



100TH GENERAL ASSEMBLY

State of Illinois

2017 and 2018

SB3617

Introduced 5/30/2018, by Sen. Kyle McCarter

SYNOPSIS AS INTRODUCED:

820 ILCS 305/8.2

820 ILCS 305/8.2a

820 ILCS 305/8.7

820 ILCS 305/19

from Ch. 48, par. 138.19

Amends the Workers' Compensation Act. Makes numerous additions and changes concerning: employers giving medical providers addresses to which medical bills should be sent; payments by employers to medical providers; explanations of benefits; interest payments by employers to medical providers under specified circumstances; petitions by medical providers if interest has not been paid; duties of the Director of Insurance regarding compliance by health care providers with requests for records by employers and insurers for the authorization of the payment of workers' compensation claims and imposition of administrative fines if an employer or insurer has intentionally failed to comply or demonstrates a repeated pattern of failing to comply with the electronic claims acceptance and response process; utilization review; entry of judgments based on final awards or decisions; and other matters. Effective immediately.

LRB100 22282 KTG 41004 b

1 AN ACT concerning employment.

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

4 Section 5. The Workers' Compensation Act is amended by
5 changing Sections 8.2, 8.2a, 8.7, and 19 as follows:

6 (820 ILCS 305/8.2)

7 Sec. 8.2. Fee schedule.

8 (a) Except as provided for in subsection (c), for
9 procedures, treatments, or services covered under this Act and
10 rendered or to be rendered on and after February 1, 2006, the
11 maximum allowable payment shall be 90% of the 80th percentile
12 of charges and fees as determined by the Commission utilizing
13 information provided by employers' and insurers' national
14 databases, with a minimum of 12,000,000 Illinois line item
15 charges and fees comprised of health care provider and hospital
16 charges and fees as of August 1, 2004 but not earlier than
17 August 1, 2002. These charges and fees are provider billed
18 amounts and shall not include discounted charges. The 80th
19 percentile is the point on an ordered data set from low to high
20 such that 80% of the cases are below or equal to that point and
21 at most 20% are above or equal to that point. The Commission
22 shall adjust these historical charges and fees as of August 1,
23 2004 by the Consumer Price Index-U for the period August 1,

1 2004 through September 30, 2005. The Commission shall establish
2 fee schedules for procedures, treatments, or services for
3 hospital inpatient, hospital outpatient, emergency room and
4 trauma, ambulatory surgical treatment centers, and
5 professional services. These charges and fees shall be
6 designated by geozip or any smaller geographic unit. The data
7 shall in no way identify or tend to identify any patient,
8 employer, or health care provider. As used in this Section,
9 "geozip" means a three-digit zip code based on data
10 similarities, geographical similarities, and frequencies. A
11 geozip does not cross state boundaries. As used in this
12 Section, "three-digit zip code" means a geographic area in
13 which all zip codes have the same first 3 digits. If a geozip
14 does not have the necessary number of charges and fees to
15 calculate a valid percentile for a specific procedure,
16 treatment, or service, the Commission may combine data from the
17 geozip with up to 4 other geozips that are demographically and
18 economically similar and exhibit similarities in data and
19 frequencies until the Commission reaches 9 charges or fees for
20 that specific procedure, treatment, or service. In cases where
21 the compiled data contains less than 9 charges or fees for a
22 procedure, treatment, or service, reimbursement shall occur at
23 76% of charges and fees as determined by the Commission in a
24 manner consistent with the provisions of this paragraph.
25 Providers of out-of-state procedures, treatments, services,
26 products, or supplies shall be reimbursed at the lesser of that

1 state's fee schedule amount or the fee schedule amount for the
2 region in which the employee resides. If no fee schedule exists
3 in that state, the provider shall be reimbursed at the lesser
4 of the actual charge or the fee schedule amount for the region
5 in which the employee resides. Not later than September 30 in
6 2006 and each year thereafter, the Commission shall
7 automatically increase or decrease the maximum allowable
8 payment for a procedure, treatment, or service established and
9 in effect on January 1 of that year by the percentage change in
10 the Consumer Price Index-U for the 12 month period ending
11 August 31 of that year. The increase or decrease shall become
12 effective on January 1 of the following year. As used in this
13 Section, "Consumer Price Index-U" means the index published by
14 the Bureau of Labor Statistics of the U.S. Department of Labor,
15 that measures the average change in prices of all goods and
16 services purchased by all urban consumers, U.S. city average,
17 all items, 1982-84=100.

18 (a-1) Notwithstanding the provisions of subsection (a) and
19 unless otherwise indicated, the following provisions shall
20 apply to the medical fee schedule starting on September 1,
21 2011:

22 (1) The Commission shall establish and maintain fee
23 schedules for procedures, treatments, products, services,
24 or supplies for hospital inpatient, hospital outpatient,
25 emergency room, ambulatory surgical treatment centers,
26 accredited ambulatory surgical treatment facilities,

1 prescriptions filled and dispensed outside of a licensed
2 pharmacy, dental services, and professional services. This
3 fee schedule shall be based on the fee schedule amounts
4 already established by the Commission pursuant to
5 subsection (a) of this Section. However, starting on
6 January 1, 2012, these fee schedule amounts shall be
7 grouped into geographic regions in the following manner:

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

10 (i) Cook County;

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

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

15 (iv) All other counties of the State.

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

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

20 (ii) Kankakee County;

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

23 (iv) Winnebago and Boone Counties;

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

26 (vi) Champaign, Piatt, and Ford Counties;

- 1 (vii) Rock Island, Henry, and Mercer Counties;
2 (viii) Sangamon and Menard Counties;
3 (ix) McLean County;
4 (x) Lake County;
5 (xi) Macon County;
6 (xii) Vermilion County;
7 (xiii) Alexander County; and
8 (xiv) All other counties of the State.

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

14 (3) In cases where the compiled data contains less than
15 9 charges or fees for a procedure, treatment, product,
16 supply, or service or where the fee schedule amount cannot
17 be determined by the non-discounted charge data,
18 non-Medicare relative values and conversion factors
19 derived from established fee schedule amounts, coding
20 crosswalks, or other data as determined by the Commission,
21 reimbursement shall occur at 76% of charges and fees until
22 September 1, 2011 and 53.2% of charges and fees thereafter
23 as determined by the Commission in a manner consistent with
24 the provisions of this paragraph.

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

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

6 (5) Implants shall be reimbursed at 25% above the net
7 manufacturer's invoice price less rebates, plus actual
8 reasonable and customary shipping charges whether or not
9 the implant charge is submitted by a provider in
10 conjunction with a bill for all other services associated
11 with the implant, submitted by a provider on a separate
12 claim form, submitted by a distributor, or submitted by the
13 manufacturer of the implant. "Implants" include the
14 following codes or any substantially similar updated code
15 as determined by the Commission: 0274
16 (prosthetics/orthotics); 0275 (pacemaker); 0276 (lens
17 implant); 0278 (implants); 0540 and 0545 (ambulance); 0624
18 (investigational devices); and 0636 (drugs requiring
19 detailed coding). Non-implantable devices or supplies
20 within these codes shall be reimbursed at 65% of actual
21 charge, which is the provider's normal rates under its
22 standard chagemaster. A standard chagemaster is the
23 provider's list of charges for procedures, treatments,
24 products, supplies, or services used to bill payers in a
25 consistent manner.

26 (6) The Commission shall automatically update all

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

3 (a-2) For procedures, treatments, services, or supplies
4 covered under this Act and rendered or to be rendered on or
5 after September 1, 2011, the maximum allowable payment shall be
6 70% of the fee schedule amounts, which shall be adjusted yearly
7 by the Consumer Price Index-U, as described in subsection (a)
8 of this Section.

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

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

23 (c) The Commission shall establish by rule a process to
24 review those medical cases or outliers that involve
25 extra-ordinary treatment to determine whether to make an
26 additional adjustment to the maximum payment within a fee

1 schedule for a procedure, treatment, or service.

2 (d) Upon receipt of notice of injury, an employer or its
3 designee shall provide to an injured worker or an injured
4 worker's medical provider a mailing address and an electronic
5 mail address to which medical bills should be sent.

6 A medical provider shall submit its bill to the employer or
7 insurer within 90 days of providing services to the injured
8 worker.

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

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

25 (2) If the claim does not contain substantially all the
26 required data elements necessary to adjudicate the bill, or

1 the claim is denied for any other reason, in whole or in
2 part, the employer or insurer shall send ~~provide~~ written
3 notification to the provider in the form of an explanation
4 of benefits, explaining the basis for the denial and
5 describing any additional necessary data elements, ~~to the~~
6 ~~provider~~ within 30 days of receipt of the bill. The
7 Commission shall adopt rules detailing the requirements
8 for the explanation of benefits required under this
9 subsection.

10 (3) In the case of: (i) nonpayment to a provider within
11 30 days of receipt of an electronic bill for which the
12 employer is liable and that contained substantially all of
13 the required data elements necessary to adjudicate the
14 bill, (ii) nonpayment to a provider of a portion of such a
15 bill as noted in item (i), or (iii) nonissuance to the
16 provider of an explanation of benefits for such a bill, the
17 bill, or the unpaid portion of the bill up to the lesser of
18 the actual charge, the contracted amount, or the payment
19 level set by the Commission in the fee scheduled
20 established in this Section, shall incur interest: (A) from
21 the date of determination of liability where there exists a
22 reasonable dispute as to liability for the expense, at a
23 rate of 1% per month, or (B) after 30 days of receipt of
24 the claim, where there is no dispute as to liability or
25 there is an unreasonable or vexatious dispute as to
26 liability for the expense, at a rate of 1% per month

1 payable by the employer, where self-insured, or its insurer
2 to the provider.

3 (4) In the case of: (i) nonpayment to a provider within
4 60 days of receipt of a nonelectronic bill for which the
5 employer is liable and that contained substantially all of
6 the required data elements necessary to adjudicate the
7 bill, (ii) nonpayment to a provider of a portion of such a
8 bill as noted in item (i), or (iii) nonissuance to the
9 provider of an explanation of benefits for a such a bill
10 the unpaid portion of the bill up to the lesser of the
11 actual charge, the contracted amount or the payment level
12 set by the Commission in the fee scheduled established in
13 this Section, shall incur interest, from the date of
14 determination of liability where there exists a dispute as
15 to liability for the expense, at a rate of 1% per month
16 payable by the employer, where self-insured, or its insurer
17 to the provider. Any required interest payments shall be
18 made by the employer or its insurer to the provider not
19 later than 30 days after payment of the bill.

20 (5) A medical provider may file a petition with the
21 Commission if interest has not been paid on undisputed
22 medical bills. Within 30 days of receipt of the petition,
23 the employer or its designee may file a response to the
24 petition. The Commission within 180 days shall determine if
25 interest is owed on the bills and if interest is owed, the
26 Commission will order the interest paid to the provider as

1 part of its decision.

2 The changes made to this subsection (d) by this amendatory
3 Act of the 100th General Assembly apply to procedures,
4 treatments, and services rendered on and after the effective
5 date of this amendatory Act of the 100th General Assembly. In
6 ~~the case of nonpayment to a provider within 30 days of receipt~~
7 ~~of the bill which contained substantially all of the required~~
8 ~~data elements necessary to adjudicate the bill or nonpayment to~~
9 ~~a provider of a portion of such a bill up to the lesser of the~~
10 ~~actual charge or the payment level set by the Commission in the~~
11 ~~fee schedule established in this Section, the bill, or portion~~
12 ~~of the bill, shall incur interest at a rate of 1% per month~~
13 ~~payable to the provider. Any required interest payments shall~~
14 ~~be made within 30 days after payment.~~

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

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

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

21 (e-10) If an employer notifies a provider that the employer
22 will pay only a portion of a bill for any procedure, treatment,
23 or service rendered in connection with a compensable illness or
24 disease, the provider may seek payment from the employee for
25 the remainder of the amount of the bill up to the lesser of the
26 actual charge, negotiated rate, if applicable, or the payment

1 level set by the Commission in the fee schedule established in
2 this Section. Once an employee informs the provider that there
3 is an application filed with the Commission to resolve a
4 dispute over payment of such charges, the provider shall cease
5 any and all efforts to collect payment for the services that
6 are the subject of the dispute. Any statute of limitations or
7 statute of repose applicable to the provider's efforts to
8 collect payment from the employee shall be tolled from the date
9 that the employee files the application with the Commission
10 until the date that the provider is permitted to resume
11 collection efforts under the provisions of this Section.

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

1 the information requested within 90 days of the date of the
2 reminder, the provider is entitled to resume any and all
3 efforts to collect payment from the employee for the services
4 rendered to the employee and the employee shall be responsible
5 for payment of any outstanding bills for a procedure,
6 treatment, or service rendered by a provider.

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

25 (f) Nothing in this Act shall prohibit an employer or
26 insurer from contracting with a health care provider or group

1 of health care providers for reimbursement levels for benefits
2 under this Act different from those provided in this Section.

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

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

9 (820 ILCS 305/8.2a)

10 Sec. 8.2a. Electronic claims.

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

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

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

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

21 (4) Ensure that health care providers have an
22 opportunity to comply with requests for records by
23 employers and insurers for the authorization of the payment
24 of workers' compensation claims.

25 (5) Provide that the Department of Insurance shall

1 impose an administrative fine if it determines that an
2 employer or insurer has intentionally failed to comply or
3 demonstrates a repeated pattern of failing to comply with
4 the electronic claims acceptance and response process. The
5 amount of the administrative fine shall be no greater than
6 \$500 per violation but shall not exceed \$10,000 for
7 violations found or determined during a calendar year.

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

13 (c) The rules requiring employers and insurers to accept
14 electronic claims for payment of medical services shall be
15 proposed on or before January 1, 2012, and shall require all
16 employers and insurers to accept electronic claims for payment
17 of medical services on or before June 30, 2012. The Director of
18 Insurance shall adopt rules by January 1, 2019 to implement the
19 changes to this Section made by this amendatory Act of this
20 100th General Assembly. The Commission, with assistance from
21 the Department, shall publish on its Internet website a
22 companion guide to assist with compliance with electronic
23 claims rules. The Medical Fee Advisory Board shall periodically
24 review the companion guide.

25 (d) The Director of Insurance shall by rule establish
26 criteria for granting exceptions to employers, insurance

1 carriers, and health care providers who are unable to submit or
2 accept medical bills electronically.

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

4 (820 ILCS 305/8.7)

5 Sec. 8.7. Utilization review programs.

6 (a) As used in this Section:

7 "Utilization review" means the evaluation of proposed or
8 provided health care services to determine the appropriateness
9 of both the level of health care services medically necessary
10 and the quality of health care services provided to a patient,
11 including evaluation of their efficiency, efficacy, and
12 appropriateness of treatment, hospitalization, or office
13 visits based on medically accepted standards. The evaluation
14 must be accomplished by means of a system that identifies the
15 utilization of health care services based on standards of care
16 of nationally recognized peer review guidelines as well as
17 nationally recognized treatment guidelines and evidence-based
18 medicine based upon standards as provided in this Act.
19 Utilization techniques may include prospective review, second
20 opinions, concurrent review, discharge planning, peer review,
21 independent medical examinations, and retrospective review
22 (for purposes of this sentence, retrospective review shall be
23 applicable to services rendered on or after July 20, 2005).
24 Nothing in this Section applies to prospective review of
25 necessary first aid or emergency treatment.

1 (b) No person may conduct a utilization review program for
2 workers' compensation services in this State unless once every
3 2 years the person registers the utilization review program
4 with the Department of Insurance and certifies compliance with
5 the Workers' Compensation Utilization Management standards or
6 Health Utilization Management Standards of URAC sufficient to
7 achieve URAC accreditation or submits evidence of
8 accreditation by URAC for its Workers' Compensation
9 Utilization Management Standards or Health Utilization
10 Management Standards. Nothing in this Act shall be construed to
11 require an employer or insurer or its subcontractors to become
12 URAC accredited.

13 (c) In addition, the Director of Insurance may certify
14 alternative utilization review standards of national
15 accreditation organizations or entities in order for plans to
16 comply with this Section. Any alternative utilization review
17 standards shall meet or exceed those standards required under
18 subsection (b).

19 (d) This registration shall include submission of all of
20 the following information regarding utilization review program
21 activities:

22 (1) The name, address, and telephone number of the
23 utilization review programs.

24 (2) The organization and governing structure of the
25 utilization review programs.

26 (3) The number of lives for which utilization review is

1 conducted by each utilization review program.

2 (4) Hours of operation of each utilization review
3 program.

4 (5) Description of the grievance process for each
5 utilization review program.

6 (6) Number of covered lives for which utilization
7 review was conducted for the previous calendar year for
8 each utilization review program.

9 (7) Written policies and procedures for protecting
10 confidential information according to applicable State and
11 federal laws for each utilization review program.

12 (e) A utilization review program shall have written
13 procedures to ensure that patient-specific information
14 obtained during the process of utilization review will be:

15 (1) kept confidential in accordance with applicable
16 State and federal laws; and

17 (2) shared only with the employee, the employee's
18 designee, and the employee's health care provider, and
19 those who are authorized by law to receive the information.
20 Summary data shall not be considered confidential if it
21 does not provide information to allow identification of
22 individual patients or health care providers.

23 Only a health care professional may make determinations
24 regarding the medical necessity of health care services during
25 the course of utilization review.

26 When making retrospective reviews, utilization review

1 programs shall base reviews solely on the medical information
2 available to the attending physician or ordering provider at
3 the time the health care services were provided.

4 (f) If the Department of Insurance finds that a utilization
5 review program is not in compliance with this Section, the
6 Department shall issue a corrective action plan and allow a
7 reasonable amount of time for compliance with the plan. If the
8 utilization review program does not come into compliance, the
9 Department may issue a cease and desist order. Before issuing a
10 cease and desist order under this Section, the Department shall
11 provide the utilization review program with a written notice of
12 the reasons for the order and allow a reasonable amount of time
13 to supply additional information demonstrating compliance with
14 the requirements of this Section and to request a hearing. The
15 hearing notice shall be sent by certified mail, return receipt
16 requested, and the hearing shall be conducted in accordance
17 with the Illinois Administrative Procedure Act.

18 (g) A utilization review program subject to a corrective
19 action may continue to conduct business until a final decision
20 has been issued by the Department.

21 (h) The Department of Insurance may by rule establish a
22 registration fee for each person conducting a utilization
23 review program.

24 (i) Upon receipt of written notice that the employer or the
25 employer's agent or insurer wishes to invoke the utilization
26 review process, the provider of medical, surgical, or hospital

1 services shall submit to the utilization review, following
2 accredited procedural guidelines.

3 (1) The provider shall make reasonable efforts to
4 provide timely and complete reports of clinical
5 information needed to support a request for treatment. If
6 the provider fails to make such reasonable efforts, the
7 charges for the treatment or service may not be compensable
8 nor collectible by the provider or claimant from the
9 employer, the employer's agent, or the employee. The
10 reporting obligations of providers shall not be
11 unreasonable or unduly burdensome.

12 (2) Written notice of utilization review decisions,
13 including the clinical rationale for certification or
14 non-certification and references to applicable standards
15 of care or evidence-based medical guidelines, shall be
16 furnished to the provider and employee.

17 (3) An employer may only deny payment of or refuse to
18 authorize payment of medical services rendered or proposed
19 to be rendered on the grounds that the extent and scope of
20 medical treatment is excessive and unnecessary in
21 compliance with an accredited utilization review program
22 under this Section.

23 (4) When a payment for medical services has been denied
24 or not authorized by an employer or when authorization for
25 medical services is denied pursuant to utilization review,
26 the employee has the burden of proof to show by a

1 preponderance of the evidence that a variance from the
2 standards of care used by the person or entity performing
3 the utilization review pursuant to subsection (a) is
4 reasonably required to cure or relieve the effects of his
5 or her injury.

6 (5) The medical professional responsible for review in
7 the final stage of utilization review or appeal must be
8 available in this State for interview or deposition; or
9 must be available for deposition by telephone, video
10 conference, or other remote electronic means. A medical
11 professional who works or resides in this State or outside
12 of this State may comply with this requirement by making
13 himself or herself available for an interview or deposition
14 in person or by making himself or herself available by
15 telephone, video conference, or other remote electronic
16 means. The remote interview or deposition shall be
17 conducted in a fair, open, and cost-effective manner. The
18 expense of interview and the deposition method shall be
19 paid by the employer. The deponent shall be in the presence
20 of the officer administering the oath and recording the
21 deposition, unless otherwise agreed by the parties. Any
22 exhibits or other demonstrative evidence to be presented to
23 the deponent by any party at the deposition shall be
24 provided to the officer administering the oath and all
25 other parties within a reasonable period of time prior to
26 the deposition. Nothing shall prohibit any party from being

1 with the deponent during the deposition, at that party's
2 expense; provided, however, that a party attending a
3 deposition shall give written notice of that party's
4 intention to appear at the deposition to all other parties
5 within a reasonable time prior to the deposition.

6 An admissible utilization review shall be considered by the
7 Commission, along with all other evidence and in the same
8 manner as all other evidence, and must be addressed along with
9 all other evidence in the determination of the reasonableness
10 and necessity of the medical bills or treatment. Nothing in
11 this Section shall be construed to diminish the rights of
12 employees to reasonable and necessary medical treatment or
13 employee choice of health care provider under Section 8(a) or
14 the rights of employers to medical examinations under Section
15 12.

16 (j) When an employer denies payment of or refuses to
17 authorize payment of first aid, medical, surgical, or hospital
18 services under Section 8(a) of this Act, if that denial or
19 refusal to authorize complies with a utilization review program
20 registered under this Section and complies with all other
21 requirements of this Section, then there shall be a rebuttable
22 presumption that the employer shall not be responsible for
23 payment of additional compensation pursuant to Section 19(k) of
24 this Act or interest penalties provided in Section 8.2 of this
25 Act and if that denial or refusal to authorize does not comply
26 with a utilization review program registered under this Section

1 and does not comply with all other requirements of this
2 Section, then that will be considered by the Commission, along
3 with all other evidence and in the same manner as all other
4 evidence, in the determination of whether the employer may be
5 responsible for the payment of additional compensation
6 pursuant to Section 19(k) of this Act or interest penalties
7 provided in Section 8.2 of this Act.

8 The changes to this Section made by this amendatory Act of
9 the 97th General Assembly apply only to health care services
10 provided or proposed to be provided on or after September 1,
11 2011.

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

13 (820 ILCS 305/19) (from Ch. 48, par. 138.19)

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

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

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

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

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

23 (b) The Arbitrator shall make such inquiries and
24 investigations as he or they shall deem necessary and may
25 examine and inspect all books, papers, records, places, or
26 premises relating to the questions in dispute and hear such

1 proper evidence as the parties may submit.

2 The hearings before the Arbitrator shall be held in the
3 vicinity where the injury occurred after 10 days' notice of the
4 time and place of such hearing shall have been given to each of
5 the parties or their attorneys of record.

6 The Arbitrator may find that the disabling condition is
7 temporary and has not yet reached a permanent condition and may
8 order the payment of compensation up to the date of the
9 hearing, which award shall be reviewable and enforceable in the
10 same manner as other awards, and in no instance be a bar to a
11 further hearing and determination of a further amount of
12 temporary total compensation or of compensation for permanent
13 disability, but shall be conclusive as to all other questions
14 except the nature and extent of said disability.

15 The decision of the Arbitrator shall be filed with the
16 Commission which Commission shall immediately send to each
17 party or his attorney a copy of such decision, together with a
18 notification of the time when it was filed. As of the effective
19 date of this amendatory Act of the 94th General Assembly, all
20 decisions of the Arbitrator shall set forth in writing findings
21 of fact and conclusions of law, separately stated, if requested
22 by either party. Unless a petition for review is filed by
23 either party within 30 days after the receipt by such party of
24 the copy of the decision and notification of time when filed,
25 and unless such party petitioning for a review shall within 35
26 days after the receipt by him of the copy of the decision, file

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

20 Whether the employee is working or not, if the employee is
21 not receiving or has not received medical, surgical, or
22 hospital services or other services or compensation as provided
23 in paragraph (a) of Section 8, or compensation as provided in
24 paragraph (b) of Section 8, the employee may at any time
25 petition for an expedited hearing by an Arbitrator on the issue
26 of whether or not he or she is entitled to receive payment of

1 the services or compensation. Provided the employer continues
2 to pay compensation pursuant to paragraph (b) of Section 8, the
3 employer may at any time petition for an expedited hearing on
4 the issue of whether or not the employee is entitled to receive
5 medical, surgical, or hospital services or other services or
6 compensation as provided in paragraph (a) of Section 8, or
7 compensation as provided in paragraph (b) of Section 8. When an
8 employer has petitioned for an expedited hearing, the employer
9 shall continue to pay compensation as provided in paragraph (b)
10 of Section 8 unless the arbitrator renders a decision that the
11 employee is not entitled to the benefits that are the subject
12 of the expedited hearing or unless the employee's treating
13 physician has released the employee to return to work at his or
14 her regular job with the employer or the employee actually
15 returns to work at any other job. If the arbitrator renders a
16 decision that the employee is not entitled to the benefits that
17 are the subject of the expedited hearing, a petition for review
18 filed by the employee shall receive the same priority as if the
19 employee had filed a petition for an expedited hearing by an
20 Arbitrator. Neither party shall be entitled to an expedited
21 hearing when the employee has returned to work and the sole
22 issue in dispute amounts to less than 12 weeks of unpaid
23 compensation pursuant to paragraph (b) of Section 8.

24 Expedited hearings shall have priority over all other
25 petitions and shall be heard by the Arbitrator and Commission
26 with all convenient speed. Any party requesting an expedited

1 hearing shall give notice of a request for an expedited hearing
2 under this paragraph. A copy of the Application for Adjustment
3 of Claim shall be attached to the notice. The Commission shall
4 adopt rules and procedures under which the final decision of
5 the Commission under this paragraph is filed not later than 180
6 days from the date that the Petition for Review is filed with
7 the Commission.

8 Where 2 or more insurance carriers, private self-insureds,
9 or a group workers' compensation pool under Article V 3/4 of
10 the Illinois Insurance Code dispute coverage for the same
11 injury, any such insurance carrier, private self-insured, or
12 group workers' compensation pool may request an expedited
13 hearing pursuant to this paragraph to determine the issue of
14 coverage, provided coverage is the only issue in dispute and
15 all other issues are stipulated and agreed to and further
16 provided that all compensation benefits including medical
17 benefits pursuant to Section 8(a) continue to be paid to or on
18 behalf of petitioner. Any insurance carrier, private
19 self-insured, or group workers' compensation pool that is
20 determined to be liable for coverage for the injury in issue
21 shall reimburse any insurance carrier, private self-insured,
22 or group workers' compensation pool that has paid benefits to
23 or on behalf of petitioner for the injury.

24 (b-1) If the employee is not receiving medical, surgical or
25 hospital services as provided in paragraph (a) of Section 8 or
26 compensation as provided in paragraph (b) of Section 8, the

1 employee, in accordance with Commission Rules, may file a
2 petition for an emergency hearing by an Arbitrator on the issue
3 of whether or not he is entitled to receive payment of such
4 compensation or services as provided therein. Such petition
5 shall have priority over all other petitions and shall be heard
6 by the Arbitrator and Commission with all convenient speed.

7 Such petition shall contain the following information and
8 shall be served on the employer at least 15 days before it is
9 filed:

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

11 (ii) the approximate location of the accident;

12 (iii) a description of the accident;

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

14 (v) the identity of the person, if known, to whom the
15 accident was reported and the date on which it was
16 reported;

17 (vi) the name and title of the person, if known,
18 representing the employer with whom the employee conferred
19 in any effort to obtain compensation pursuant to paragraph
20 (b) of Section 8 of this Act or medical, surgical or
21 hospital services pursuant to paragraph (a) of Section 8 of
22 this Act and the date of such conference;

23 (vii) a statement that the employer has refused to pay
24 compensation pursuant to paragraph (b) of Section 8 of this
25 Act or for medical, surgical or hospital services pursuant
26 to paragraph (a) of Section 8 of this Act;

1 (viii) the name and address, if known, of each witness
2 to the accident and of each other person upon whom the
3 employee will rely to support his allegations;

4 (ix) the dates of treatment related to the accident by
5 medical practitioners, and the names and addresses of such
6 practitioners, including the dates of treatment related to
7 the accident at any hospitals and the names and addresses
8 of such hospitals, and a signed authorization permitting
9 the employer to examine all medical records of all
10 practitioners and hospitals named pursuant to this
11 paragraph;

12 (x) a copy of a signed report by a medical
13 practitioner, relating to the employee's current inability
14 to return to work because of the injuries incurred as a
15 result of the accident or such other documents or
16 affidavits which show that the employee is entitled to
17 receive compensation pursuant to paragraph (b) of Section 8
18 of this Act or medical, surgical or hospital services
19 pursuant to paragraph (a) of Section 8 of this Act. Such
20 reports, documents or affidavits shall state, if possible,
21 the history of the accident given by the employee, and
22 describe the injury and medical diagnosis, the medical
23 services for such injury which the employee has received
24 and is receiving, the physical activities which the
25 employee cannot currently perform as a result of any
26 impairment or disability due to such injury, and the

1 prognosis for recovery;

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

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

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

13 Fifteen days after receipt by the employer of the petition
14 with the required information the employee may file said
15 petition and required information and shall serve notice of the
16 filing upon the employer. The employer may file a motion
17 addressed to the sufficiency of the petition. If an objection
18 has been filed to the sufficiency of the petition, the
19 arbitrator shall rule on the objection within 2 working days.
20 If such an objection is filed, the time for filing the final
21 decision of the Commission as provided in this paragraph shall
22 be tolled until the arbitrator has determined that the petition
23 is sufficient.

24 The employer shall, within 15 days after receipt of the
25 notice that such petition is filed, file with the Commission
26 and serve on the employee or his representative a written

1 response to each claim set forth in the petition, including the
2 legal and factual basis for each disputed allegation and the
3 following information: (i) complete copies of any reports,
4 records, documents and affidavits in the possession of the
5 employer on which the employer intends to rely in support of
6 his response, (ii) a list of any reports, records, documents
7 and affidavits which the employer has demanded by subpoena and
8 on which the employer intends to rely in support of his
9 response, (iii) the name and address of each witness on whom
10 the employer will rely to support his response, and (iv) the
11 names and addresses of any medical practitioners selected by
12 the employer pursuant to Section 12 of this Act and the time
13 and place of any examination scheduled to be made pursuant to
14 such Section.

15 Any employer who does not timely file and serve a written
16 response without good cause may not introduce any evidence to
17 dispute any claim of the employee but may cross examine the
18 employee or any witness brought by the employee and otherwise
19 be heard.

20 No document or other evidence not previously identified by
21 either party with the petition or written response, or by any
22 other means before the hearing, may be introduced into evidence
23 without good cause. If, at the hearing, material information is
24 discovered which was not previously disclosed, the Arbitrator
25 may extend the time for closing proof on the motion of a party
26 for a reasonable period of time which may be more than 30 days.

1 No evidence may be introduced pursuant to this paragraph as to
2 permanent disability. No award may be entered for permanent
3 disability pursuant to this paragraph. Either party may
4 introduce into evidence the testimony taken by deposition of
5 any medical practitioner.

6 The Commission shall adopt rules, regulations and
7 procedures whereby the final decision of the Commission is
8 filed not later than 90 days from the date the petition for
9 review is filed but in no event later than 180 days from the
10 date the petition for an emergency hearing is filed with the
11 Illinois Workers' Compensation Commission.

12 All service required pursuant to this paragraph (b-1) must
13 be by personal service or by certified mail and with evidence
14 of receipt. In addition for the purposes of this paragraph, all
15 service on the employer must be at the premises where the
16 accident occurred if the premises are owned or operated by the
17 employer. Otherwise service must be at the employee's principal
18 place of employment by the employer. If service on the employer
19 is not possible at either of the above, then service shall be
20 at the employer's principal place of business. After initial
21 service in each case, service shall be made on the employer's
22 attorney or designated representative.

23 (c) (1) At a reasonable time in advance of and in connection
24 with the hearing under Section 19(e) or 19(h), the Commission
25 may on its own motion order an impartial physical or mental
26 examination of a petitioner whose mental or physical condition

1 is in issue, when in the Commission's discretion it appears
2 that such an examination will materially aid in the just
3 determination of the case. The examination shall be made by a
4 member or members of a panel of physicians chosen for their
5 special qualifications by the Illinois State Medical Society.
6 The Commission shall establish procedures by which a physician
7 shall be selected from such list.

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

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

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

17 (5) The examination shall be made, and the physician or
18 physicians, if called, shall testify, without cost to the
19 parties. The Commission shall determine the compensation and
20 the pay of the physician or physicians. The compensation for
21 this service shall not exceed the usual and customary amount
22 for such service.

23 (6) The fees and payment thereof of all attorneys and
24 physicians for services authorized by the Commission under this
25 Act shall, upon request of either the employer or the employee
26 or the beneficiary affected, be subject to the review and

1 decision of the Commission.

2 (d) If any employee shall persist in insanitary or
3 injurious practices which tend to either imperil or retard his
4 recovery or shall refuse to submit to such medical, surgical,
5 or hospital treatment as is reasonably essential to promote his
6 recovery, the Commission may, in its discretion, reduce or
7 suspend the compensation of any such injured employee. However,
8 when an employer and employee so agree in writing, the
9 foregoing provision shall not be construed to authorize the
10 reduction or suspension of compensation of an employee who is
11 relying in good faith, on treatment by prayer or spiritual
12 means alone, in accordance with the tenets and practice of a
13 recognized church or religious denomination, by a duly
14 accredited practitioner thereof.

15 (e) This paragraph shall apply to all hearings before the
16 Commission. Such hearings may be held in its office or
17 elsewhere as the Commission may deem advisable. The taking of
18 testimony on such hearings may be had before any member of the
19 Commission. If a petition for review and agreed statement of
20 facts or transcript of evidence is filed, as provided herein,
21 the Commission shall promptly review the decision of the
22 Arbitrator and all questions of law or fact which appear from
23 the statement of facts or transcript of evidence.

24 In all cases in which the hearing before the arbitrator is
25 held after December 18, 1989, no additional evidence shall be
26 introduced by the parties before the Commission on review of

1 the decision of the Arbitrator. In reviewing decisions of an
2 arbitrator the Commission shall award such temporary
3 compensation, permanent compensation and other payments as are
4 due under this Act. The Commission shall file in its office its
5 decision thereon, and shall immediately send to each party or
6 his attorney a copy of such decision and a notification of the
7 time when it was filed. Decisions shall be filed within 60 days
8 after the Statement of Exceptions and Supporting Brief and
9 Response thereto are required to be filed or oral argument
10 whichever is later.

11 In the event either party requests oral argument, such
12 argument shall be had before a panel of 3 members of the
13 Commission (or before all available members pursuant to the
14 determination of 7 members of the Commission that such argument
15 be held before all available members of the Commission)
16 pursuant to the rules and regulations of the Commission. A
17 panel of 3 members, which shall be comprised of not more than
18 one representative citizen of the employing class and not more
19 than one representative citizen of the employee class, shall
20 hear the argument; provided that if all the issues in dispute
21 are solely the nature and extent of the permanent partial
22 disability, if any, a majority of the panel may deny the
23 request for such argument and such argument shall not be held;
24 and provided further that 7 members of the Commission may
25 determine that the argument be held before all available
26 members of the Commission. A decision of the Commission shall

1 be approved by a majority of Commissioners present at such
2 hearing if any; provided, if no such hearing is held, a
3 decision of the Commission shall be approved by a majority of a
4 panel of 3 members of the Commission as described in this
5 Section. The Commission shall give 10 days' notice to the
6 parties or their attorneys of the time and place of such taking
7 of testimony and of such argument.

8 In any case the Commission in its decision may find
9 specially upon any question or questions of law or fact which
10 shall be submitted in writing by either party whether ultimate
11 or otherwise; provided that on issues other than nature and
12 extent of the disability, if any, the Commission in its
13 decision shall find specially upon any question or questions of
14 law or fact, whether ultimate or otherwise, which are submitted
15 in writing by either party; provided further that not more than
16 5 such questions may be submitted by either party. Any party
17 may, within 20 days after receipt of notice of the Commission's
18 decision, or within such further time, not exceeding 30 days,
19 as the Commission may grant, file with the Commission either an
20 agreed statement of the facts appearing upon the hearing, or,
21 if such party shall so elect, a correct transcript of evidence
22 of the additional proceedings presented before the Commission,
23 in which report the party may embody a correct statement of
24 such other proceedings in the case as such party may desire to
25 have reviewed, such statement of facts or transcript of
26 evidence to be authenticated by the signature of the parties or

1 their attorneys, and in the event that they do not agree, then
2 the authentication of such transcript of evidence shall be by
3 the signature of any member of the Commission.

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

17 At the request of either party or on its own motion, the
18 Commission shall set forth in writing the reasons for the
19 decision, including findings of fact and conclusions of law
20 separately stated. The Commission shall by rule adopt a format
21 for written decisions for the Commission and arbitrators. The
22 written decisions shall be concise and shall succinctly state
23 the facts and reasons for the decision. The Commission may
24 adopt in whole or in part, the decision of the arbitrator as
25 the decision of the Commission. When the Commission does so
26 adopt the decision of the arbitrator, it shall do so by order.

1 Whenever the Commission adopts part of the arbitrator's
2 decision, but not all, it shall include in the order the
3 reasons for not adopting all of the arbitrator's decision. When
4 a majority of a panel, after deliberation, has arrived at its
5 decision, the decision shall be filed as provided in this
6 Section without unnecessary delay, and without regard to the
7 fact that a member of the panel has expressed an intention to
8 dissent. Any member of the panel may file a dissent. Any
9 dissent shall be filed no later than 10 days after the decision
10 of the majority has been filed.

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

16 (f) The decision of the Commission acting within its
17 powers, according to the provisions of paragraph (e) of this
18 Section shall, in the absence of fraud, be conclusive unless
19 reviewed as in this paragraph hereinafter provided. However,
20 the Arbitrator or the Commission may on his or its own motion,
21 or on the motion of either party, correct any clerical error or
22 errors in computation within 15 days after the date of receipt
23 of any award by such Arbitrator or any decision on review of
24 the Commission and shall have the power to recall the original
25 award on arbitration or decision on review, and issue in lieu
26 thereof such corrected award or decision. Where such correction

1 is made the time for review herein specified shall begin to run
2 from the date of the receipt of the corrected award or
3 decision.

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

14 A proceeding for review shall be commenced within 20
15 days of the receipt of notice of the decision of the
16 Commission. The summons shall be issued by the clerk of
17 such court upon written request returnable on a designated
18 return day, not less than 10 or more than 60 days from the
19 date of issuance thereof, and the written request shall
20 contain the last known address of other parties in interest
21 and their attorneys of record who are to be served by
22 summons. Service upon any member of the Commission or the
23 Secretary or the Assistant Secretary thereof shall be
24 service upon the Commission, and service upon other parties
25 in interest and their attorneys of record shall be by
26 summons, and such service shall be made upon the Commission

1 and other parties in interest by mailing notices of the
2 commencement of the proceedings and the return day of the
3 summons to the office of the Commission and to the last
4 known place of residence of other parties in interest or
5 their attorney or attorneys of record. The clerk of the
6 court issuing the summons shall on the day of issue mail
7 notice of the commencement of the proceedings which shall
8 be done by mailing a copy of the summons to the office of
9 the Commission, and a copy of the summons to the other
10 parties in interest or their attorney or attorneys of
11 record and the clerk of the court shall make certificate
12 that he has so sent said notices in pursuance of this
13 Section, which shall be evidence of service on the
14 Commission and other parties in interest.

15 The Commission shall not be required to certify the
16 record of their proceedings to the Circuit Court, unless
17 the party commencing the proceedings for review in the
18 Circuit Court as above provided, shall file with the
19 Commission notice of intent to file for review in Circuit
20 Court. It shall be the duty of the Commission upon such
21 filing of notice of intent to file for review in the
22 Circuit Court to prepare a true and correct copy of such
23 testimony and a true and correct copy of all other matters
24 contained in such record and certified to by the Secretary
25 or Assistant Secretary thereof. The changes made to this
26 subdivision (f)(1) by this amendatory Act of the 98th

1 General Assembly apply to any Commission decision entered
2 after the effective date of this amendatory Act of the 98th
3 General Assembly.

4 No request for a summons may be filed and no summons
5 shall issue unless the party seeking to review the decision
6 of the Commission shall exhibit to the clerk of the Circuit
7 Court proof of filing with the Commission of the notice of
8 the intent to file for review in the Circuit Court or an
9 affidavit of the attorney setting forth that notice of
10 intent to file for review in the Circuit Court has been
11 given in writing to the Secretary or Assistant Secretary of
12 the Commission.

13 (2) No such summons shall issue unless the one against
14 whom the Commission shall have rendered an award for the
15 payment of money shall upon the filing of his written
16 request for such summons file with the clerk of the court a
17 bond conditioned that if he shall not successfully
18 prosecute the review, he will pay the award and the costs
19 of the proceedings in the courts. The amount of the bond
20 shall be fixed by any member of the Commission and the
21 surety or sureties of the bond shall be approved by the
22 clerk of the court. The acceptance of the bond by the clerk
23 of the court shall constitute evidence of his approval of
24 the bond.

25 Every county, city, town, township, incorporated
26 village, school district, body politic or municipal

1 corporation against whom the Commission shall have
2 rendered an award for the payment of money shall not be
3 required to file a bond to secure the payment of the award
4 and the costs of the proceedings in the court to authorize
5 the court to issue such summons.

6 The court may confirm or set aside the decision of the
7 Commission. If the decision is set aside and the facts
8 found in the proceedings before the Commission are
9 sufficient, the court may enter such decision as is
10 justified by law, or may remand the cause to the Commission
11 for further proceedings and may state the questions
12 requiring further hearing, and give such other
13 instructions as may be proper. Appeals shall be taken to
14 the Appellate Court in accordance with Supreme Court Rules
15 22(g) and 303. Appeals shall be taken from the Appellate
16 Court to the Supreme Court in accordance with Supreme Court
17 Rule 315.

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

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

25 (g) Except in the case of a claim against the State of
26 Illinois, or a medical provider receiving an award of interest

1 under Section 8.2, either party may present a certified copy of
2 the award of the Arbitrator, or a certified copy of the
3 decision of the Commission when the same has become final, when
4 no proceedings for review are pending, providing for the
5 payment of compensation according to this Act, to the Circuit
6 Court of the county in which such accident occurred or either
7 of the parties are residents, whereupon the court shall enter a
8 judgment in accordance therewith. In a case where the employer
9 refuses to pay compensation according to such final award or
10 such final decision upon which such judgment is entered the
11 court shall in entering judgment thereon, tax as costs against
12 him the reasonable costs and attorney fees in the arbitration
13 proceedings and in the court entering the judgment for the
14 person in whose favor the judgment is entered, which judgment
15 and costs taxed as therein provided shall, until and unless set
16 aside, have the same effect as though duly entered in an action
17 duly tried and determined by the court, and shall with like
18 effect, be entered and docketed. The Circuit Court shall have
19 power at any time upon application to make any such judgment
20 conform to any modification required by any subsequent decision
21 of the Supreme Court upon appeal, or as the result of any
22 subsequent proceedings for review, as provided in this Act.

23 Judgment shall not be entered until 15 days' notice of the
24 time and place of the application for the entry of judgment
25 shall be served upon the employer by filing such notice with
26 the Commission, which Commission shall, in case it has on file

1 the address of the employer or the name and address of its
2 agent upon whom notices may be served, immediately send a copy
3 of the notice to the employer or such designated agent.

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

10 However, as to accidents occurring subsequent to July 1,
11 1955, which are covered by any agreement or award under this
12 Act providing for compensation in installments made as a result
13 of such accident, such agreement or award may at any time
14 within 30 months, or 60 months in the case of an award under
15 Section 8(d)1, after such agreement or award be reviewed by the
16 Commission at the request of either the employer or the
17 employee on the ground that the disability of the employee has
18 subsequently recurred, increased, diminished or ended.

19 On such review, compensation payments may be
20 re-established, increased, diminished or ended. The Commission
21 shall give 15 days' notice to the parties of the hearing for
22 review. Any employee, upon any petition for such review being
23 filed by the employer, shall be entitled to one day's notice
24 for each 100 miles necessary to be traveled by him in attending
25 the hearing of the Commission upon the petition, and 3 days in
26 addition thereto. Such employee shall, at the discretion of the

1 Commission, also be entitled to 5 cents per mile necessarily
2 traveled by him within the State of Illinois in attending such
3 hearing, not to exceed a distance of 300 miles, to be taxed by
4 the Commission as costs and deposited with the petition of the
5 employer.

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

10 (i) Each party, upon taking any proceedings or steps
11 whatsoever before any Arbitrator, Commission or court, shall
12 file with the Commission his address, or the name and address
13 of any agent upon whom all notices to be given to such party
14 shall be served, either personally or by registered mail,
15 addressed to such party or agent at the last address so filed
16 with the Commission. In the event such party has not filed his
17 address, or the name and address of an agent as above provided,
18 service of any notice may be had by filing such notice with the
19 Commission.

20 (j) Whenever in any proceeding testimony has been taken or
21 a final decision has been rendered and after the taking of such
22 testimony or after such decision has become final, the injured
23 employee dies, then in any subsequent proceedings brought by
24 the personal representative or beneficiaries of the deceased
25 employee, such testimony in the former proceeding may be
26 introduced with the same force and effect as though the witness

1 having so testified were present in person in such subsequent
2 proceedings and such final decision, if any, shall be taken as
3 final adjudication of any of the issues which are the same in
4 both proceedings.

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

15 When determining whether this subsection (k) shall apply,
16 the Commission shall consider whether an Arbitrator has
17 determined that the claim is not compensable or whether the
18 employer has made payments under Section 8(j).

19 (l) If the employee has made written demand for payment of
20 benefits under Section 8(a) or Section 8(b), the employer shall
21 have 14 days after receipt of the demand to set forth in
22 writing the reason for the delay. In the case of demand for
23 payment of medical benefits under Section 8(a), the time for
24 the employer to respond shall not commence until the expiration
25 of the allotted 30 days specified under Section 8.2(d). In case
26 the employer or his or her insurance carrier shall without good

1 and just cause fail, neglect, refuse, or unreasonably delay the
2 payment of benefits under Section 8(a) or Section 8(b), the
3 Arbitrator or the Commission shall allow to the employee
4 additional compensation in the sum of \$30 per day for each day
5 that the benefits under Section 8(a) or Section 8(b) have been
6 so withheld or refused, not to exceed \$10,000. A delay in
7 payment of 14 days or more shall create a rebuttable
8 presumption of unreasonable delay.

9 (m) If the commission finds that an accidental injury was
10 directly and proximately caused by the employer's wilful
11 violation of a health and safety standard under the Health and
12 Safety Act or the Occupational Safety and Health Act in force
13 at the time of the accident, the arbitrator or the Commission
14 shall allow to the injured employee or his dependents, as the
15 case may be, additional compensation equal to 25% of the amount
16 which otherwise would be payable under the provisions of this
17 Act exclusive of this paragraph. The additional compensation
18 herein provided shall be allowed by an appropriate increase in
19 the applicable weekly compensation rate.

20 (n) After June 30, 1984, decisions of the Illinois Workers'
21 Compensation Commission reviewing an award of an arbitrator of
22 the Commission shall draw interest at a rate equal to the yield
23 on indebtedness issued by the United States Government with a
24 26-week maturity next previously auctioned on the day on which
25 the decision is filed. Said rate of interest shall be set forth
26 in the Arbitrator's Decision. Interest shall be drawn from the

1 date of the arbitrator's award on all accrued compensation due
2 the employee through the day prior to the date of payments.
3 However, when an employee appeals an award of an Arbitrator or
4 the Commission, and the appeal results in no change or a
5 decrease in the award, interest shall not further accrue from
6 the date of such appeal.

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

12 (o) By the 15th day of each month each insurer providing
13 coverage for losses under this Act shall notify each insured
14 employer of any compensable claim incurred during the preceding
15 month and the amounts paid or reserved on the claim including a
16 summary of the claim and a brief statement of the reasons for
17 compensability. A cumulative report of all claims incurred
18 during a calendar year or continued from the previous year
19 shall be furnished to the insured employer by the insurer
20 within 30 days after the end of that calendar year.

21 The insured employer may challenge, in proceeding before
22 the Commission, payments made by the insurer without
23 arbitration and payments made after a case is determined to be
24 noncompensable. If the Commission finds that the case was not
25 compensable, the insurer shall purge its records as to that
26 employer of any loss or expense associated with the claim,

1 reimburse the employer for attorneys' fees arising from the
2 challenge and for any payment required of the employer to the
3 Rate Adjustment Fund or the Second Injury Fund, and may not
4 reflect the loss or expense for rate making purposes. The
5 employee shall not be required to refund the challenged
6 payment. The decision of the Commission may be reviewed in the
7 same manner as in arbitrated cases. No challenge may be
8 initiated under this paragraph more than 3 years after the
9 payment is made. An employer may waive the right of challenge
10 under this paragraph on a case by case basis.

11 (p) After filing an application for adjustment of claim but
12 prior to the hearing on arbitration the parties may voluntarily
13 agree to submit such application for adjustment of claim for
14 decision by an arbitrator under this subsection (p) where such
15 application for adjustment of claim raises only a dispute over
16 temporary total disability, permanent partial disability or
17 medical expenses. Such agreement shall be in writing in such
18 form as provided by the Commission. Applications for adjustment
19 of claim submitted for decision by an arbitrator under this
20 subsection (p) shall proceed according to rule as established
21 by the Commission. The Commission shall promulgate rules
22 including, but not limited to, rules to ensure that the parties
23 are adequately informed of their rights under this subsection
24 (p) and of the voluntary nature of proceedings under this
25 subsection (p). The findings of fact made by an arbitrator
26 acting within his or her powers under this subsection (p) in

1 the absence of fraud shall be conclusive. However, the
2 arbitrator may on his own motion, or the motion of either
3 party, correct any clerical errors or errors in computation
4 within 15 days after the date of receipt of such award of the
5 arbitrator and shall have the power to recall the original
6 award on arbitration, and issue in lieu thereof such corrected
7 award. The decision of the arbitrator under this subsection (p)
8 shall be considered the decision of the Commission and
9 proceedings for review of questions of law arising from the
10 decision may be commenced by either party pursuant to
11 subsection (f) of Section 19. The Advisory Board established
12 under Section 13.1 shall compile a list of certified Commission
13 arbitrators, each of whom shall be approved by at least 7
14 members of the Advisory Board. The chairman shall select 5
15 persons from such list to serve as arbitrators under this
16 subsection (p). By agreement, the parties shall select one
17 arbitrator from among the 5 persons selected by the chairman
18 except that if the parties do not agree on an arbitrator from
19 among the 5 persons, the parties may, by agreement, select an
20 arbitrator of the American Arbitration Association, whose fee
21 shall be paid by the State in accordance with rules promulgated
22 by the Commission. Arbitration under this subsection (p) shall
23 be voluntary.

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

26 Section 99. Effective date. This Act takes effect upon

1 becoming law.