

HB1544



103RD GENERAL ASSEMBLY

State of Illinois

2023 and 2024

HB1544

Introduced 1/31/2023, 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.

LRB103 05097 SPS 50111 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
16 hospital charges and fees as of August 1, 2004 but not earlier
17 than August 1, 2002. These charges and fees are provider
18 billed amounts and shall not include discounted charges. The
19 80th percentile is the point on an ordered data set from low to
20 high such that 80% of the cases are below or equal to that
21 point and at most 20% are above or equal to that point. The
22 Commission shall adjust these historical charges and fees as
23 of August 1, 2004 by the Consumer Price Index-U for the period

1 August 1, 2004 through September 30, 2005. The Commission
2 shall establish fee schedules for procedures, treatments, or
3 services for hospital inpatient, hospital outpatient,
4 emergency room and trauma, ambulatory surgical treatment
5 centers, and professional services. These charges and fees
6 shall be designated by geozip or any smaller geographic unit.
7 The data shall in no way identify or tend to identify any
8 patient, employer, or health care provider. As used in this
9 Section, "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
17 the geozip with up to 4 other geozips that are demographically
18 and 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

1 that state's fee schedule amount or the fee schedule amount
2 for the region in which the employee resides. If no fee
3 schedule exists in that state, the provider shall be
4 reimbursed at the lesser of the actual charge or the fee
5 schedule amount for the region in which the employee resides.
6 Not later than September 30 in 2006 and each year thereafter,
7 the Commission shall automatically increase or decrease the
8 maximum allowable payment for a procedure, treatment, or
9 service established and in effect on January 1 of that year by
10 the percentage change in the Consumer Price Index-U for the 12
11 month period ending August 31 of that year. The increase or
12 decrease shall become effective on January 1 of the following
13 year. As used in this Section, "Consumer Price Index-U" means
14 the index published by the Bureau of Labor Statistics of the
15 U.S. Department of Labor, that measures the average change in
16 prices of all goods and services purchased by all urban
17 consumers, U.S. city average, 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
11 forth in this Section, then the Commission shall average
12 or 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
15 than 9 charges or fees for a procedure, treatment,
16 product, supply, or service or where the fee schedule
17 amount cannot be determined by the non-discounted charge
18 data, 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
24 with 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
13 the 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
6 be 70% of the fee schedule amounts, which shall be adjusted
7 yearly by the Consumer Price Index-U, as described in
8 subsection (a) of this Section.

9 (a-3) Prescriptions filled and dispensed outside of a
10 licensed pharmacy shall be subject to a fee schedule that
11 shall not exceed the Average Wholesale Price (AWP) plus a
12 dispensing fee of \$4.18. AWP or its equivalent as registered
13 by the National Drug Code shall be set forth for that drug on
14 that 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 subsection (a-6) shall be
25 approved for payment only if the compound meets all of the
26 following standards:

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

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

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

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

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

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

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

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

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
20 Index-U increase or decrease for that specific field or
21 specific geographic limitation on access to health care to
22 address that 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) When a patient notifies a provider that the treatment,
3 procedure, or service being sought is for a work-related
4 illness or injury and furnishes the provider the name and
5 address of the responsible employer, the provider shall bill
6 the employer or its designee directly. The employer or its
7 designee shall make payment for treatment in accordance with
8 the provisions of this Section directly to the provider,
9 except that, if a provider has designated a third-party
10 billing entity to bill on its behalf, payment shall be made
11 directly to the billing entity. Providers shall submit bills
12 and records in accordance with the provisions of this Section.

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

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

1 adopt rules detailing the requirements for the explanation
2 of benefits required under this subsection.

3 (3) In the case (i) of nonpayment to a provider within
4 30 days of receipt of the bill which contained
5 substantially all of the required data elements necessary
6 to adjudicate the bill, (ii) of nonpayment to a provider
7 of a portion of such a bill, or (iii) where the provider
8 has not been issued an explanation of benefits for a bill,
9 the bill, or portion of the bill up to the lesser of the
10 actual charge or the payment level set by the Commission
11 in the fee schedule established in this Section, shall
12 incur interest at a rate of 1% per month payable by the
13 employer to the provider. Any required interest payments
14 shall be made by the employer or its insurer to the
15 provider within 30 days after payment of the bill.

16 (4) If the employer or its insurer fails to pay
17 interest within 30 days after payment of the bill as
18 required pursuant to paragraph (3), the provider may bring
19 an action in circuit court for the sole purpose of seeking
20 payment of interest pursuant to paragraph (3) against the
21 employer or its insurer responsible for insuring the
22 employer's liability pursuant to item (3) of subsection
23 (a) of Section 4. The circuit court's jurisdiction shall
24 be limited to enforcing payment of interest pursuant to
25 paragraph (3). Interest under paragraph (3) is only
26 payable to the provider. An employee is not responsible

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

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

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

1 Commission to be excessive or unnecessary.

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

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

1 charges, the provider shall cease any and all efforts to
2 collect payment for the services that are the subject of the
3 dispute. Any statute of limitations or statute of repose
4 applicable to the provider's efforts to collect payment from
5 the employee shall be tolled from the date that the employee
6 files the application with the Commission until the date that
7 the provider is permitted to resume collection efforts under
8 the provisions of this Section.

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

1 the services rendered to the employee and the employee shall
2 be responsible for payment of any outstanding bills for a
3 procedure, treatment, or service rendered by a provider.

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

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

26 (g) On or before January 1, 2010 the Commission shall

1 provide to the Governor and General Assembly a report
2 regarding the implementation of the medical fee schedule and
3 the index used for annual adjustment to that schedule as
4 described in this Section.

5 (Source: P.A. 100-1117, eff. 11-27-18; 100-1175, eff.
6 1-11-19.)

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