Sen. Christine Radogno

Filed: 3/1/2017

AMENDMENT TO SENATE BILL 12

AMENDMENT NO. _____. Amend Senate Bill 12 on page 10, line 23, by deleting "1,"; and

on page 10, line 23, by deleting "8.7,"; and

on page 10, line 24, by changing "14.3" to "29.3"; and

by deleting all of pages 11 through 18; and

on page 19, by deleting lines 1 through 15; and

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

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

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

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

on page 45, line 22, by inserting immediately following the period the following:
"For purposes of this subdivision (e)17 only, "same part of the spine" means: (1) cervical spine and thoracic spine from vertebra C1 through T12 and (2) lumbar and sacral spine and coccyx from vertebra L1 through S5."; and

on page 46, by replacing lines 6 through 21 with the following: "members, and in a subsequent independent accident loses another or suffers the permanent and complete loss of the use of any one of such members the employer for whom the injured employee is working at the time of the last independent accident is liable to pay compensation only for the loss or permanent and complete loss of the use of the member occasioned

by the last independent accident."; and

by replacing lines 15 through 25 of page 57 and lines 1 through 22 of page 58 with the following:

"(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment. A report under this subsection may be waived by joint written agreement of the parties.

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

In determining the level of permanent partial disability, the Commission shall base its determination on the reported level of impairment pursuant to subsection (a). In addition to any impairment report submitted, the Commission may, by a preponderance of credible evidence, use the following

additional factors to determine disability: (i) the occupation of the injured employee; (ii) the age of the employee at the time of the injury; (iii) the employee's future earning capacity; and (iv) evidence of disability at maximum medical improvement corroborated by objective findings in the treating medical records and independent medical exams. In determining the level of permanent partial disability, the Commission may base its determination on a report of impairment, after considering by a preponderance of credible evidence, the additional factors to determine disability.

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

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

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

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

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

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

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

(1) In this Section:

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

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

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

"Health care services" means those CPT and DRG codes for procedures, treatments, products, services or supplies

for hospital inpatient, hospital outpatient, emergency room, ambulatory surgical treatment centers, accredited ambulatory surgical treatment facilities, and professional services. It does not include codes classified as healthcare common procedure coding systems or dental.

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

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

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

(2) The Commission shall establish and maintain fee schedules for procedures, treatments, products, services,

or supplies for hospital inpatient, hospital outpatient, emergency room, ambulatory surgical treatment centers, accredited ambulatory surgical treatment facilities, prescriptions filled and dispensed outside of a licensed pharmacy, dental services, and professional services. These fee schedule amounts shall be grouped into geographic regions in the following manner:

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

(i) Cook County;

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

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

(iv) All other counties of the State.

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

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

(ii) Kankakee County;

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

(iv) Winnebago and Boone Counties;

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

(vi) Champaign, Piatt, and Ford Counties;

(vii) Rock Island, Henry, and Mercer Counties;

(viii) Sangamon and Menard Counties;

(ix) McLean County;

(x) Lake County;

(xi) Macon County;

(xii) Vermilion County;

(xiii) Alexander County; and

(xiv) All other counties of the State.

If a geozip overlaps into one or more of the regions set forth in this Section, then the Commission shall average or repeat the charges and fees in a geozip in order to designate charges and fees for each region.

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

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

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

(B) Within 30 days after the Commission makes the determinations required by subdivision (3)(A) of this

subsection (a-1.5), the Commission shall determine an adjustment to be made to the workers' compensation maximum fee for each CPT and DRG code as follows:

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

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

(iii) If the Medicare percentage amount for that CPT or DRG code is greater than 150% but less than or equal to 225%, then the workers' compensation maximum fee for that CPT or DRG code shall be adjusted so that it equals the greater of (I) 150% of the most recent Medicare maximum fee for that CPT or DRG code or (II) 80% of the most recent workers' compensation maximum amount for that CPT or DRG code.

(iv) If the Medicare percentage amount for that CPT or DRG code is greater than 225% but less than or equal to 428.57%, then the workers' compensation maximum fee for that CPT or DRG code

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

(v) If the Medicare percentage amount for that CPT or DRG code is greater than 428.57%, then the workers' compensation maximum fee for that CPT or DRG code shall be adjusted so that it equals 275% of the most recent Medicare maximum fee for that CPT or DRG code.

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

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

(4) The Commission, as of September 1, 2018 and September 1 of each year thereafter, shall adjust the workers' compensation maximum fee for each CPT or DRG code to exactly half of the most recent annual increase in the Consumer Price Index-U.

(5) A person who believes that the workers' compensation maximum fee for a CPT or DRG code, as otherwise determined pursuant to this subsection, creates or would create upon implementation a significant limitation on access to quality health care in either a specific field of health care services or a specific geographic limitation on access to health care may petition the Commission to modify the workers' compensation maximum fee for that CPT or DRG code so as to not create that significant limitation.

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

The Commission shall take final action on each petition within 180 days of filing. The Commission may, but is not required to, seek the recommendation of the Medical Fee Advisory Board to assist with this determination. If the Commission grants the petition, the Commission shall

further increase the workers' compensation maximum fee for that CPT or DRG code by the amount minimally necessary to avoid creating a significant limitation on access to quality health care in either a specific field of health care services or a specific geographic limitation on access to health care. The increased workers' compensation maximum fee shall take effect upon entry of the Commission's final action."; and

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

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

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

on page 66, by replacing lines 1 through 15 with the following:

"(a-3) Prescriptions, other than custom compound medications, filled and dispensed outside of a licensed pharmacy shall be subject to a fee schedule that shall not exceed the Average Wholesale Price (AWP) plus a dispensing fee of $4.18. AWP or its equivalent as registered by the National Drug Code shall be set forth for that drug on that date as published in Medi-Span. Custom compound medications are governed by subsection (a-4).

(a-4) As used in this Section:

"Custom compound medication" means a customized medication prescribed or ordered by a duly licensed prescriber for the specific patient that is prepared in a pharmacy by a licensed pharmacist in response to a licensed prescriber's prescription or order by combining, mixing, or altering of ingredients, but not reconstituting, to meet the unique needs of an individual patient. A custom compound medication does not include a drug reconstituted pursuant to a manufacturer's direction nor does it include the sole act of tablet splitting or crushing, capsule opening, or the addition of a flavoring agent to enhance palatability.

A custom compound medication shall be approved for payment only if the custom compound medication meets all of the following standards:

(1) there is no readily available commercially manufactured therapeutically equivalent product;

(2) no other Food and Drug Administration-approved alternative drug or combination of readily available drugs is appropriate for the patient;

(3) the active ingredients of the custom compound medication each have a National Drug Code (NDC) number, are components of drugs approved by the Food and Drug Administration, and the active ingredients in the custom compound medication are being used to treat conditions for which the component drugs have been approved for use by the Food and Drug Administration;

(4) no component of the custom compound medication has been withdrawn or removed from the market for safety reasons; and

(5) the prescriber is able to demonstrate to the payer that the custom compound medication is reasonable and necessary.

The Average Wholesale Price (AWP) for the specific amount of each component, as identified by its National Drug Code (NDC) from the original labeler, shall be used to determine the maximum reimbursement of a custom compound medication meeting the standards of subsection (a-5). A single dispensing fee for a custom compound medication shall be based on the actual costs of preparing and dispensing the custom compound medication as determined by the Commission. The dispensing fee for a custom compound medication shall be billed with code WC 700-C.

This Section is subject to the other provisions of this Act including, but not limited to, Section 8.7.

The changes to this Section made by this amendatory Act of the 100th General Assembly apply to compounding medications provided on or after the effective date of this amendatory Act of the 100th General Assembly.

(a-5) Notwithstanding any other provision of this Section, on or before March 1, 2018 and on or before March 1 of each subsequent year, the Commission must investigate all procedures, treatments, and services covered under this Act for ambulatory surgical treatment centers and accredited

ambulatory surgical treatment facilities and establish fee schedule amounts for procedures, treatments, and services for which fee schedule amounts have not been established. The Commission must adopt, in a timely and ongoing manner, all rules necessary to ensure that its responsibilities under this subsection are carried out.

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

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

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

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

"Whether the employee is working or not, if the employee is not receiving or has not received medical, surgical, or hospital services or other services or compensation as provided in paragraph (a) of Section 8, or compensation as provided in paragraph (b) of Section 8, or if the employer has refused or

failed to respond to a written request for authorization of medical care and treatment, the employee may at any time petition for an expedited hearing by an Arbitrator on the issue of whether or not he or she is entitled to receive payment of the services or compensation or authorization of medical care. Provided the employer continues to pay compensation pursuant to paragraph (b) of Section 8, the employer may at any time petition for an expedited hearing on the issue of whether or not the employee is entitled to receive medical, surgical, or hospital services or other services or compensation as provided in paragraph (a) of Section 8, whether or not the employee is entitled to authorization of medical care and treatment, or compensation as provided in paragraph (b) of Section 8. When an employer has petitioned for an expedited hearing, the employer shall continue to pay compensation as provided in paragraph (b) of Section 8 unless the arbitrator renders a decision that the employee is not entitled to the benefits that are the subject of the expedited hearing or unless the employee's treating physician has released the employee to return to work at his or her regular job with the employer or the employee actually returns to work at any other job. If the arbitrator renders a decision that the employee is not entitled to the benefits or medical care that is ~~are~~ the subject of the expedited hearing, a petition for review filed by the employee shall receive the same priority as if the employee had filed a petition for an expedited hearing by an Arbitrator. Neither party shall be

entitled to an expedited hearing when the employee has returned to work and the sole issue in dispute amounts to less than 12 weeks of unpaid compensation pursuant to paragraph (b) of Section 8."; and

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

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

on page 131, by deleting lines 23 and 24; and

on page 131, line 25, by changing "(6)" to "(5)"; and

on page 132, line 2, by changing "(7)" to "(6)"; and

on page 132, line 12, by changing "(8)" to "(7)"; and

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

"(820 ILCS 305/29.3 new)

Sec. 29.3. Workers' Compensation Transparency Task Force.

(a) There is created the Workers' Compensation Transparency Task Force consisting of the following members:

(1) The Director of Insurance or his or her designee.

(2) The Chairman of the Illinois Workers' Compensation Commission or his or her designee.

(3) One member of the House of Representatives appointed by the Speaker of the House of Representatives.

(4) One member of the House of Representatives appointed by the Minority Leader of the House of Representatives.

(5) One member of the Senate appointed by the President of the Senate.

(6) One member of the Senate appointed by the Minority Leader of the Senate.

(b) The Task Force shall collect and review information and data on the effects of the changes in workers' compensation law enacted by the General Assembly. The purpose of the collection and review of information under this Section is to make as transparent as possible all information relating to the medical treatment and benefits paid to injured workers in this State.

(c) In order to enable the Task Force to complete its

purpose, insurers, advisory organizations, and medical providers involved in the provision of services to persons covered under the workers' compensation laws of this State shall report data and information to the Task Force on an annual basis.

(d) Insurers and advisory organizations shall report to the Task Force the information required to be reported under Section 29.2.

(e) Medical providers shall report workers' compensation information including, but not limited to, the following:

(1) Gross revenue attributable to workers' compensation care of injured workers.

(2) Expenses incurred in the medical treatment of injured workers.

(3) The number of patients treated with respect to workers' compensation claims.

(4) The time and resources expended on the medical treatment of injured workers.

(5) Complaints registered with the licensing authority for medical providers related to the treatment of injured workers relating to the workers' compensation laws.

(6) Profits made as a result of the medical treatment provided to injured workers.

(7) Any additional information that is determined by the Task Force to be necessary for the effective analysis of the effect of changes in workers' compensation laws.

(f) The Task Force shall report its findings to the Governor and General Assembly by March 31 of each year. The findings in the report shall be based upon the information reported to the Task Force by December 31 of the year preceding the date of the report.

(g) The Task Force shall end its collection of information on December 31, 2021 and issue its final report no later than March 31, 2022.

(h) A person or entity that fails to comply with the reporting requirements of this Section is subject to a civil penalty of $100 per day for each category of information required to be reported up to a maximum of $10,000. The Attorney General may bring an action to enforce the penalty authorized under this subsection. If a person or entity incurs more than $10,000 in penalties under this subsection, the license of the person or entity may be suspended.

(i) This Section is repealed on January 1, 2022.

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