



## 100TH GENERAL ASSEMBLY

### State of Illinois

2017 and 2018

HB2892

by Rep. Barbara Wheeler

#### SYNOPSIS AS INTRODUCED:

820 ILCS 305/8.2

Amends the Workers' Compensation Act. Provides that no medical provider shall be reimbursed for a supply of prescriptions filled outside of a licensed pharmacy except when there exists no licensed pharmacy within 5 miles of the prescribing physician's practice. Provides that, if there exists no licensed pharmacy within 5 miles of the prescribing physician's practice, no medical provider shall be reimbursed for a prescription, the supply of which lasts for longer than 72 hours from the date of injury or 24 hours from the date of first referral to the medical service provider, whichever is greater, filled and dispensed outside of a licensed pharmacy. Provides that the limitations on filling and dispensing prescriptions do not apply if there exists a pre-arranged agreement between the medical provider and a preferred provider program regarding the filling of prescriptions outside a licensed pharmacy.

LRB100 08478 JLS 18597 b

FISCAL NOTE ACT  
MAY APPLY

A BILL FOR

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 Section 8.2 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 chargemaster. A standard chargemaster 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 (a-4) No medical provider shall be reimbursed under this  
16 Act for a supply of prescriptions filled and dispensed outside  
17 of a licensed pharmacy except where there exists no licensed  
18 pharmacy within 5 miles of the prescribing physician's  
19 practice.

20 Where there exists no licensed pharmacy within 5 miles of  
21 the prescribing physician's practice, no medical provider  
22 shall be reimbursed under this Act for a prescription filled  
23 and dispensed outside of a licensed pharmacy the supply of  
24 which lasts for longer than 72 hours from the date of the  
25 injury or 24 hours from the date of first referral to the  
26 medical service provider, whichever is greater.



1       This limitation on filling and dispensing prescriptions  
2       shall not apply where there exists a pre-arranged agreement  
3       regarding the filling and dispensing of prescriptions outside a  
4       licensed pharmacy between the medical provider and a preferred  
5       provider program pursuant to Section 8.1a on the date that the  
6       employee sustained his or her injuries.

7       (b) Notwithstanding the provisions of subsection (a), if  
8       the Commission finds that there is a significant limitation on  
9       access to quality health care in either a specific field of  
10      health care services or a specific geographic limitation on  
11      access to health care, it may change the Consumer Price Index-U  
12      increase or decrease for that specific field or specific  
13      geographic limitation on access to health care to address that  
14      limitation.

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

20      (d) When a patient notifies a provider that the treatment,  
21      procedure, or service being sought is for a work-related  
22      illness or injury and furnishes the provider the name and  
23      address of the responsible employer, the provider shall bill  
24      the employer directly. The employer shall make payment and  
25      providers shall submit bills and records in accordance with the  
26      provisions of this Section.

1           (1) All payments to providers for treatment provided  
2 pursuant to this Act shall be made within 30 days of  
3 receipt of the bills as long as the claim contains  
4 substantially all the required data elements necessary to  
5 adjudicate the bills.

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

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

23           (e) Except as provided in subsections (e-5), (e-10), and  
24 (e-15), a provider shall not hold an employee liable for costs  
25 related to a non-disputed procedure, treatment, or service  
26 rendered in connection with a compensable injury. The

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

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

1 until the date that the provider is permitted to resume  
2 collection efforts under the provisions of this Section.

3 (e-10) If an employer notifies a provider that the employer  
4 will pay only a portion of a bill for any procedure, treatment,  
5 or service rendered in connection with a compensable illness or  
6 disease, the provider may seek payment from the employee for  
7 the remainder of the amount of the bill up to the lesser of the  
8 actual charge, negotiated rate, if applicable, or the payment  
9 level set by the Commission in the fee schedule established in  
10 this Section. Once an employee informs the provider that there  
11 is an application filed with the Commission to resolve a  
12 dispute over payment of such charges, the provider shall cease  
13 any and all efforts to collect payment for the services that  
14 are the subject of the dispute. Any statute of limitations or  
15 statute of repose applicable to the provider's efforts to  
16 collect payment from the employee shall be tolled from the date  
17 that the employee files the application with the Commission  
18 until the date that the provider is permitted to resume  
19 collection efforts under the provisions of this Section.

20 (e-15) When there is a dispute over the compensability of  
21 or amount of payment for a procedure, treatment, or service,  
22 and a case is pending or proceeding before an Arbitrator or the  
23 Commission, the provider may mail the employee reminders that  
24 the employee will be responsible for payment of any procedure,  
25 treatment or service rendered by the provider. The reminders  
26 must state that they are not bills, to the extent practicable

1 include itemized information, and state that the employee need  
2 not pay until such time as the provider is permitted to resume  
3 collection efforts under this Section. The reminders shall not  
4 be provided to any credit rating agency. The reminders may  
5 request that the employee furnish the provider with information  
6 about the proceeding under this Act, such as the file number,  
7 names of parties, and status of the case. If an employee fails  
8 to respond to such request for information or fails to furnish  
9 the information requested within 90 days of the date of the  
10 reminder, the provider is entitled to resume any and all  
11 efforts to collect payment from the employee for the services  
12 rendered to the employee and the employee shall be responsible  
13 for payment of any outstanding bills for a procedure,  
14 treatment, or service rendered by a provider.

15 (e-20) Upon a final award or judgment by an Arbitrator or  
16 the Commission, or a settlement agreed to by the employer and  
17 the employee, a provider may resume any and all efforts to  
18 collect payment from the employee for the services rendered to  
19 the employee and the employee shall be responsible for payment  
20 of any outstanding bills for a procedure, treatment, or service  
21 rendered by a provider as well as the interest awarded under  
22 subsection (d) of this Section. In the case of a procedure,  
23 treatment, or service deemed compensable, the provider shall  
24 not require a payment rate, excluding the interest provisions  
25 under subsection (d), greater than the lesser of the actual  
26 charge or the payment level set by the Commission in the fee

1 schedule established in this Section. Payment for services  
2 deemed not covered or not compensable under this Act is the  
3 responsibility of the employee unless a provider and employee  
4 have agreed otherwise in writing. Services not covered or not  
5 compensable under this Act are not subject to the fee schedule  
6 in this Section.

7 (f) Nothing in this Act shall prohibit an employer or  
8 insurer from contracting with a health care provider or group  
9 of health care providers for reimbursement levels for benefits  
10 under this Act different from those provided in this Section.

11 (g) On or before January 1, 2010 the Commission shall  
12 provide to the Governor and General Assembly a report regarding  
13 the implementation of the medical fee schedule and the index  
14 used for annual adjustment to that schedule as described in  
15 this Section.

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