote his
16 recovery, the Commission may, in its discretion, reduce or
17 suspend the compensation of any such injured employee. However,
18 when an employer and employee so agree in writing, the
19 foregoing provision shall not be construed to authorize the
20 reduction or suspension of compensation of an employee who is
21 relying in good faith, on treatment by prayer or spiritual
22 means alone, in accordance with the tenets and practice of a
23 recognized church or religious denomination, by a duly
24 accredited practitioner thereof.
25 (e) This paragraph shall apply to all hearings before the
26 Commission. Such hearings may be held in its office or

1 elsewhere as the Commission may deem advisable. The taking of
2 testimony on such hearings may be had before any member of the
3 Commission. If a petition for review and agreed statement of
4 facts or transcript of evidence is filed, as provided herein,
5 the Commission shall promptly review the decision of the
6 Arbitrator and all questions of law or fact which appear from
7 the statement of facts or transcript of evidence.
8 In all cases in which the hearing before the arbitrator is
9 held after December 18, 1989, no additional evidence shall be
10 introduced by the parties before the Commission on review of
11 the decision of the Arbitrator. In reviewing decisions of an
12 arbitrator the Commission shall award such temporary
13 compensation, permanent compensation and other payments as are
14 due under this Act. The Commission shall file in its office its
15 decision thereon, and shall immediately send to each party or
16 his attorney a copy of such decision and a notification of the
17 time when it was filed. Decisions shall be filed within 60 days
18 after the Statement of Exceptions and Supporting Brief and
19 Response thereto are required to be filed or oral argument
20 whichever is later.
21 In the event either party requests oral argument, such
22 argument shall be had before a panel of 3 members of the
23 Commission (or before all available members pursuant to the
24 determination of 7 members of the Commission that such argument
25 be held before all available members of the Commission)
26 pursuant to the rules and regulations of the Commission. A

1 panel of 3 members, which shall be comprised of not more than
2 one representative citizen of the employing class and not more
3 than one representative citizen of the employee class, shall
4 hear the argument; provided that if all the issues in dispute
5 are solely the nature and extent of the permanent partial
6 disability, if any, a majority of the panel may deny the
7 request for such argument and such argument shall not be held;
8 and provided further that 7 members of the Commission may
9 determine that the argument be held before all available
10 members of the Commission. A decision of the Commission shall
11 be approved by a majority of Commissioners present at such
12 hearing if any; provided, if no such hearing is held, a
13 decision of the Commission shall be approved by a majority of a
14 panel of 3 members of the Commission as described in this
15 Section. The Commission shall give 10 days' notice to the
16 parties or their attorneys of the time and place of such taking
17 of testimony and of such argument.

18 In any case the Commission in its decision may find
19 specially upon any question or questions of law or fact which
20 shall be submitted in writing by either party whether ultimate
21 or otherwise; provided that on issues other than nature and
22 extent of the disability, if any, the Commission in its
23 decision shall find specially upon any question or questions of
24 law or fact, whether ultimate or otherwise, which are submitted
25 in writing by either party; provided further that not more than
26 5 such questions may be submitted by either party. Any party

may, within 20 days after receipt of notice of the Commission's decision, or within such further time, not exceeding 30 days, as the Commission may grant, file with the Commission either an agreed statement of the facts appearing upon the hearing, or, if such party shall so elect, a correct transcript of evidence of the additional proceedings presented before the Commission, in which report the party may embody a correct statement of such other proceedings in the case as such party may desire to have reviewed, such statement of facts or transcript of evidence to be authenticated by the signature of the parties or their attorneys, and in the event that they do not agree, then the authentication of such transcript of evidence shall be by the signature of any member of the Commission.

If a reporter does not for any reason furnish a transcript of the proceedings before the Arbitrator in any case for use on a hearing for review before the Commission, within the limitations of time as fixed in this Section, the Commission may, in its discretion, order a trial de novo before the Commission in such case upon application of either party. The applications for adjustment of claim and other documents in the nature of pleadings filed by either party, together with the decisions of the Arbitrator and of the Commission and the statement of facts or transcript of evidence hereinbefore provided for in paragraphs (b) and (c) shall be the record of the proceedings of the Commission, and shall be subject to review as hereinafter provided.

At the request of either party or on its own motion, the Commission shall set forth in writing the reasons for the decision, including findings of fact and conclusions of law separately stated. The Commission shall by rule adopt a format for written decisions for the Commission and arbitrators. The written decisions shall be concise and shall succinctly state the facts and reasons for the decision. The Commission may adopt in whole or in part, the decision of the arbitrator as the decision of the Commission. When the Commission does so adopt the decision of the arbitrator, it shall do so by order. Whenever the Commission adopts part of the arbitrator's decision, but not all, it shall include in the order the reasons for not adopting all of the arbitrator's decision. When a majority of a panel, after deliberation, has arrived at its decision, the decision shall be filed as provided in this Section without unnecessary delay, and without regard to the fact that a member of the panel has expressed an intention to dissent. Any member of the panel may file a dissent. Any dissent shall be filed no later than 10 days after the decision of the majority has been filed.

Decisions rendered by the Commission and dissents, if any, shall be published together by the Commission. The conclusions of law set out in such decisions shall be regarded as precedents by arbitrators for the purpose of achieving a more uniform administration of this Act.

(f) The decision of the Commission acting within its

powers, according to the provisions of paragraph (e) of this Section shall, in the absence of fraud, be conclusive unless reviewed as in this paragraph hereinafter provided. However, the Arbitrator or the Commission may on his or its own motion, or on the motion of either party, correct any clerical error or errors in computation within 15 days after the date of receipt of any award by such Arbitrator or any decision on review of the Commission and shall have the power to recall the original award on arbitration or decision on review, and issue in lieu thereof such corrected award or decision. Where such correction is made the time for review herein specified shall begin to run from the date of the receipt of the corrected award or decision.

(1) Except in cases of claims against the State of Illinois other than those claims under Section 18.1, in which case the decision of the Commission shall not be subject to judicial review, the Circuit Court of the county where any of the parties defendant may be found, or if none of the parties defendant can be found in this State then the Circuit Court of the county where the accident occurred, shall by summons to the Commission have power to review all questions of law and fact presented by such record.

A proceeding for review shall be commenced within 20 days of the receipt of notice of the decision of the Commission. The summons shall be issued by the clerk of

1 such court upon written request returnable on a designated
2 return day, not less than 10 or more than 60 days from the
3 date of issuance thereof, and the written request shall
4 contain the last known address of other parties in interest
5 and their attorneys of record who are to be served by
6 summons. Service upon any member of the Commission or the
7 Secretary or the Assistant Secretary thereof shall be
8 service upon the Commission, and service upon other parties
9 in interest and their attorneys of record shall be by
10 summons, and such service shall be made upon the Commission
11 and other parties in interest by mailing notices of the
12 commencement of the proceedings and the return day of the
13 summons to the office of the Commission and to the last
14 known place of residence of other parties in interest or
15 their attorney or attorneys of record. The clerk of the
16 court issuing the summons shall on the day of issue mail
17 notice of the commencement of the proceedings which shall
18 be done by mailing a copy of the summons to the office of
19 the Commission, and a copy of the summons to the other
20 parties in interest or their attorney or attorneys of
21 record and the clerk of the court shall make certificate
22 that he has so sent said notices in pursuance of this
23 Section, which shall be evidence of service on the
24 Commission and other parties in interest.

25 The Commission shall not be required to certify the
26 record of their proceedings to the Circuit Court, unless

1 the party commencing the proceedings for review in the
2 Circuit Court as above provided, shall file with the
3 Commission notice of intent to file for review in Circuit
4 Court. It shall be the duty of the Commission upon such
5 filing of notice of intent to file for review in the
6 Circuit Court to prepare a true and correct copy of such
7 testimony and a true and correct copy of all other matters
8 contained in such record and certified to by the Secretary
9 or Assistant Secretary thereof. The changes made to this
10 subdivision (f)(1) by this amendatory Act of the 98th
11 General Assembly apply to any Commission decision entered
12 after the effective date of this amendatory Act of the 98th
13 General Assembly.

14 No request for a summons may be filed and no summons
15 shall issue unless the party seeking to review the decision
16 of the Commission shall exhibit to the clerk of the Circuit
17 Court proof of filing with the Commission of the notice of
18 the intent to file for review in the Circuit Court or an
19 affidavit of the attorney setting forth that notice of
20 intent to file for review in the Circuit Court has been
21 given in writing to the Secretary or Assistant Secretary of
22 the Commission.

23 (2) No such summons shall issue unless the one against
24 whom the Commission shall have rendered an award for the
25 payment of money shall upon the filing of his written
26 request for such summons file with the clerk of the court a

bond conditioned that if he shall not successfully prosecute the review, he will pay the award and the costs of the proceedings in the courts. The amount of the bond shall be fixed by any member of the Commission and the surety or sureties of the bond shall be approved by the clerk of the court. The acceptance of the bond by the clerk of the court shall constitute evidence of his approval of the bond.

The State of Illinois, including its constitutional officers, boards, commissions, agencies, public institutions of higher learning, and funds administered by the treasurer ex officio, and every ~~Every~~ county, city, town, township, incorporated village, school district, body politic or municipal corporation against whom the Commission shall have rendered an award for the payment of money shall not be required to file a bond to secure the payment of the award and the costs of the proceedings in the court to authorize the court to issue such summons.

The court may confirm or set aside the decision of the Commission. If the decision is set aside and the facts found in the proceedings before the Commission are sufficient, the court may enter such decision as is justified by law, or may remand the cause to the Commission for further proceedings and may state the questions requiring further hearing, and give such other instructions as may be proper. Appeals shall be taken to

the Appellate Court in accordance with Supreme Court Rules 22(g) and 303. Appeals shall be taken from the Appellate Court to the Supreme Court in accordance with Supreme Court Rule 315.

It shall be the duty of the clerk of any court rendering a decision affecting or affirming an award of the Commission to promptly furnish the Commission with a copy of such decision, without charge.

The decision of a majority of the members of the panel of the Commission, shall be considered the decision of the Commission.

(g) Except in the case of a claim against the State of Illinois, either party may present a certified copy of the award of the Arbitrator, or a certified copy of the decision of the Commission when the same has become final, when no proceedings for review are pending, providing for the payment of compensation according to this Act, to the Circuit Court of the county in which such accident occurred or either of the parties are residents, whereupon the court shall enter a judgment in accordance therewith. In a case where the employer refuses to pay compensation according to such final award or such final decision upon which such judgment is entered the court shall in entering judgment thereon, tax as costs against him the reasonable costs and attorney fees in the arbitration proceedings and in the court entering the judgment for the person in whose favor the judgment is entered, which judgment

1 and costs taxed as therein provided shall, until and unless set
2 aside, have the same effect as though duly entered in an action
3 duly tried and determined by the court, and shall with like
4 effect, be entered and docketed. The Circuit Court shall have
5 power at any time upon application to make any such judgment
6 conform to any modification required by any subsequent decision
7 of the Supreme Court upon appeal, or as the result of any
8 subsequent proceedings for review, as provided in this Act.

9 Judgment shall not be entered until 15 days' notice of the
10 time and place of the application for the entry of judgment
11 shall be served upon the employer by filing such notice with
12 the Commission, which Commission shall, in case it has on file
13 the address of the employer or the name and address of its
14 agent upon whom notices may be served, immediately send a copy
15 of the notice to the employer or such designated agent.

16 (h) An agreement or award under this Act providing for
17 compensation in installments, may at any time within 18 months
18 after such agreement or award be reviewed by the Commission at
19 the request of either the employer or the employee, on the
20 ground that the disability of the employee has subsequently
21 recurred, increased, diminished or ended.

22 However, as to accidents occurring subsequent to July 1,
23 1955, which are covered by any agreement or award under this
24 Act providing for compensation in installments made as a result
25 of such accident, such agreement or award may at any time
26 within 30 months, or 60 months in the case of an award under

Section 8(d)1, after such agreement or award be reviewed by the Commission at the request of either the employer or the employee on the ground that the disability of the employee has subsequently recurred, increased, diminished or ended.

On such review, compensation payments may be re-established, increased, diminished or ended. The Commission shall give 15 days' notice to the parties of the hearing for review. Any employee, upon any petition for such review being filed by the employer, shall be entitled to one day's notice for each 100 miles necessary to be traveled by him in attending the hearing of the Commission upon the petition, and 3 days in addition thereto. Such employee shall, at the discretion of the Commission, also be entitled to 5 cents per mile necessarily traveled by him within the State of Illinois in attending such hearing, not to exceed a distance of 300 miles, to be taxed by the Commission as costs and deposited with the petition of the employer.

When compensation which is payable in accordance with an award or settlement contract approved by the Commission, is ordered paid in a lump sum by the Commission, no review shall be had as in this paragraph mentioned.

(i) Each party, upon taking any proceedings or steps whatsoever before any Arbitrator, Commission or court, shall file with the Commission his address, or the name and address of any agent upon whom all notices to be given to such party shall be served, either personally or by registered mail,

addressed to such party or agent at the last address so filed with the Commission. In the event such party has not filed his address, or the name and address of an agent as above provided, service of any notice may be had by filing such notice with the Commission.

(j) Whenever in any proceeding testimony has been taken or a final decision has been rendered and after the taking of such testimony or after such decision has become final, the injured employee dies, then in any subsequent proceedings brought by the personal representative or beneficiaries of the deceased employee, such testimony in the former proceeding may be introduced with the same force and effect as though the witness having so testified were present in person in such subsequent proceedings and such final decision, if any, shall be taken as final adjudication of any of the issues which are the same in both proceedings.

(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.

1 When determining whether this subsection (k) shall apply,
2 the Commission shall consider whether an Arbitrator has
3 determined that the claim is not compensable or whether the
4 employer has made payments under Section 8(j).
5 (l) If the employee has made written demand for payment of
6 benefits under Section 8(a) or Section 8(b), the employer shall
7 have 14 days after receipt of the demand to set forth in
8 writing the reason for the delay. In the case of demand for
9 payment of medical benefits under Section 8(a), the time for
10 the employer to respond shall not commence until the expiration
11 of the allotted 30 days specified under Section 8.2(d). In case
12 the employer or his or her insurance carrier shall without good
13 and just cause fail, neglect, refuse, or unreasonably delay the
14 payment of benefits under Section 8(a) or Section 8(b), the
15 Arbitrator or the Commission shall allow to the employee
16 additional compensation in the sum of $30 per day for each day
17 that the benefits under Section 8(a) or Section 8(b) have been
18 so withheld or refused, not to exceed $10,000. A delay in
19 payment of 14 days or more shall create a rebuttable
20 presumption of unreasonable delay.
21 (m) If the commission finds that an accidental injury was
22 directly and proximately caused by the employer's wilful
23 violation of a health and safety standard under the Health and
24 Safety Act or the Occupational Safety and Health Act in force
25 at the time of the accident, the arbitrator or the Commission
26 shall allow to the injured employee or his dependents, as the

case may be, additional compensation equal to 25% of the amount which otherwise would be payable under the provisions of this Act exclusive of this paragraph. The additional compensation herein provided shall be allowed by an appropriate increase in the applicable weekly compensation rate.

(n) After June 30, 1984, decisions of the Illinois Workers' Compensation Commission reviewing an award of an arbitrator of the Commission shall draw interest at a rate equal to the yield on indebtedness issued by the United States Government with a 26-week maturity next previously auctioned on the day on which the decision is filed. Said rate of interest shall be set forth in the Arbitrator's Decision. Interest shall be drawn from the date of the arbitrator's award on all accrued compensation due the employee through the day prior to the date of payments. However, when an employee appeals an award of an Arbitrator or the Commission, and the appeal results in no change or a decrease in the award, interest shall not further accrue from the date of such appeal.

The employer or his insurance carrier may tender the payments due under the award to stop the further accrual of interest on such award notwithstanding the prosecution by either party of review, certiorari, appeal to the Supreme Court or other steps to reverse, vacate or modify the award.

(o) By the 15th day of each month each insurer providing coverage for losses under this Act shall notify each insured employer of any compensable claim incurred during the preceding

month and the amounts paid or reserved on the claim including a summary of the claim and a brief statement of the reasons for compensability. A cumulative report of all claims incurred during a calendar year or continued from the previous year shall be furnished to the insured employer by the insurer within 30 days after the end of that calendar year.

The insured employer may challenge, in proceeding before the Commission, payments made by the insurer without arbitration and payments made after a case is determined to be noncompensable. If the Commission finds that the case was not compensable, the insurer shall purge its records as to that employer of any loss or expense associated with the claim, reimburse the employer for attorneys' fees arising from the challenge and for any payment required of the employer to the Rate Adjustment Fund or the Second Injury Fund, and may not reflect the loss or expense for rate making purposes. The employee shall not be required to refund the challenged payment. The decision of the Commission may be reviewed in the same manner as in arbitrated cases. No challenge may be initiated under this paragraph more than 3 years after the payment is made. An employer may waive the right of challenge under this paragraph on a case by case basis.

(p) After filing an application for adjustment of claim but prior to the hearing on arbitration the parties may voluntarily agree to submit such application for adjustment of claim for decision by an arbitrator under this subsection (p) where such

1 application for adjustment of claim raises only a dispute over
2 temporary total disability, permanent partial disability or
3 medical expenses. Such agreement shall be in writing in such
4 form as provided by the Commission. Applications for adjustment
5 of claim submitted for decision by an arbitrator under this
6 subsection (p) shall proceed according to rule as established
7 by the Commission. The Commission shall promulgate rules
8 including, but not limited to, rules to ensure that the parties
9 are adequately informed of their rights under this subsection
10 (p) and of the voluntary nature of proceedings under this
11 subsection (p). The findings of fact made by an arbitrator
12 acting within his or her powers under this subsection (p) in
13 the absence of fraud shall be conclusive. However, the
14 arbitrator may on his own motion, or the motion of either
15 party, correct any clerical errors or errors in computation
16 within 15 days after the date of receipt of such award of the
17 arbitrator and shall have the power to recall the original
18 award on arbitration, and issue in lieu thereof such corrected
19 award. The decision of the arbitrator under this subsection (p)
20 shall be considered the decision of the Commission and
21 proceedings for review of questions of law arising from the
22 decision may be commenced by either party pursuant to
23 subsection (f) of Section 19. The Advisory Board established
24 under Section 13.1 shall compile a list of certified Commission
25 arbitrators, each of whom shall be approved by at least 7
26 members of the Advisory Board. The chairman shall select 5

persons from such list to serve as arbitrators under this subsection (p). By agreement, the parties shall select one arbitrator from among the 5 persons selected by the chairman except that if the parties do not agree on an arbitrator from among the 5 persons, the parties may, by agreement, select an arbitrator of the American Arbitration Association, whose fee shall be paid by the State in accordance with rules promulgated by the Commission. Arbitration under this subsection (p) shall be voluntary.

(Source: P.A. 97-18, eff. 6-28-11; 98-40, eff. 6-28-13; 98-874, eff. 1-1-15.)

(820 ILCS 305/25.5)

Sec. 25.5. Unlawful acts; penalties.

(a) It is unlawful for any person, company, corporation, insurance carrier, healthcare provider, or other entity to:

(1) Intentionally present or cause to be presented any false or fraudulent claim for the payment of any workers' compensation benefit.

(2) Intentionally make or cause to be made any false or fraudulent material statement or material representation for the purpose of obtaining or denying any workers' compensation benefit.

(3) Intentionally make or cause to be made any false or fraudulent statements with regard to entitlement to workers' compensation benefits with the intent to prevent

an injured worker from making a legitimate claim for any workers' compensation benefits.

(4) Intentionally prepare or provide an invalid, false, or counterfeit certificate of insurance as proof of workers' compensation insurance.

(5) Intentionally make or cause to be made any false or fraudulent material statement or material representation for the purpose of obtaining workers' compensation insurance at less than the proper amount ~~rate~~ for that insurance.

(6) Intentionally make or cause to be made any false or fraudulent material statement or material representation on an initial or renewal self-insurance application or accompanying financial statement for the purpose of obtaining self-insurance status or reducing the amount of security that may be required to be furnished pursuant to Section 4 of this Act.

(7) Intentionally make or cause to be made any false or fraudulent material statement to the Department of Insurance's fraud and insurance non-compliance unit in the course of an investigation of fraud or insurance non-compliance.

(8) Intentionally assist, abet, solicit, or conspire with any person, company, or other entity to commit any of the acts in paragraph (1), (2), (3), (4), (5), (6), or (7) of this subsection (a).

(9) Intentionally present a bill or statement for the payment for medical services that were not provided.

For the purposes of paragraphs (2), (3), (5), (6), (7), and (9), the term "statement" includes any writing, notice, proof of injury, bill for services, hospital or doctor records and reports, or X-ray and test results.

(b) Sentence. ~~Sentences for violations of subsection (a) are as follows:~~

(1) A violation of paragraph (a)(3) is a Class 4 felony.

(2) A violation of paragraph (a)(4) or (a)(7) is a Class 3 felony.

(3) A violation of paragraph (a)(1), (a)(2), (a)(5), (a)(6), or (a)(9) in which the value of the property obtained or attempted to be obtained is $500 or less is a Class A misdemeanor.

(4) A violation of paragraph (a)(1), (a)(2), (a)(5), (a)(6), or (a)(9) in which the value of the property obtained or attempted to be obtained is more than $500 but not more than $10,000 is a Class 3 felony.

(5) A violation of paragraph (a)(1), (a)(2), (a)(5), (a)(6), or (a)(9) in which the value of the property obtained or attempted to be obtained is more than $10,000 but not more than $100,000 is a Class 2 felony.

(6) A violation of paragraph (a)(1), (a)(2), (a)(5), (a)(6), or (a)(9) in which the value of the property

obtained or attempted to be obtained is more than $100,000 is a Class 1 felony.

(7) A violation of paragraph (8) of subsection (a) shall be punishable as the class of offense for which the person convicted assisted, abetted, solicited, or conspired to commit, as set forth in paragraphs (1) through (6) of this subsection.

~~(1) A violation in which the value of the property obtained or attempted to be obtained is $300 or less is a Class A misdemeanor.~~

~~(2) A violation in which the value of the property obtained or attempted to be obtained is more than $300 but not more than $10,000 is a Class 3 felony.~~

~~(3) A violation in which the value of the property obtained or attempted to be obtained is more than $10,000 but not more than $100,000 is a Class 2 felony.~~

~~(4) A violation in which the value of the property obtained or attempted to be obtained is more than $100,000 is a Class 1 felony.~~

(8) ~~(5)~~ A person convicted under this Section shall be ordered to pay monetary restitution to the insurance company or self-insured entity or any other person for any financial loss sustained as a result of a violation of this Section, including any court costs and attorney fees. An order of restitution also includes expenses incurred and paid by the State of Illinois or an insurance company or

self-insured entity in connection with any medical evaluation or treatment services.

For a violation of paragraph (a)(1) or (a)(2), the value of the property obtained or attempted to be obtained shall include payments pursuant to the provisions of this Act as well as the amount paid for medical expenses. For a violation of paragraph (a)(5), the value of the property obtained or attempted to be obtained shall be the difference between the proper amount for the coverage sought or provided and the actual amount billed for workers' compensation insurance. For a violation of paragraph (a)(6), the value of the property obtained or attempted to be obtained shall be the difference between the proper amount of security required pursuant to Section 4 of this Act and the amount furnished pursuant to the false or fraudulent statements or representations. ~~For the purposes of this Section, where the exact value of property obtained or attempted to be obtained is either not alleged or is not specifically set by the terms of a policy of insurance, the value of the property shall be the fair market replacement value of the property claimed to be lost, the reasonable costs of reimbursing a vendor or other claimant for services to be rendered, or both~~. Notwithstanding the foregoing, an insurance company, self-insured entity, or any other person suffering financial loss sustained as a result of violation of this Section may seek restitution, including court costs and attorney's fees in a civil action in a court of competent

1 jurisdiction.
2 (c) The Department of Insurance shall establish a fraud and
3 insurance non-compliance unit responsible for investigating
4 incidences of fraud and insurance non-compliance pursuant to
5 this Section. The size of the staff of the unit shall be
6 subject to appropriation by the General Assembly. It shall be
7 the duty of the fraud and insurance non-compliance unit to
8 determine the identity of insurance carriers, employers,
9 employees, or other persons or entities who have violated the
10 fraud and insurance non-compliance provisions of this Section.
11 The fraud and insurance non-compliance unit shall report
12 violations of the fraud and insurance non-compliance
13 provisions of this Section to the Special Prosecutions Bureau
14 of the Criminal Division of the Office of the Attorney General
15 or to the State's Attorney of the county in which the offense
16 allegedly occurred, either of whom has the authority to
17 prosecute violations under this Section.
18 With respect to the subject of any investigation being
19 conducted, the fraud and insurance non-compliance unit shall
20 have the general power of subpoena of the Department of
21 Insurance, including the authority to issue a subpoena to a
22 medical provider, pursuant to Section 8-802 of the Code of
23 Civil Procedure.
24 (d) Any person may report allegations of insurance
25 non-compliance and fraud pursuant to this Section to the
26 Department of Insurance's fraud and insurance non-compliance

1 unit whose duty it shall be to investigate the report. The unit
2 shall notify the Commission of reports of insurance
3 non-compliance. Any person reporting an allegation of
4 insurance non-compliance or fraud against either an employee or
5 employer under this Section must identify himself. Except as
6 provided in this subsection and in subsection (e), all reports
7 shall remain confidential except to refer an investigation to
8 the Attorney General or State's Attorney for prosecution or if
9 the fraud and insurance non-compliance unit's investigation
10 reveals that the conduct reported may be in violation of other
11 laws or regulations of the State of Illinois, the unit may
12 report such conduct to the appropriate governmental agency
13 charged with administering such laws and regulations. Any
14 person who intentionally makes a false report under this
15 Section to the fraud and insurance non-compliance unit is
16 guilty of a Class A misdemeanor.

17 (e) In order for the fraud and insurance non-compliance
18 unit to investigate a report of fraud related to an employee's
19 claim, (i) the employee must have filed with the Commission an
20 Application for Adjustment of Claim and the employee must have
21 either received or attempted to receive benefits under this Act
22 that are related to the reported fraud or (ii) the employee
23 must have made a written demand for the payment of benefits
24 that are related to the reported fraud. There shall be no
25 immunity, under this Act or otherwise, for any person who files
26 a false report or who files a report without good and just

cause. Confidentiality of medical information shall be strictly maintained. Investigations that are not referred for prosecution shall be destroyed upon the expiration of the statute of limitations for the acts under investigation and shall not be disclosed except that the person making the report shall be notified that the investigation is being closed. It is unlawful for any employer, insurance carrier, service adjustment company, third party administrator, self-insured, or similar entity to file or threaten to file a report of fraud against an employee because of the exercise by the employee of the rights and remedies granted to the employee by this Act.

The Department of Insurance's papers, documents, reports, or evidence relevant to the subject of an investigation under this Section shall be confidential and not subject to subpoena, public inspection, or to disclosure under the Freedom of Information Act for so long as the Director deems reasonably necessary to complete the investigation, to protect the person investigated from unwarranted injury, or to be in the public interest. No officer, agent, or employee of the Department is subject to subpoena in any civil or administrative action to testify concerning a matter of which they have knowledge under a pending fraud or insurance non-compliance investigation by the Department.

No cause of action exists and no liability may be imposed, either civil or criminal, against the State, the Director of Insurance, any officer, agent, or employee of the Department of

Insurance, or individuals employed or retained by the Director of Insurance, for an act or omission by them in the performance of a power or duty authorized by this Section, unless the act or omission was performed in bad faith and with intent to injure a particular person.

(e-5) The fraud and insurance non-compliance unit shall procure and implement a system utilizing advanced analytics inclusive of predictive modeling, data mining, social network analysis, and scoring algorithms for the detection and prevention of fraud, waste, and abuse on or before January 1, 2012. The fraud and insurance non-compliance unit shall procure this system using a request for proposals process governed by the Illinois Procurement Code and rules adopted under that Code. The fraud and insurance non-compliance unit shall provide a report to the President of the Senate, Speaker of the House of Representatives, Minority Leader of the House of Representatives, Minority Leader of the Senate, Governor, Chairman of the Commission, and Director of Insurance on or before July 1, 2012 and annually thereafter detailing its activities and providing recommendations regarding opportunities for additional fraud waste and abuse detection and prevention.

(f) Any person convicted of fraud related to workers' compensation pursuant to this Section shall be subject to the penalties prescribed in the Criminal Code of 2012 and shall be ineligible to receive or retain any compensation, disability,

or medical benefits as defined in this Act if the compensation, disability, or medical benefits were owed or received as a result of fraud for which the recipient of the compensation, disability, or medical benefit was convicted. This subsection applies to accidental injuries or diseases that occur on or after the effective date of this amendatory Act of the 94th General Assembly.

(g) Civil liability. Any person convicted of fraud who knowingly obtains, attempts to obtain, or causes to be obtained any benefits under this Act by the making of a false claim or who knowingly misrepresents any material fact shall be civilly liable to the payor of benefits or the insurer or the payor's or insurer's subrogee or assignee in an amount equal to 3 times the value of the benefits or insurance coverage wrongfully obtained or twice the value of the benefits or insurance coverage attempted to be obtained, plus reasonable attorney's fees and expenses incurred by the payor or the payor's subrogee or assignee who successfully brings a claim under this subsection. This subsection applies to accidental injuries or diseases that occur on or after the effective date of this amendatory Act of the 94th General Assembly.

(h) The fraud and insurance non-compliance unit shall submit a written report on an annual basis to the Chairman of the Commission, the Workers' Compensation Advisory Board, the General Assembly, the Governor, and the Attorney General by January 1 and July 1 of each year. This report shall include,

at the minimum, the following information:

(1) The number of allegations of insurance non-compliance and fraud reported to the fraud and insurance non-compliance unit.

(2) The source of the reported allegations (individual, employer, or other).

(3) The number of allegations investigated by the fraud and insurance non-compliance unit.

(4) The number of criminal referrals made in accordance with this Section and the entity to which the referral was made.

(5) All proceedings under this Section.

(Source: P.A. 97-18, eff. 6-28-11; 97-1150, eff. 1-25-13.)

(820 ILCS 305/29.2)

Sec. 29.2. Insurance and self-insurance oversight.

(a) The Department of Insurance shall annually submit to the Governor, the Chairman of the Commission, the President of the Senate, the Speaker of the House of Representatives, the Minority Leader of the Senate, and the Minority Leader of the House of Representatives a written report that details the state of the workers' compensation insurance market in Illinois. The report shall be completed by April 1 of each year, beginning in 2012, or later if necessary data or analyses are only available to the Department at a later date. The report shall be posted on the Department of Insurance's

Internet website. Information to be included in the report shall be for the preceding calendar year. The report shall include, at a minimum, the following:

(1) Gross premiums collected by workers' compensation carriers in Illinois and the national rank of Illinois based on premium volume.

(2) The number of insurance companies actively engaged in Illinois in the workers' compensation insurance market, including both holding companies and subsidiaries or affiliates, and the national rank of Illinois based on number of competing insurers.

(3) The total number of insured participants in the Illinois workers' compensation assigned risk insurance pool, and the size of the assigned risk pool as a proportion of the total Illinois workers' compensation insurance market.

(4) The advisory organization premium rate for workers' compensation insurance in Illinois for the previous year.

(5) The advisory organization prescribed assigned risk pool premium rate.

(6) The total amount of indemnity payments made by workers' compensation insurers in Illinois.

(7) The total amount of medical payments made by workers' compensation insurers in Illinois, and the national rank of Illinois based on average cost of medical

claims per injured worker.

(8) The gross profitability of workers' compensation insurers in Illinois, and the national rank of Illinois based on profitability of workers' compensation insurers.

(9) The loss ratio of workers' compensation insurers in Illinois and the national rank of Illinois based on the loss ratio of workers' compensation insurers. For purposes of this loss ratio calculation, the denominator shall include all premiums and other fees collected by workers' compensation insurers and the numerator shall include the total amount paid by the insurer for care or compensation to injured workers.

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

(11) The number of injured workers receiving wage loss differential awards and the average wage loss differential award payout.

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

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

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

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

(iv) the maximum and minimum death benefit level.

(13) The aggregate growth of medical benefit payout by non-hospital providers and hospitals.

(14) The aggregate growth of medical utilization for the top 10 most common injuries to specific body parts by non-hospital providers and hospitals.

(15) The percentage of injured workers filing claims at the Commission that are represented by an attorney.

(16) The total amount paid by injured workers for attorney representation.

(a-5) The Commission shall annually submit to the Governor and the General Assembly a written report that details the state of self-insurance for workers' compensation in Illinois. The report shall be based on information currently collected by the Commission or the Department of Insurance from self-insurers, as of the effective date of this amendatory Act of the 100th General Assembly. The report shall be completed by April 1 of each year, beginning in 2017. The report shall be posted on the Commission's Internet website. Information to be included in the report shall be for the preceding calendar year. The report shall include, at a minimum, the following in the aggregate:

(1) The number of employers that self-insure for workers' compensation.

(2) The total number of employees covered by self-insurance.

(3) The total amount of indemnity payments made by self-insureds.

(4) The total amount of medical payments made by self-insureds.

(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.

Any information collected by the Commission from self-insureds shall be exempt from public inspection and disclosure under the Freedom of Information Act.

(b) The Director of Insurance shall promulgate rules requiring each insurer licensed to write workers' compensation coverage in the State to record and report the following information on an aggregate basis to the Department of Insurance before March 1 of each year, relating to claims in

the State opened within the prior calendar year:

(1) The number of claims opened.

(2) The number of reported medical only claims.

(3) The number of contested claims.

(4) The number of claims for which the employee has attorney representation.

(5) The number of claims with lost time and the number of claims for which temporary total disability was paid.

(6) The number of claim adjusters employed to adjust workers' compensation claims.

(7) The number of claims for which temporary total disability was not paid within 14 days from the first full day off, regardless of reason.

(8) The number of medical bills paid 60 days or later from date of service and the average days paid on those paid after 60 days for the previous calendar year.

(9) The number of claims in which in-house defense counsel participated, and the total amount spent on in-house legal services.

(10) The number of claims in which outside defense counsel participated, and the total amount paid to outside defense counsel.

(11) The total amount billed to employers for bill review.

(12) The total amount billed to employers for fee schedule savings.

(13) The total amount charged to employers for any and all managed care fees.

(14) The number of claims involving in-house medical nurse case management, and the total amount spent on in-house medical nurse case management.

(15) The number of claims involving outside medical nurse case management, and the total amount paid for outside medical nurse case management.

(16) The total amount paid for Independent Medical exams.

(17) The total amount spent on in-house Utilization Review for the previous calendar year.

(18) The total amount paid for outside Utilization Review for the previous calendar year.

The Department shall make the submitted information publicly available on the Department's Internet website or such other media as appropriate in a form useful for consumers.

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

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