HB2794

101ST GENERAL ASSEMBLY

State of Illinois

2019 and 2020

HB2794

by Rep. Dan Ugaste

SYNOPSIS AS INTRODUCED:

820 ILCS 305/8.2

Amends the Workers' Compensation Act in relation to custom compound medications. Sets forth conditions for approval of payment. Provides that charges shall be based upon the specific amount of each component drug and its original manufacturer's National Drug Code number and also upon specified criteria. Provides that a provider may prescribe a one-time 7-day supply unless a prescription for more than 7 days is preauthorized by the employer. Effective immediately.

LRB101 08360 JLS 53429 b

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

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

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

(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 Medi-Span ~~Medispan~~.
15 (a-4) As used in this Section:
16 "Custom compound medication" means a customized medication
17 prescribed or ordered by a duly licensed prescriber for a
18 specific patient that is prepared in a pharmacy by a licensed
19 pharmacist in response to a licensed prescriber's prescription
20 or order by combining, mixing, or altering of ingredients, but
21 not reconstituting, to meet the unique needs of a specific
22 patient.
23 (a-5) A custom compound medication for longer than the
24 one-time 7-day supply described in (a-6) shall be approved for
25 payment only if the compound meets all of the following
26 standards:

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

(2) no other Food and Drug Administration approved alternative drug is appropriate for the patient;

(3) the active ingredients of the compound each have a National Drug Code number, are components of drugs approved by the Food and Drug Administration, and the active ingredients in the custom compound medication are being used for diagnosis or conditions approved use by the Food and Drug Administration and not being used for off-label use;

(4) the drug has not been withdrawn or removed from the market for safety reasons; and

(5) the prescriber is able to demonstrate to the payer that the compound medication is clinically appropriate for the intended use.

(a-6) Custom compound medications shall be charged using the specific amount of each component drug and its original manufacturer's National Drug Code number included in the compound. Charges shall be based on a maximum charge of the AWP based upon the original manufacturer's National Drug Code number, as published by Red Book or Medi-Span and prorated for each component amount used. If the National Drug Code for the compound ingredient is a repackaged drug, the maximum allowable fee for the repackaged drug shall be determined by the National Drug Code and the average wholesale price of the underlying

original manufacturer. Components without National Drug Code numbers shall not be charged. A single dispensing fee for a custom compound medication as determined by the Commission based on the actual costs of preparing and dispensing the custom compound medication shall be paid. The dispensing fee for a compound prescription shall be billed with code WC 700-C. The provider may prescribe a one-time 7-day supply. Any custom compound medication prescriptions for more than 7 days shall be preauthorized by the employer. Under all circumstances, if the compound medication meets the requirements in (a-5), a 7-day supply shall be covered.

(a-7) This Section is subject to the other provisions of this Act including, but not limited to, Section 8.7.

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

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

1 (d) When a patient notifies a provider that the treatment,
2 procedure, or service being sought is for a work-related
3 illness or injury and furnishes the provider the name and
4 address of the responsible employer, the provider shall bill
5 the employer or its designee directly. The employer or its
6 designee shall make payment for treatment in accordance with
7 the provisions of this Section directly to the provider, except
8 that, if a provider has designated a third-party billing entity
9 to bill on its behalf, payment shall be made directly to the
10 billing entity. Providers shall submit bills and records in
11 accordance with the provisions of this Section.

12 (1) All payments to providers for treatment provided
13 pursuant to this Act shall be made within 30 days of
14 receipt of the bills as long as the bill contains
15 substantially all the required data elements necessary to
16 adjudicate the bill.

17 (2) If the bill does not contain substantially all the
18 required data elements necessary to adjudicate the bill, or
19 the claim is denied for any other reason, in whole or in
20 part, the employer or insurer shall provide written
21 notification to the provider in the form of an explanation
22 of benefits explaining the basis for the denial and
23 describing any additional necessary data elements within
24 30 days of receipt of the bill. The Commission, with
25 assistance from the Medical Fee Advisory Board, shall adopt
26 rules detailing the requirements for the explanation of

1 benefits required under this subsection.
2 (3) In the case (i) of nonpayment to a provider within
3 30 days of receipt of the bill which contained
4 substantially all of the required data elements necessary
5 to adjudicate the bill, (ii) of nonpayment to a provider of
6 a portion of such a bill, or (iii) where the provider has
7 not been issued an explanation of benefits for a bill, the
8 bill, or portion of the bill up to the lesser of the actual
9 charge or the payment level set by the Commission in the
10 fee schedule established in this Section, shall incur
11 interest at a rate of 1% per month payable by the employer
12 to the provider. Any required interest payments shall be
13 made by the employer or its insurer to the provider within
14 30 days after payment of the bill.
15 (4) If the employer or its insurer fails to pay
16 interest within 30 days after payment of the bill as
17 required pursuant to paragraph (3), the provider may bring
18 an action in circuit court for the sole purpose of seeking
19 payment of interest pursuant to paragraph (3) against the
20 employer or its insurer responsible for insuring the
21 employer's liability pursuant to item (3) of subsection (a)
22 of Section 4. The circuit court's jurisdiction shall be
23 limited to enforcing payment of interest pursuant to
24 paragraph (3). Interest under paragraph (3) is only payable
25 to the provider. An employee is not responsible for the
26 payment of interest under this Section. The right to

1 interest under paragraph (3) shall not delay, diminish,
2 restrict, or alter in any way the benefits to which the
3 employee or his or her dependents are entitled under this
4 Act.

5 The changes made to this subsection (d) by this amendatory
6 Act of the 100th General Assembly apply to procedures,
7 treatments, and services rendered on and after the effective
8 date of this amendatory Act of the 100th General Assembly.

9 (e) Except as provided in subsections (e-5), (e-10), and
10 (e-15), a provider shall not hold an employee liable for costs
11 related to a non-disputed procedure, treatment, or service
12 rendered in connection with a compensable injury. The
13 provisions of subsections (e-5), (e-10), (e-15), and (e-20)
14 shall not apply if an employee provides information to the
15 provider regarding participation in a group health plan. If the
16 employee participates in a group health plan, the provider may
17 submit a claim for services to the group health plan. If the
18 claim for service is covered by the group health plan, the
19 employee's responsibility shall be limited to applicable
20 deductibles, co-payments, or co-insurance. Except as provided
21 under subsections (e-5), (e-10), (e-15), and (e-20), a provider
22 shall not bill or otherwise attempt to recover from the
23 employee the difference between the provider's charge and the
24 amount paid by the employer or the insurer on a compensable
25 injury, or for medical services or treatment determined by the
26 Commission to be excessive or unnecessary.

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

15 (e-10) If an employer notifies a provider that the employer
16 will pay only a portion of a bill for any procedure, treatment,
17 or service rendered in connection with a compensable illness or
18 disease, the provider may seek payment from the employee for
19 the remainder of the amount of the bill up to the lesser of the
20 actual charge, negotiated rate, if applicable, or the payment
21 level set by the Commission in the fee schedule established in
22 this Section. Once an employee informs the provider that there
23 is an application filed with the Commission to resolve a
24 dispute over payment of such charges, the provider shall cease
25 any and all efforts to collect payment for the services that
26 are the subject of the dispute. Any statute of limitations or

1 statute of repose applicable to the provider's efforts to
2 collect payment from the employee shall be tolled from the date
3 that the employee files the application with the Commission
4 until the date that the provider is permitted to resume
5 collection efforts under the provisions of this Section.
6 (e-15) When there is a dispute over the compensability of
7 or amount of payment for a procedure, treatment, or service,
8 and a case is pending or proceeding before an Arbitrator or the
9 Commission, the provider may mail the employee reminders that
10 the employee will be responsible for payment of any procedure,
11 treatment or service rendered by the provider. The reminders
12 must state that they are not bills, to the extent practicable
13 include itemized information, and state that the employee need
14 not pay until such time as the provider is permitted to resume
15 collection efforts under this Section. The reminders shall not
16 be provided to any credit rating agency. The reminders may
17 request that the employee furnish the provider with information
18 about the proceeding under this Act, such as the file number,
19 names of parties, and status of the case. If an employee fails
20 to respond to such request for information or fails to furnish
21 the information requested within 90 days of the date of the
22 reminder, the provider is entitled to resume any and all
23 efforts to collect payment from the employee for the services
24 rendered to the employee and the employee shall be responsible
25 for payment of any outstanding bills for a procedure,
26 treatment, or service rendered by a provider.

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

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

23 (g) On or before January 1, 2010 the Commission shall
24 provide to the Governor and General Assembly a report regarding
25 the implementation of the medical fee schedule and the index
26 used for annual adjustment to that schedule as described in

1 this Section.
2 (Source: P.A. 100-1117, eff. 11-27-18; 100-1175, eff.
3 1-11-19.)

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